

**BOURNEMOUTH UNIVERSITY**  
**THE FACULTY OF HEALTH AND SOCIAL SCIENCES**

**Barriers and enablers to new and different ways of  
working in dysphagia care**

by

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## **Abstract**

### **Barriers and enablers to new and different ways of working in dysphagia care**

**Elizabeth Roberts**

In this research, the barriers and enablers to new and different ways of working and role extension in dysphagia care were explored using the grounded theory approach described by Corbin and Strauss (2008). Despite calls for new and innovative ways of providing clinical care, including role extension, researchers have pointed to slow progress amongst Allied Health Professionals (AHPs). Barriers to change that have been identified include professional resistance. Role extension in the field of dysphagia care has made very little progress. The purpose of the research was to construct a substantive theory to help explain the process of role extension in the field of dysphagia care and associated nutrition and detail the enabling conditions and the barriers to these new and different ways of working.

In order to explore the process of role extension, data were collected in two phases using semi-structured interviews. The first phase identified the initial theoretical categories and theoretical model; the second phase further developed these categories and refined the theoretical model. Data were collected from two main research settings, with additional data collected from the respective professional bodies and other areas that had initiated role extension. The two main research settings were: an acute and a community care site with limited role expansion in dysphagia, and a combined community and acute Trust with a nationally celebrated programme of role expansion for nurses. Participants included dietitians (n=10), SLTs (n=15), assistant staff (n=2), nurses and other health care professionals (n=8), service users and their carers (6 interviews, n=12), commissioners (n=3) and service managers (n=6).

The model and theory developed from the analysis was a shift in the perception and definition of explicit and tacit skills and knowledge. The model that was constructed describes how the professional groups in the domain manipulated this line in order to retain or relinquish professional control over the area.

The substantive theory and model developed from this research provides an insight into both how and why professionals at the frontline of dysphagia care in the research settings studied use the tacitness or explicitness of clinical knowledge and skills to retain, or relinquish, control over the clinical area, thus allowing or preventing role extension. Future research may identify that the concepts identified in this research also have applicability in other clinical settings and between other clinical groups.

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## Authors' Declaration

I, **Elizabeth Roberts**, declare that this thesis, entitled '**Barriers and enablers to new and different ways of working in dysphagia care**' and the work presented in the thesis are both my own and have been generated by me as the result of my own original research. I confirm that:

- This work was done wholly or mainly while in candidature for a research degree at this University;
- Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- Where I have consulted the published works of others, this is always clearly attributed;
- Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- The developing theoretical model presented in Figure 10 (page 99) was presented as a poster at the European Healthcare Management Association Annual Conference June 2013. No other parts of this work have been published before submission.

**Signed:** .....

**Date:** .....

## Chapter 1 INTRODUCTION

### 1.1 Background to this research

My first role in the National Health Service (NHS) was as a ward dietitian in an acute hospital, caring for adults with swallowing difficulties (dysphagia). Later, I moved to a community post caring for adults receiving artificial nutrition at home.

It was my observation that there was significant overlap in the roles between the different professionals involved in people's care and that, over time, we developed expertise in each others' field of work. There were usually three types of practitioners involved in the care of this patient group: the nutrition nurses looking after the tubes and skin, the Speech and Language Therapists (SLTs) managing their dysphagia, and the dietitian, who would advise on nutritional requirements, calorie intake and prescribe the artificial feed and supplements. We spent a considerable amount of time liaising with one another, either in the form of reports and letters, or passing around messages and referring back to each other. Living in a rural area, a large proportion of our clinical time was also spent travelling to assess and review patients.

Patients and their carers would often ask me for advice about what to eat and drink in terms of the dietary textures. I was not able to provide an answer, as this was not my role, and instead, referred them back to their SLT. This seemed an inefficient way of working, particularly as our caseloads were growing.

I recollect a number of instances that demonstrate this issue. The first was a phone call from the company nurse, asking me to prescribe an extra 20 ml of water to flush a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube; the second, an SLT asking me to review a patient, at home, because she felt he needed an extra 200 ml water. 'Surely skilled professionals could make a judgement about these minor changes?' I asked myself. This coincided with an incident in our department, when I was on annual leave, and a patient was given telephone advice by a dietitian colleague covering in my absence. The information turned out to be incorrect, as my dietetic colleague no longer worked in the field of nutrition support and so, was no longer up-to-date with the area. The nutrition nurse, however, although not technically authorised to advise on feed and fluid regimens, would have known what to do. I was on leave as my grandfather was ill, with some swallowing difficulties. The cause of his swallowing difficulty turned out to be benign, little more than oral thrush, but I remember thinking that if it were *him* who had telephoned the department for advice, I would rather that the nutrition nurse had advised him.

Patient reviews and response times were falling behind and staff put under increasing pressure. Our response to this situation was to request an increase in funding to meet the demand. Whereas these requests were met at the time, it seemed clear when embarking on the PhD that ever increasing funding was not going to be the longer term solution to the growing demand for health care in the UK (Appleby et al. 2009; DH 2009). Today, we can see that rising NHS funding on a par with post-2000 is almost certainly unlikely (Appleby 2013).

## **1.2 Initial steps towards extended scope practice**

In an attempt to improve the efficiency of the home tube feed service, I started to learn about tube care. Over time I was able to assess, change and generally advise on care for feeding tubes. This became part of my routine visits and reviews. Despite some resistance from colleagues locally, this approach was not uncommon, with several other dietitians in the country also extending their role to include tube care. It was well received by the nutrition nurse, as it freed up her time. She no longer had to visit the patient to perform routine tube reviews and therefore had greater capacity to respond to more urgent requests. She was also able to provide staff training on day-to-day tube care in care homes, enabling them to manage the tubes better, thus preventing some urgent review requests.

Following this success, I made tentative enquiries about extending my role to include dysphagia management. This culminated with me successfully completing the Manchester Post-Basic Dysphagia course in 2008. This post-qualifying course was at the time one of two or three available nationally that SLTs would complete to enable them to manage dysphagia. I was the first dietitian to complete the course in the UK, and I thought this would enable me to play a greater role in dysphagia management during my patient reviews, as I had done with tube care.

## **1.3 Meeting professional resistance to practice**

To my surprise, I was unable to start including some dysphagia management within my practice. Despite government policy extolling the potential benefits of extended scope practice, and the success that I had experienced taking a role in tube care, professional resistance barred me from practising dysphagia care. Although many practitioners locally supported the approach, and indeed had helped provide case studies for the dysphagia course, service managers and many staff were opposed to the idea. Indeed, after completing the dysphagia course, my professional body, the British Dietetic Association (BDA), passed me queries from other dietetic colleagues facing the same resistance. I was unable to help them in any other way other than to pose the question through this PhD.

The issues raised by SLT colleagues opposed to the idea, expressed during my attempts to introduce extended scope of practice in Somerset, fell into the following general categories:

- It is not your role, it is ours. The different professions exist for a reason. You are “empire building” for your own profession. It is inconsiderate to step on the toes of another profession(al).
- You will “do us out of a job”. We have newly qualified staff who cannot find work.
- “They” will employ fewer staff if one person could do everything. “They” will cut our funding.
- You do not have the right/ same background and skills as speech and language therapists and therefore the knowledge around the anatomical structures.
- How would we manage clinical responsibility if a patient is referred to us, but seen by a different profession?
- How would we manage operational issues, such as annual and maternity leave? These things tend to die a death when somebody keen leaves a department.

I was met with similar resistance from my own profession when exploring whether SLTs could take on some of the role of the dietitian in a reciprocal fashion. This resistance did not appear to be an exclusive phenomenon of either profession. The vehement resistance was incomprehensible to me, as more flexible ways of working and managing our caseloads seemed to be a solution to ever increasing demands on our services, and on us as professionals. It also appeared that, by providing a “one-stop” service, users of the services would have their queries answered in a more holistic way. Duplication in the services would also be reduced, thereby improving efficiency and releasing time to provide care, as it had for the nutrition nurse.

#### **1.4 The changing demands on health care and implications for current practice**

Shortages of health care workers globally (Dubois and Singh 2009) are necessitating new ways of providing health care and the boundaries “between and within groups” (Huby et al. 2014, p. 401). It is recognised that not getting skill mix right can result in the misuse, overuse and underuse of available workers (Dubois and Singh 2009). In many countries, health care workers may not be employed effectively (White et al. 2008).

Referring to the need for more effective working practices, Larkin (2002) suggests:

“...with regard to health professions, it has become transformed into calls for a redrawing of professional boundaries and identified as part of the project of modernizing health care...” (Larkin 2002, p. 127)

The NHS has attempted to introduce role revision in various forms, such as skill mixing and extending roles, to curb rising health care costs while maintaining quality of care (Currie, Finn and Martin 2010). As the NHS entered a “cold climate” of funding growth post-2008 (Appleby et al. 2009), it has become increasingly clear that significant further investment in clinical staff to meet the rising demand for health care is an unlikely solution for the future (DH 2009; NHS England 2014). Trede and Higgs (2008) suggest that in many areas of health care practice, including speech pathology, there is a movement towards: “dual community and professional expectations of a more market-based approach” (p. 47). There was, and is, therefore a need for clinical services to consider new and different ways of working to manage demand, increase productivity and meet the expectations of improved quality of care with limited resources (Royal College of Nursing 2012). The health policy trend continues, since the start of this research, to be “committed to breaking down traditional divides and professional silos”, with “patients having to visit multiple professionals for multiple appointments” (NHS England, 2014, p.8). This need applies to both health and social care services (Skills for Care 2011).

One way in which these challenges may be addressed is by reviewing the process of patient care along a pathway and the skills of clinical staff (Appleby et al. 2010). This is happening in many areas, particularly in shifting elements of care from more expensive doctors on to less expensive nurses, Allied Health Professions (AHPs) and physician assistants (Laurant et al. 2010). The Cavendish Review (2013b) noted that some Health Care Assistants (HCAs) are now doing jobs that used to be the preserve of nurses, even doctors:

“The Review met a group of healthcare assistants from a busy A&E who are inserting intravenous (IV) drips, taking blood and plastering. Yet they are paid at three levels below a newly qualified nurse.” (p. 6)

Reviewing the steps of a process and staff skills to improve efficiency is not a new phenomenon and has been used extensively in industries such as car manufacturing (Womack et al. 2007). The NHS Institute for Innovation and Improvement produced tools based on principles from other industries, such as the Productive Series. These tools were designed to bring process review to care systems and pathways, reducing

duplication and other inefficiencies, thereby “Releasing Time To Care” (NHS Institute 2010).

Despite the opportunities for revision of tasks and roles, the evidence base for extended roles across all professions is limited. In reality, the urgent need for these changes has meant that clinical practice is advancing more rapidly than academic knowledge (Laurant et al. 2010). Several authors have called for a better understanding of the benefits of extended roles and role revision (McPherson et al. 2006; Laurant et al. 2010).

Another key factor in considering different ways of working are the social, organisational and professional elements of accepting and leading such change. Authors have called for more research to better understand professional attitudes to role revision and extended scope practice, as well as the barriers and enablers to adopting revised roles (McPherson et al. 2006; Laurant et al. 2010).

“Although professional dominance...is seen as antithetical to the demands of modern healthcare, moves towards its displacement are currently very slow.”  
(Larkin 2002, p. 133)

Given the resistance that I met in extending my own clinical role, understanding the barriers and enablers to adopting new and different ways of working is a crucial aspect of the success, or not, of national initiatives.

### **1.5 Using dysphagia care in stroke as a model**

Dysphagia is taken from the Greek, meaning a disorder of eating. Today, we use the term in clinical practice to refer to a disorder of swallowing. Dysphagia can result in either penetration, the entry of bolus matter into the trachea (airway) but not passing below the vocal folds, or to aspiration, the entry of bolus matter into the trachea past the level of the vocal folds and thus into the lungs (Robbins et al. 2007).

Dysphagia care in stroke is considered less complex than many other areas of dysphagia and nutritional care and therefore lends itself more readily to extended scope practice. Although it has been reported that as many as 50% of those with newly diagnosed stroke have ongoing swallowing difficulties (Bath et al. 1999), dysphagia in stroke usually resolves spontaneously (Mann et al. 1999). Dysphagia in stroke also usually improves rather than deteriorates (Carnaby et al. 2006) and is not complicated by tumours and/or the presence of tubes for artificial ventilation. From a nutritional point of view, the priority for dysphagic stroke survivors in the initial phase is to ensure adequate hydration and nutrition (Royal College of Physicians 2008). For these

reasons, and in order to meet targets set by the Royal College of Physicians (RCP) guidelines, National Sentinel Stroke Audits and the National Institute for Health and Care Excellence (NICE), dysphagia screening in stroke is now performed by nurses in many parts of the country. Thus, role extension in dysphagia care in the area of stroke is the most advanced area of extended practice in dysphagia care and has been practised for some time (Daniels et al. 2012).

“...almost all of the assumptions and treatment models applied in patients with OPD come from early descriptions of post-cerebrovascular accident (CVA) dysphagic patients.” (Campbell-Taylor 2008)

The highest prevalence of dysphagia (approximately 65%) is attributed to acute stroke (Smithard 1996; Mann et al. 2000). There is therefore a good understanding amongst practitioners and a long precedent in the clinical area (Davies 2002; Smithard et al. 1997).

Stroke survivors were therefore chosen as the research focus to explore the research questions, due to the less complex nature of dysphagia in stroke and the opportunities for extended scope practice in this area.

## **1.6 My role as clinician and researcher**

The research presented here aims to address the problem of how clinical services are provided, derived from my own experience in the field. While this dual position as researcher and practising clinician may confer some benefits, such as identifying the problems of everyday clinical practice, it is also a challenging one. Firstly, it can create assumptions in me, assumptions about what might work and what the problem is, as viewed from my own perspective and experience of practice (Charmaz 2011, Altheide and Johnson). I attempted to address this in part through reflexivity and by capturing my assumptions, described in Chapters 4 and 5. A second difficulty is in how to approach those who I am researching, as a researcher, while also still a practising clinician in the field. This was not an issue I had realised I would encounter before embarking on the research itself.

Many staff participants, especially SLTs and dietitians, knew I was a practising dietitian. Some asked me directly. Others knew of my background through the gatekeeper. Other clinical and commissioning staff seemed less interested in my background and addressed me as a researcher. Sometimes I used my background to gain rapport – this is particularly evident in some of the interview recordings, where I laugh and joke with participants about common problems that face the professions/ clinicians generally/ the NHS. Karnieli-Miller, Strier and Pesach (2009) refer to the need to create an “anti-

authoritative” (p. 281) and informal atmosphere to enable participants to open up and “share personal experiences and beliefs” (p. 281).

In order to manage this position as co-worker and researcher, and particularly to avoid interviews focussing on professional viewpoints, I felt that I had to set the tone at the outset of each interview. At the very beginning of each interview, I emphasized that I may need to clarify “for the purposes of the recording and the research”, any professional terms used. I felt that this approach helped to set the tone of the encounter as a research interview, rather than a professional conversation, reminding participants of the nature of the interview as part of a research study (Karnieli-Miller, Strier and Pesach 2009).

Karnieli-Miller, Strier and Pesach (2009) refer to the inherent power imbalance between researcher and participant in qualitative interview research specifically in health care settings, where the participant is introduced to the researcher through a clinical gatekeeper. Participants may perceive this power imbalance, “despite the interviewer’s deliberate attempt to shed off power to appear less powerful” (Anyan 2013). Service users did not know my professional background before I met them. Again, some asked. On three occasions I was asked specific clinical questions. In each case, I politely suggested that they should discuss this with their clinician. On one occasion, a service user complained that nobody would tell her whether her swallow would recover. I felt it was unethical to not offer some compassionate words in this case, and suggested that staff were probably not withholding information from her, but that is it just impossible to predict who, and to what degree, each person will be able to swallow again.

### **1.7 Definitions used throughout this thesis**

My initial research proposal used the term Extended Scope Practitioner (ESP). At the time of proposing the research study, ESP was something of a “buzzword”, as a result of a policy drive towards extended roles through the NHS Plan (DH 2000a). It became used in many areas of practice, for example ESP physiotherapists and GPs with a special interest (GPwSI) (DH 2000b; DH 2002b). One of the problems found with these new and specialised roles, was further “silo working” and, in the case of GPwSIs, little evidence of reduced costs (Royal College of General Practitioners 2013). It is increasingly recognised that a health care workforce fit for the future must move away from:

“...an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach.” (NHS England 2014, p.30).

Although maintained in many areas, (for example, job vacancies for ESP physiotherapists are regularly posted, and the Chartered Society of Physiotherapy hosts an ESP network), ESP-specific roles have fallen somewhat out of fashion. As the direction of health policy in this area has changed, I now use the terms role extension or role revision. These terms describe an extension to the existing role of the clinical area or a revision of the type of worker performing a task. This is in keeping with the philosophy of “disruptive innovation” (Christensen 2009). According to “disruptive innovation”, as tasks become routine, they will naturally be passed down to less skilled workers and/ or automated. This change can be seen in nursing. In recent years, many tasks previously performed by doctors have been passed down to trained nurses, who in turn have passed many previously trained nursing tasks down to health care assistant (non-nursing trained) staff (see for example, Duffield et al. 2014), without necessarily an increase in pay. Throughout this thesis the terms role extension and role revision will therefore be used, although the reader will note that my initial literature review used the term ESP.

## **1.8 Overview of the thesis**

In Chapter 2 the reader will be guided through a review of the academic and health policy literature regarding extended scope practice in dysphagia care. Gaps in our knowledge of the subject will be identified and the questions that this research aims to bridge will be posed.

In Chapter 3, I will outline the methodological approach taken for the study, the reasons for the methodological choices that were made and how these choices were best suited to answer the research questions posed.

The methods used to address the research questions are presented in Chapters 4 and 5. In Chapter 4 I describe the methods used during the first phase of the research. In Chapter 5 I describe the methods used during phase 2.

The findings of the research are then presented in Chapters 6, 7 and 8. Chapter 6 presents the theoretical model and substantive theory constructed through this research. This chapter also describes in detail the factors maintaining the status quo (the barriers to change).

Chapter 7 explores the conditions required to ignite the shift, or change. These conditions can also be described as the enabling factors. Chapter 8 concludes the findings of the research by exploring the factors sustaining the change in the theoretical model.

The thesis concludes with a discussion of the key findings of this research in Chapter 9. In this chapter I will also evaluate the quality of the study and identify strengths and weaknesses that the reader may wish to consider. I conclude this chapter with recommendations that follow the findings and areas for future research.

I shall begin by presenting the reader with a review of the literature in the field in the next chapter.

## Chapter 2 LITERATURE REVIEW

### 2.1 Introduction

The research presented in this thesis uses grounded theory as the research methodology, which I will describe in more detail in Chapters 3 and 4. As Clarke (2005) states:

“In a traditional grounded theory study, the key or basic social process is typically articulated... Around this basic process, the analyst then constellates the particular and distinctive conditions, strategies, actions, and practices engaged in by human and nonhuman actors involved with/ in the process and their consequences.” (p. xxxii)

Thus, the purpose of grounded theory research can be said to inductively “...form a theory of the substantive area...” (Clarke 2005, p. xxxi) that explains the conditions, actions and interactions engaged in by actors in a substantive area, thus generating theory that explains the social process in the substantive area.

### 2.2 The role of the literature review in grounded theory

The role of the literature review remains a topic of debate in grounded theory research (McGhee et al. 2007). It is argued that knowledge of the subject area may develop assumptions in the researcher. The data that are then collected may be ‘forced’ into existing theory, rather than allowing key themes to emerge. Corbin and Strauss (2008) suggest that:

“..there is no need to review all of the literature in the field beforehand....It is impossible to know prior to the investigation what salient problems or what relevant concepts will be derived (p. 35) from this set of data....Also, the researcher does not want to be so steeped in the literature that he or she is constrained and even stifled by it.” (p. 36)

For many researchers, myself included, one cannot help but already be fairly familiar with the literature in the area of study, this being the area of one’s work. In addition to this, ordinarily a literature review will be expected to satisfy a research ethics committee. Dey (1999) suggests that the initial propositions of Glaser and Strauss (1967) did not recommend ignoring the literature completely, but rather:

“...the researcher had to explore evidence in its own terms rather than immediately fitting it into some preconceived framework.” (p. 4)

### **2.3 Literature reviewed for this study**

I reviewed the literature prior to constructing the research design and conducting the research. The decision to use the grounded theory approach to answer the research questions was therefore made after I had already performed an initial literature review. As Corbin and Strauss state:

“Before beginning a project, a researcher can turn to the literature to formulate questions for initial observations and interviews...” (p. 38)

As data collection and analysis progressed, I remained up-to-date with the literature in the field by returning to new literature using the search terms of the original review. After completing the research itself, and having constructed a substantive theory addressing the research questions posed, I performed a second literature review. This time, the review focussed on the terms and concepts of the developing theoretical model to assess whether, and to what extent, this substantive theory supported, extended or challenged existing literature and theory in the field. This is not presented as a literature review, but will contribute to discussion of the research findings in Chapters 6, 7 and 8.

Throughout the research process, I continued to keep up-to-date with developments in the area of dysphagia care. This was partly necessary due to my clinical work, but also to remain credible with research participants.

In this Chapter, I will present the literature identified before data collection and analysis first, followed by that identified as the research progressed. I will also describe the process of identifying literature relating to the theoretical model constructed. As I present the findings of the research itself (Chapters 6-8), I will weave the literature that I discovered into the story where this informs the work that I present.

### **2.4 Literature identified before data collection**

At the start of this research journey, I initially considered a quantitative experiment, comparing dietitians and SLTs for outcomes in terms of dysphagia assessment and management. I assumed that the reason for a lack of role expansion in the area was due to evidence of adverse outcomes, or from the lack of evidence of any benefits. I therefore conducted a literature review, described below, hoping to identify any gaps that I would then aim to answer through my research, and thus influence a change in practice.

## **2.5 The process of the initial literature review**

I reviewed the literature regarding the feasibility of role extension in the area of dysphagia care between SLTs and dietitians. I included the databases that were available at that time through the Athens collaboration, namely EMBASE, MEDLINE, The Cumulative Index to Nursing and Allied Health Literature (CINAHL), British Nursing Index (BNI) and Allied and Complementary Database (AMED), for the years 1985 to 2008. As this initial literature review, performed in 2009, revealed only two studies comparing dietitians and SLTs (outlined below), I expanded the search to include extended scope dysphagia practice between other Allied Health Professional groups (such as Occupational Therapists), as well as position statements, practice papers and conference proceedings. Although these papers merely describe clinical practice and practice developments, they were included, in order to have some direction to the research topic. I also included papers that could shed light on the feasibility of role extension between SLTs and dietitians that I identified during this review in reference lists or that had cited papers already identified, but which had not appeared through the free text or MeSH terms. An example of this is Bateman et al. (2007). This is a survey of dysphagia assessment practice between SLTs in the UK and Ireland, which describes the degree of training SLTs receive in order to become competent in dysphagia management.

In addition to the feasibility of role extension between dietitians and SLTs, I sought to review the literature relating to role extension more broadly in health care. As Sibbald et al. (2004) report, this is a difficult area to access, as:

“...there are no search strategies that are both sensitive (identify all relevant material) and specific (exclude irrelevant material).” (p. S1:34)

I immediately discovered a systematic and robust review of reviews into changing the skill mix of the health care workforce (Sibbald et al. 2004). I also identified a systematic review, commissioned by the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) that specifically reviewed the range of extended roles for allied health practitioners and the effectiveness of those roles (McPherson et al. 2004, 2006). Finally, as I was reviewing research methodology and constructing the research proposal, I was made aware of a further robust systematic review that was published during that time (Laurant et al. 2010). I also included a scoping paper, published in 2001, which explored the extent of extended roles in the UK NHS (Read et al. 2001) and which identified some of the barriers to role extension. Most importantly, one of the project teams of this scoping exercise had focussed specifically on extended AHP roles.

In light of these robust reviews, I did not systematically review the literature pertaining to role extension, but did use the information from these reviews regarding barriers and enablers to frame the research questions and design the Interview Schedules for the first phase of the research. The Interview Schedules were necessarily broad, as the identified barriers and enablers had been broadly framed in Read et al. (2001), McPherson et al. (2004) and Laurant et al. (2010). Additionally, I anticipated that the focus of each interview would change soon after data collection started as codes started to emerge.

I used the population, intervention, comparator and outcome (PICO) process to identify studies comparing dietitians and SLTs in the field of dysphagia assessment (Appendix 1). I used the same process to identify studies relating to extended scope practice in dysphagia care and in health care more generally (also to be found at Appendix 1). The search strategy focussed on the following four areas:

1. Is it feasible for dietitians (population) to extend their scope of practice (intervention) into dysphagia care (outcome)?
2. Is it feasible for Speech & Language Therapist (SLTs) (population) to extend their scope of practice (intervention) into nutritional management (outcome)?
3. Are there any benefits (outcome) to extended scope practice (intervention) in health care (population)?
4. Are there any drawbacks (outcome) to extended scope practice in health care (intervention)?

Relevant studies were identified through a literature search encompassing the years 1985 to 2008. The literature search combined search terms and MeSH headings in the title or abstract using Boolean operators, as described in Appendix 1. Truncation was used to widen the search results.

MeSH headings included: "dietitian", "dietician", "dietetics", "diet therapy" or "dietary services", "dysphagia", "swallow\*", "deglutition" or "deglutition disorders", "speech-language pathology", "speech therap\*" or "speech patholog\*", "nutrition\*", "nutrition disorders", "nutrition services", "diet" or "geriatric nutrition", "Healthcare" and "Health Care".

I used free text search for terms where there were no appropriate and accurate MeSH headings: "extended role\*" and "extended scope", "benefit" (as MeSH headings

referred to cost-benefit analysis), “drawback\*” and “drawback” (as MeSH headings referred to cultural deprivation).

The search was limited to: “Human”, Adults (18+, definition dependent on database) and Aged (18 – 65+ years) and included “All languages”. Hand searching of the bibliographies of the included studies was conducted to identify potential articles not recovered using the search terms. I accepted the authors’ definitions and assessments of both dysphagia, dietitian and Speech & Language Therapist or Pathologist. This initial review was broad, and any articles which may have described the professional roles in the main body of the text were initially included. As a description of the roles in clinical practice was sought, this included conference proceedings and opinion papers.

This process was repeated in two steps in order to identify existing literature regarding extended scope practice in dysphagia care and in health care generally (Appendix 1).

All abstracts of retrieved papers were scanned and the full article obtained for those which were deemed relevant.

## **2.6 The influence of the literature on this research study**

It is without doubt that the literature that I reviewed prior to the study influenced both the research design and data collection. I started my journey questioning the feasibility of dietitians and SLTs extending their roles into the others’ domain. The literature review demonstrated that this was probably feasible. It also raised the question of the efficacy of dysphagia assessment and therapy, and inter-rater agreement amongst SLTs. It is also likely that developing trends influenced data collection and analysis as the research progressed over two years. For example, in the time since the initial literature review, the trend has moved away from considering extended scope practitioners in the health care arena (Stanhope et al. 2012; Saxon, Gray and Oprescu 2014; Mavrommatis 2015), towards the delegation of tasks to nursing and assistant staff (Ilott et al. 2010; Traynor, Nissen and Buus 2015; Colombo et al. 2011). These factors will have played some role both in what I ‘saw’ and looked for in the data, and the interpretation that I placed in analysis.

Since commencing the PhD, I have held non-clinical secondment roles. Through this, I was exposed to organisational theory literature, a body of literature beyond the healthcare-focussed literature that I had reviewed. I had taken an active decision to not review this literature ahead of data collection, to avoid ‘framing’ data analysis and collection by being overly aware of current theory and thereby ‘forcing’ the data into existing models. I aimed to account for, and manage as best I could, the influence of

new developments, as well as developing trends and further literature, by remaining aware and open to the influence of the literature on my research. I regularly reflected on the impact of the literature and captured the influence of this in reflective memos.

I will now present the findings of this initial review as a narrative account.

## **2.7 What is dysphagia?**

Dysphagia is the inability to effectively chew and swallow food and fluids, while protecting the airway from penetration with bolus matter (Cichero 2006). This requires careful co-ordination of neurological features with musculature and other soft tissue involved in the swallowing process, all of which can be compromised by a variety of clinical conditions. This can be attributed to the normal aging processes, it can result from structural abnormalities, such as tumours, or it can be the result of neurological conditions affecting the co-ordination of the anatomical structures (Cichero 2006).

Neurological conditions that can cause such impairments in the adult population include stroke and head injury, progressive neurological conditions, such as Alzheimer's disease, multiple sclerosis, motor neurone disease, Huntington's disease, Parkinson's disease and the neurological effects of some learning disabilities (Cichero 2006).

Dysphagia affects as many as 40% of stroke survivors and can result in recurrent chest infections, dehydration and malnutrition (Royal College of Physicians 2008). 78% of all stroke patients suffer dysphagia (RCSLT 2009) and as many as 50% of those with newly diagnosed stroke have ongoing swallowing difficulties (Bath et al. 1999). 51% of those suffering post-stroke dysphagia require SLT input (Mann et al. 1999). Some estimates in the US put the incidence of dysphagia at 15% of the over 60's living in their own homes, and almost 40% of the same age group living in care settings (Robbins et al. 2007).

Numerous studies have tried to establish the incidence of dysphagia after stroke with figures ranging from 23% to 50% (Singh and Hamdy 2006). Singh and Hamdy (2006) suggest that the variation in these figures is explained by:

1. Study design:
  - a. few studies have looked at sample sizes greater than 100
  - b. differences in reported entry criteria resulting in a variable case mix.
  - c. studies are started at different time points, which means a variable amount of recovery will have taken place at the time of assessment.

2. Differences in how dysphagia is identified (whether assessment is by bedside assessment or instrumental investigation (e.g. videofluoroscopy))

## **2.8 The consequences of dysphagia**

Dysphagia has serious consequences, ranging from coughing and discomfort on eating and drinking, through to aspiration pneumonia and choking (Robbins et al. 2007). Food, eating and mealtimes provide pleasure as well as nutrition and are an important social activity (Robbins et al. 2007). In 2008, there were three studies exploring different aspects of users' experience of dysphagia (Jacobsson et al. 2000; Colodny 2005; Vesey et al. 2008). Colodny (2005) described the consequences on treatment compliance with dysphagia care that has been prescribed by the clinician, rather than arrived at in collaboration with the patient. The initial purpose of the study was to understand issues of compliance through the lens of the Social-Cognitive Transition Model in relation to coping and denial. The Social-Cognitive Transition Model (Brennan 2001) seeks to explain how individuals cope with major transitional events, such as a diagnosis of cancer (Brennan 2001) or stroke (Taylor, Todman and Broomfield 2011), by adjusting their assumptions and beliefs about the world they experience and about themselves and their position in that world. Through 63 patient interviews, the authors sought to understand why patients did not follow SLT recommendations.

Vesey et al. (2008) interviewed seven individuals with dysphagia who had had a feeding tube placed. The authors concluded that patients perceived a lack of information from health care professionals and pressure to accept the tube, from a perceived lack of alternatives and a situation of inevitability. Jacobsson et al. (2000) demonstrated feelings of dependency and shame when eating and drinking in their interviews with 26 people with dysphagia following stroke.

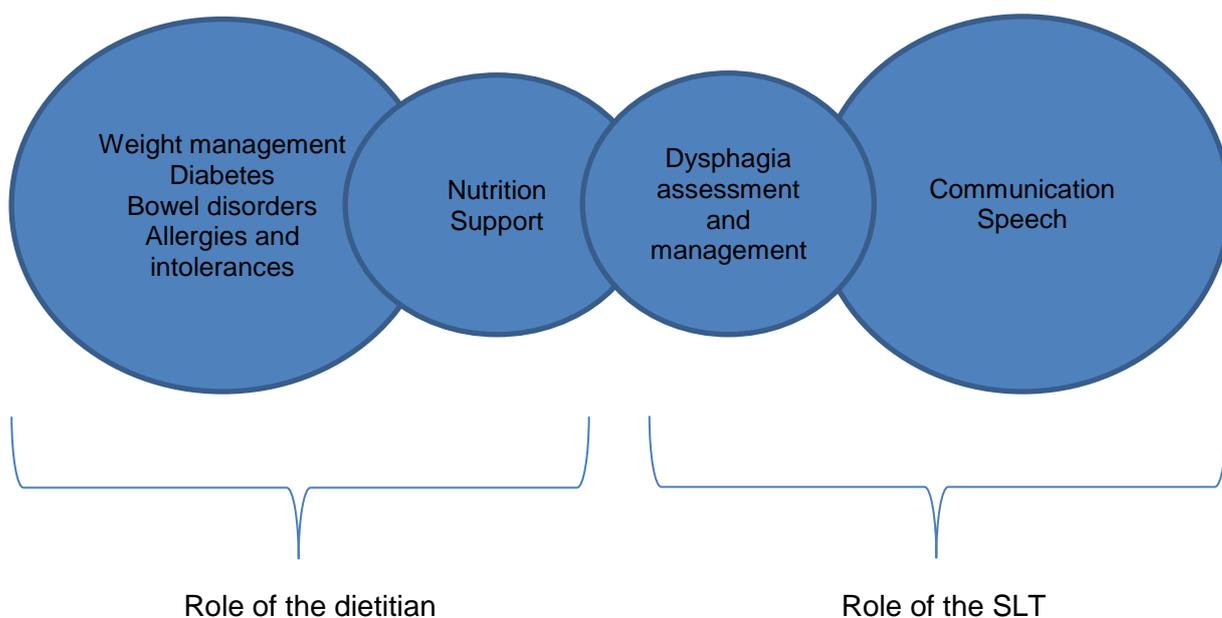
Although these studies explored outcomes in terms of survival and nutritional status for elements of dysphagia care (such as tube feeding) (Vesey et al. 2008), the patient experience of dysphagia and the care that they receive was less well explored. This is important, both in terms of collaborative patient/ clinician decision making, but also practically if treatment plans are to be acceptable and utilised and thus effective. For this reason, I felt it was important to include the perspective of those receiving care in this study.

## **2.9 Current practice in dysphagia management**

Dysphagia affects as many as 40% of stroke survivors and can result in recurrent chest infections, dehydration and malnutrition (Royal College of Physicians 2008). The risk of

dysphagia increases with advancing age, as a result of age-related changes in swallowing function (Robbins et al. 2007).

Although there is an intricate relationship between swallowing ability and food and fluid intake, swallowing and nutritional assessment and management are provided by two separate professional groups: Dietitians and Speech & Language Therapists (SLTs). The SLT and the Dietitian make separate assessments of the patient, provide management plans and review the patient in relation to their field of expertise, from initial hospital admission, through to return to normal swallow or long-term community follow up. The SLT assesses the patient and provides advice on the swallowing function itself. This includes recommendations on whether or not the individual should have oral intake at all and if so, of which consistency. The dietitian assesses nutritional status and provides advice on meeting nutritional requirements, whether orally or through artificial tube feeding. The role of the dietitian and the SLT in the dysphagia arena can be visualised as in Figure 1 below:



**Figure 1:** The respective roles of the dietitian and the SLT in the dysphagia arena

### 2.10 Dysphagia assessment

Dysphagia is currently managed by SLTs and dietitians, each responsible for a distinct area of the whole picture, rooted in their clinical background. The main role of the SLT in dysphagia management is to assess, at the patient's bedside, for the presence of dysphagia. He or she may examine the oral structures, vocal folds and larynx and test the reflexes, before trialling different consistencies of food and fluids. This assessment is termed the Bedside Swallow Assessment (BSA). Attempts have been made to standardize the BSA, including MASA, the Mann Assessment of Swallowing Ability (Mann 2002), but it remains an intuitive assessment in practice (Bateman 2007).

Where there are doubts about a patient's swallowing function following a dysphagia screen by e.g. a nurse, the patient is typically referred to an SLT for a more detailed assessment (Cichero 2006).

Swallow assessment may also include referring the patient for instrumental examination, usually for patients who have been assessed by a SLT. There are two types of instrumental examinations. The first method to come into use was videofluoroscopy (commonly referred to as VFSS, or VF), a sort of modified barium swallow which shows the passage of a radio-opaque bolus on an x-ray monitor. More recently, the fiberoptic endoscopic evaluation of swallowing (referred to as FEES) has come into use. In this procedure, an endoscopic tube is inserted into the pharynx, usually through the nose, and pharyngeal swallowing and pooling can be observed (Cichero 2006). Both procedures were initially performed by doctors, but some SLTs are trained to perform both or either. Although it has limitations of its own, VF is considered "gold standard" (NICE 2008), against which other tools are measured.

The evidence for the link between dysphagia and poor clinical outcomes (chest infection, disability, discharge destination, length of stay and death) is strong, reinforcing the need for early detection and management (NICE 2008). Despite this, the sensitivity and specificity of bedside assessments compared to FEES and VF (NICE 2008) range from 54% to 100%, and 50% to 89%, respectively. Although the accuracy of the bedside assessment may be less reliable for the detection of aspiration compared to videofluoroscopy, SLTs do achieve a significantly better rater agreement with this intuitive assessment than doctors using a standardised tool, again compared to videofluoroscopy (Smithard et al. 1998). Intra-judge reliability ranges from low to excellent, and inter-judge reliability from good to excellent (Mann 2000; McCullough 2000; McCullough 2001; Leder 2002; McCullough 2005; Trapl 2007).

All in all, this suggests varying degrees of reproducibility of the assessments in clinical practice, which is supported by Logemann et al. (2008). In this study, chin tuck was compared with thickened fluids in patients with dysphagia due to dementia and Parkinson's Disease. Chin tuck (also known as chin-down) position is a technique commonly used to close off the laryngeal vestibule at the moment of swallow, thereby directing the bolus correctly into the oesophagus by closing off the airway to bolus matter (Logemann et al. 2008). As the name suggests, the patient tilts the chin to the chest and then swallows the bolus. 25% of the patients studied did not aspirate at all on thin (e.g. unthickened) fluids without a chin tuck on videofluoroscopy, despite being referred in to the trial by their SLT precisely because the bedside assessment indicated that they may be aspirating. This suggests that, in this study at least, 25% of patients

identified as unable to safely swallow thin fluids at the bedside by the SLT were actually able to swallow safely.

A key result of the dysphagia assessment is to recommend whether or not it is safe for the patient to have oral diet and fluids, and if so, of which texture (NICE 2010). The dietitian's role in dysphagia assessment is typically to estimate current and likely nutritional intake. This will be based on the diet prescribed by the SLT, nutritional status and nutrient requirements (Cichero 2006) and the likelihood or not of meeting these requirements. The dietitian will advise on measures to be taken to make sure that the patient, carers and staff can meet the individuals' nutrient requirements. This may include using nutritional supplements and/ or a recommendation for tube (enteral or artificial) feeding.

Nutrition is important in the early stages of stroke, as nutritional status can deteriorate as a result of the stroke itself, but also because poor nutritional status at 1 week post-stroke is in itself a strong predictor of outcomes at three months (Yoo et al. 2008). Texture-modified diets often result in reduced nutritional intake, as measured by kcal and protein intake (Robbins et al. 2007). Dysphagia typically results in challenges in obtaining adequate nutrition and fluids, both as a result of the swallowing difficulty itself, but also secondary to the strategies to address dysphagia.

Artificial feeding is not always the answer, as many stroke survivors who receive more permanent PEG feeding tubes early on, often go on to survive with greater morbidity than those who do not receive these types of tubes early on (Clarke et al. 2005). The FOOD trial (Dennis et al. 2006) demonstrated survival with a worse quality of life among those allocated early tube feeding. The authors concluded that early tube feeding may keep patients alive but in a severely disabled state when they would otherwise have died. Tube feeding may also result in increased morbidity and mortality in other dysphagia populations. In dementia, for example, feeding tube insertion has considerable disadvantages in surviving with severe morbidity (Finucane et al. 1999) - hence the more recent practice of not using feeding tubes with advanced dementia sufferers.

## **2.11 Dysphagia screening**

Several tools have been developed for the screening of dysphagia risk, with varying degrees of sensitivity and specificity (Perry and Love 2001; Martino et al. 2005). Their main drawback is compromises between sensitivity and specificity: dysphagia screening tools offering good sensitivity, which is desirable to rule out dysphagia, often have lower specificity, potentially leading to over prescribing of NBM (Nil By Mouth),

artificial feeding and modified texture diet and fluids. Dysphagia screening protocols also typically screen patients in or out of oral feeding, but do not provide information about the nature of the swallowing problem (Robbins et al. 2007), and thus potential remedial strategies.

Dysphagia screening tools typically fall into two parts. The first part is a bedside assessment without trialling the patient on oral food or fluids. This part of the assessment will typically include an assessment of alertness, ability to follow commands, It may also include speech patterns, facial and oral movement that are used to assess lip seal, tongue strength, vocal fold adduction and palatal elevation. The second part of a test will typically involve the administration of water in varying boluses and may also include trials on various texture diets, also in varying amounts. In more recent years, swallow screening by nurses has now become widespread (Head et al. 2007). Dysphagia screening by nurses has been driven by growing demands on SLT services, the absence of SLT services out of hours and long waiting times for assessment. Although continued development of such tools, and their widespread use, they are only able to detect dysphagia and may not be able to predict silent aspiration (aspiration without signs or symptoms of dysphagia, such as coughing). Despite concerns over sensitivity and specificity, dysphagia screening by nurses of some description is performed in as many as 77% of acute hospitals in England and Wales (Head et al. 2007).

Swallow screening is an algorithmic tool, designed to detect clinical indications of impaired swallowing ability, rather than a detailed description of the swallow function provided in a Bedside Swallow Assessment (Huhmann et al. 2004). It does not detect “silent” aspiration, and patients who have “passed” a screen will normally still need to be monitored for signs of dysphagia (NICE 2008). Swallow screening is an algorithmic tool:

“Usually, small volumes of water are administered and a judgement is made about whether the patient coughs, has a change in voice quality, respiratory patterns, pooling of fluid within the oral cavity or leakage from the mouth.” (NICE 2008, p. 91).

According to Huhmann et al. (2004), the outcome of a dysphagia assessment is a detailed description of the swallow function, with an evaluation of degree of dysfunction and aspiration risk, whereas dysphagia screening is a pre-defined procedure designed to detect clinical indication of impaired swallowing ability.

## 2.12 Dysphagia treatment

Dysphagia management falls into three broad categories: therapeutic strategies (dysphagia therapy, such as exercises), compensatory strategies (texture modification, head positioning, swallowing manoeuvres, seating position and the use of specialist utensils) and environmental modifications (e.g. the absence of distractions during mealtimes) (Deane et al. 2001). Although there is good evidence for a link between aspiration and a worse outcome (NICE 2008), there is little high quality evidence to support these techniques in the prevention of chest infection or other adverse outcomes. Studies are often small, poorly designed and of such heterogeneous study populations that it is difficult to draw conclusions (Deane et al. 2001). The exception to this is altering dietary texture (Groher 1987; Carnaby et al. 2006; Logemann et al. 2008), and this is the predominant therapy technique still used today (Cichero 2006). For example, Logemann et al. (2008) compared chin tuck (or chin-down) position with both nectar-thickened fluids and honey-thickened fluids in 711 subjects with dysphagia due to dementia, Parkinson's Disease or both. The results of this study confirm that thickened fluids significantly reduced aspiration on VFSS compared to normal (thin) fluids. Honey-thickened fluids prevented significantly more aspiration than nectar-thickened fluids. Surprisingly, significantly more patients aspirated on chin-down posture than on either nectar or honey-thickened fluid categories (68% vs. 63% and 68% vs. 53% respectively). It is also worth noting that, despite elimination of aspiration on VFSS in some patients, a full 53% still aspirated on the most effective therapy of the study.

Apart from dysphagia assessment and management planning, SLTs may also provide dysphagia therapy. This may include exercises and manoeuvres intended to improve the swallow function (rehabilitation) or redirect the bolus flow (compensation) (Cichero 2006). Although there is growing interest in, and evidence for, therapeutic strategies, evidence regarding dose and frequency remains patchy (Foley et al. 2008). The Cochrane Collaboration (Bath et al. 1999) found insufficient evidence to support specific therapeutic interventions for dysphagia.

Many of the techniques employed today were developed empirically by Logemann (Cichero 2006) through studying the effect of positioning on the direction of the bolus on VF. Facilitation techniques and swallow manoeuvres that may have a positive effect on dysphagia (Shaker et al. 2002) would be practically and physically difficult for many patients to follow in practice, i.e. 18 strokes of the faecal pillars at the back of the throat with a chilled laryngoscope 5 times per day (Rosenbek et al. 1996).

Despite the absence of demonstrable benefits of most of the techniques employed in clinical practice, assumptions about the efficacy of these treatments exist amongst SLTs (Smith 2007; Logemann et al. 2008). Smith (2007) reported common assumptions amongst SLTs in a survey about the efficacy of some treatments which have since been demonstrated to have limited effect (such as avoidance of thin water for the prevention of aspiration). These assumptions originated from the early literature and possibly from an overemphasis on aspiration risk at the expense of other important, holistic factors, such as maintaining adequate nutrition and hydration and oral hygiene (Langmore et al. 1998; Campbell-Taylor 2008).

### **2.13 Development of the role of the SLT in dysphagia management**

It is unclear how SLTs have become the “lead expert in ... swallowing disorders” (Pettigrew and O’Toole 2007). This may be due to their knowledge of the anatomical structures of speech – these same structures are the organs of swallowing. This started with the work by Jeri Logemann in the late 1970s and the publication of two manuals in the 1980s. At the time, this extension of their role from speech, language and communication met fierce resistance within the profession, but dysphagia is now a fundamental part of the SLT caseload.

### **2.14 Dysphagia competency**

The Royal College of Speech & Language Therapists (RCSLT), produced their competency framework in 2003, followed by the Skills for Health *Dysphagia-Specific National Occupational Standards* in 2004. More recently, the *Interprofessional Dysphagia Framework* was developed in 2006 (Boaden and Davies 2006) in conjunction with the DH and the National Patient Safety Agency, after extensive consultation. This framework sets out the competencies required to practice at five levels of expertise, from basic awareness through to the practitioner who can be called upon to manage the most complex patients. None of these three competency frameworks stipulate a requirement that the practitioner attends formal tuition.

In 2008, it was generally accepted that the newly qualified SLT would not have the skills to independently manage dysphagia as a core part of his or her role. Following qualification and professional registration, he or she will normally attend a RCSLT-endorsed post-qualification course hosted by an academic facility, consisting of 5 days tuition, followed by a period of clinical exposure under supervision and self-directed learning, with a final examination. The courses themselves are open to both SLT, nursing and other professional staff. Occasionally, this training will be provided in-house.

Some practising SLTs, who qualified a number of years ago, may not have undertaken a formal post-qualification course, gaining their training through experience alone. Bateman et al. (2007) reported that of the 296 respondents in their survey of dysphagia practice amongst practicing SLTs in the UK and Ireland, around 29 (9.8%) had had no classroom training. Around 45 (15.2%) had had no supervision before commencing dysphagia work (Bateman et al. 2007). In more recent years, basic dysphagia training is included in the core undergraduate curriculum.

### **2.15 Guidelines for the management of dysphagia in stroke**

As many as 50% of those with newly diagnosed stroke have ongoing swallowing difficulties (Bath et al. 1999). The definitive guidance to the management of stroke, including aspects of dysphagia and nutrition, are provided by the Intercollegiate Working Party of the Royal College of Physicians (RCP) *National Clinical Guideline for Stroke*, the most recent edition of which was published in 2012. This guideline incorporates the recommendations from *Stroke: National Clinical Guideline for Diagnosis and Management of Acute Stroke and Transient Ischaemic Attack (TIA)* by the National Collaborating Centre for Chronic Conditions, funded by the National Institute for Health and Care Excellence (NICE). These were also published in 2008 by the Royal College of Physicians. The National Sentinel Stroke Audits (1998, 1999, 2002, 2004, 2006, 2008) monitor NHS organisations against a set of key indicators, originally based on the RCP (2008) guidelines.

Although the RCP 2008 recommendations provided guidelines regarding factors such as the timeliness of initial assessments, they did not go into precise details about the nature of these assessments, who performs them, and what should happen to the patient after initial assessment. In these guidelines, reference is made to comprehensive assessment of dysphagia by an SLT or other appropriately trained professional with specialism in dysphagia preferably within 24 hours of admission and not more than 72 hours. In the 2010 National Sentinel Stroke Audit, this recommendation was replaced with an audit domain of swallow assessment by SLT within 72 hours as one of the 12 key indicators – it is unclear why this change was made from the original guidelines.

In relation to detailed nutritional assessment, individualised advice and monitoring, the RCP guidelines recommend referral to an appropriately trained healthcare professional, rather than specifically a dietitian. Neither the NICE (2008) nor the RCP (2008) guidelines provided further information regarding the expected outcome of a referral, nor which steps constituted an assessment.

Having reviewed the literature regarding dysphagia management, and specifically the guidelines in relation to stroke care, I will now describe our current understanding of extended scope roles in health care.

## **2.16 Definitions of extended scope practice**

Extended scope practice refers to “working beyond the recognised scope of practice of the profession of interest in innovative or non-traditional roles” (McPherson et al. 2006, p. 241), which may include clinical duties normally performed by one of the other professionals.

Sibbald et al. (2004) describes seven categories of role development in relation to skill mix:

- *Enhancement* – increasing the depth of a job by extending the skills of or role of a particular type of worker,
- *Substitution* – working across professional divides to expand the breadth of a job, or replacing one type of worker with another,
- *Delegation* – moving a task up or down a traditional multidisciplinary ladder,
- *Innovation* – introducing new types of workers,
- *Transfer* – moving the provision of a service from one health sector or provider to another,
- *Relocation* – moving the venue from which a service is provided, without changing the people who deliver the service,
- *Liaison* – using specialists in one sector to educate and support staff in another sector.

Other authors have presented other ways to consider role extension and role revision. For example, Nancarrow and Mackey (2005) use the terms delegation and assignment. Delegation refers to the delegation of specific task to another type of worker, while accountability for the task remains with the qualified professional. With assignment, both the responsibility and the accountability for a task is transferred from one type of worker to another. Delegation usually refers to assistant staff who remain under the supervision of the qualified professional. With assignment the task is usually transferred from one type of professionally qualified worker to another, such as a nurse performing dysphagia screening.

Another way of looking at role division and extension is through diversification and specialisation (Nancarrow and Borthwick 2005). Diversification refers to the expansion of professional boundaries within a discipline, whereas specialisation to an inter-

disciplinary change, such as a nurse undertaking dysphagia screening. The latter term could be taken to mean by either delegation or assignment.

Others have used the terms skill mix changes, job widening and job deepening (Hyde et al. 2005). Skill mix changes refer to the transfer of a task to another, lower-paid worker, with or without direct supervision. This could refer to either delegation or assignment as used by Nancarrow and Mackey (2005). Job widening and deepening are related terms, referring to the expansion of tasks within a role – the former performing tasks originally performed by another type of worker, the latter by acquiring skills not previously used in the setting. This would equate with Nancarrow and Borthwick's (2005) term of diversification. Substitution can be horizontal or vertical (Nancarrow and Borthwick 2005). The latter is also called "encroachment" (Nancarrow and Borthwick 2005, p. 905).

In practice, revision of professional roles is often complex and involves interdependent changes in more than one of these categories (Laurant et al. 2010). ESP can be said to compromise aspects of enhancement and/ or substitution, where the role and/ or skills of one professional group are extended, often across professional divides. This can mean replacing one type of worker with another, or introducing another type of worker.

## **2.17 Health care policy in relation to extended scope practice and extended roles**

*A Health Service of all the Talents* (DH 2000c) envisaged greater workforce flexibility. From this, the NHS Modernisation Agency was founded in 2001, which led to the New Ways of Working Team and from there, the Changing Workforce Programme (Hyde et al. 2005). From 2001 to March 2005 the Changing Workforce Programme (CWP) implemented, tested and evaluated various role design projects in NHS and other health and social care organisations.

CWP was one of the NHS Modernisation Agency's New Ways of Working teams, which worked across health and social care to deliver service improvements that benefit both staff and patients, focusing on the key workforce priorities outlined in the *HR in the NHS Plan* (2002). *The NHS plan* (DH 2000b) highlighted the need to look at new ways of working to improve patient care and ensure good use of skills and laid out plans for increases in staffing numbers and redesign of job roles (Hyde et al. 2005). Role redesign and expansion along care pathways was identified by the NHS Modernisation Agency (2004) as one of the 10 high impact changes necessary to manage future healthcare demand.

The UK-wide Modernising AHP Careers project started in 2005. The resulting competence based career framework was launched in July 2008. The *Modernising Allied Health Professions (AHP) Careers: A Competence Based Career Framework* (DH 2008a) identified both transferable skills amongst AHPs and the opportunity that existed for new styles of health care provision by using these skills. The framework envisaged increasing specialised practitioners who no longer covered the whole range of the profession's scope of practice and also extended their scope of practice. The Department of Health suggested that this would allow AHPs to increase "the breadth and/or depth of their knowledge and skills" (DH 2008a, p. 11) and open up opportunities for "vertical, horizontal and diagonal career development" (DH 2008a, p. 16).

Hyde et al. (2005) found that remuneration, management, accountability, education and training were the most important employment issues in the Changing Workforce Programme.

Many of these initiatives, and assessments of their effectiveness, took place during a period of unprecedented growth in NHS spending, growth in staffing numbers and greater remuneration of NHS workers, either as a result of the initiative or through Agenda for Change. This resulted in many new and extended roles being remunerated more generously (Hyde et al. 2005). Ever more complex AHP roles (Larkin 2002) and a desire to ditch the "dirty work" (Nancarrow and Borthwick 2005, p. 899) may have incentivised AHP groups to give up less desirable aspects of their roles. Since that time, and during the time that this research study was conceived and conducted, both the UK economy and funding growth to the NHS has suffered a major set-back. This has resulted in a dynamic contextual setting for the research and the research questions posed. Any role redesign initiatives today would need to be considered against the background of current funding conditions for the NHS.

The House of Commons Health Committee conducted an inquiry in 2007 into NHS workforce planning, setting out four significant challenges:

- a need to increase workforce planning capacity at national, regional and local levels – ensuring that plans reflect the wide range of factors that will affect supply and demand in the future,
- a need for workforce planning to be better integrated – across the workforce (medical and non-medical), across the NHS (finance and service), and across health care (NHS and non-NHS organisations),
- to deliver a more productive workforce,

- to deliver a more flexible workforce.

This inquiry was followed by the Tooke report (2008) into medical education and training, which identified significant failings in the existing systems. *The NHS Next Stage Review* initiated a specific examination of workforce and workforce planning (DH 2008c) to address these shortfalls. The review concluded that service providers needed to be given a leading role in workforce planning, and that workforce, service and financial planning needed to be more closely aligned. Despite the need to focus on multiprofessional working and education to improve productivity, workforce planning had until then continued along professional silos (Appleby et al. 2009). The King's Fund also noted that emphasis had to shift from focussing on training new entrants to planning for new skills and work patterns for existing staff:

“...most of the staff who will be working in the NHS in 10 years' time are already NHS employees” (p. 5).

The need to create a more flexible and productive workforce had been raised by both Appleby et al. (2009), the Department of Health (2008b) and as far back as The House of Commons Health Committee inquiry in 2007.

Although the new framework would see healthcare providers – with their local clinical leadership – taking a lead role in planning and developing their workforce, the success of this approach will depend in part on the various healthcare professions seeing beyond their own profession and organisation towards a strategic view of service delivery.

## **2.18 Current knowledge around extended and enhanced roles**

While role enhancement has the potential to reduce the number of workers in contact with the patient, the impact of role enhancement remains uncertain (Dubois and Singh 2009). Three review papers identified in 2008 explored various aspects of role revision in health care. Two were a broad review of skill mix and role change (Sibbald et al. 2004; Laurant et al. 2010) and one specifically examined extended scope AHP roles (McPherson et al. 2004, 2006). Overall, the reviews demonstrated a dearth of good quality research, making conclusions about the benefits of such roles difficult.

The reviews of role revision in 2009 pointed to a lack of rigour to be able to fully assess the benefits and limitations of the ESP role and role revision (McPherson et al. 2004, 2006, Laurant et al. 2010). Previous research on the effect and outcomes of various forms of role expansion have been criticised for their methodological flaws and descriptive focus, or for failing to take account of key variables and complexity (Dubois

and Singh 2009). There is also a need for evaluation of the effectiveness and cost-effectiveness of such roles, and how role revision can be optimised (Laurant et al. 2010). Better descriptions of what constitutes “typical” or “usual” care was also found to be needed, (Laurant et al. 2010) as well as research into the impact of extended roles on patient outcomes and the patient perspective of such roles (McPherson et al. 2004, 2006).

Whereas the focus has been on skill mix, or the right ratio or numbers of specific types of workers, interest is increasingly focussing on achieving the right skill set (Dubois and Singh 2009). Dubois and Singh (2009) term this “skill management” (p. 88). In more recent years, the focus has been on the introduction of assistant practitioners following the NHS Modernisation Programme (DH 2000c, 2001, 2002) and the Changing Workforce Programme (Nancarrow and Mackey 2005).

Reviews and reports on role expansion in the NHS focussed overwhelmingly on the extension of the skills of non-medical staff into traditionally medical areas of practice (e.g. Sibbald et al. 2004). While this is understandable, given the potential benefits of substitution of more expensive practitioners with a less costly alternative, reducing duplication between professionals is less well explored. Of marginal relevance to this research, Sibbald et al. (2004) included two studies in their review that involved dietitians. One was substitution of doctors with dietitians, nurses or a written information sheet for cholesterol reduction (Thompson et al. 2002). Although the authors of the study concluded that dietitians were better than doctors at lowering blood cholesterol in the short to medium term, there was no evidence that they were better than self-help resources or nurses. Sibbald et al. (2004) concluded that the methodological quality of this research was low.

Read et al. (2001) explored “innovative” roles in a selection of acute Trusts in England. The main thrust of the roles reviewed focused on relieving hospital doctors of activities. Indeed, many of the roles had developed as a result of the Working Time Directive. Although both McPherson et al. (2004) and Read et al. (2001) specifically explored expansion of allied health professional roles, as with other reviews, these too predominantly focussed on role expansion of AHPs into traditionally medical areas of practice. The feasibility, opportunities, benefits and attitudes of role expansion across and between non-medical professions has been less well-explored. They may provide similar opportunities for staff satisfaction, greater alignment of services around patients and clinical outcomes and experience for patients, as well as efficiency gains.

Although AHP role extension has been explored (Read et al. 2001; McPherson et al. 2004), and several reports have called for greater flexibility in AHP roles (DH 2001; DH 2008a), crossing professional divides, this has primarily focussed on role expansion into traditionally medical areas of practice. Although substitution of doctors with nurses in primary care is well-researched (Sibbald et al. 2004), the substitution of non-physician clinicians working either as substitutes or supplements for physicians is less well researched (McPherson et al. 2004, 2006; Laurant et al. 2010). Although there was some descriptive evidence of concerns regarding the extended scope role, discursive perspectives were mainly positive. However, the authors noted that all the studies included lacked sufficient rigour to fully assess the benefits and limitations of the ESP role. Concerns centred mainly around adequate training and the legal implications for Extended Scope Practitioner (ESP) AHPs. There was also very little information on the patient perspective of the ESP role, other than satisfaction surveys of services (McPherson et al. 2006). Benefits are mainly positive, but variable, and evaluation of the cost-effectiveness of role revision is generally absent.

Specifically, in relation to extended scope AHP roles, where AHPs perform tasks normally performed by a doctor, some of the unanswered concerns include (McPherson et al. 2004, 2006):

- Variability in training and education,
- Competence and legal responsibility,
- Opportunity costs and cost shifting within services, rather than cost saving,
- Increased demand through increased capacity, where the role has developed in response to long waiting times.

Dietetics and SLT services have been largely overlooked in reviews of AHP role expansion, which have focussed on the larger AHP groups (i.e. radiography, physiotherapy and paramedics). Read et al. (2001) provided a description of the line management arrangements of SLT and dietetic services at the sites they studied in their report, with specific concerns around these arrangements. These concerns included complex line management arrangements and lack of clarity on the management arrangements, generating feelings of isolation. McPherson et al. (2004) focussed on five specific AHP extended roles in their report, which included extension of SLT roles into voice therapy.

## 2.19 Barriers and enablers to adopting extended roles

A further area that existing research failed to address was an understanding of professional acceptance and willingness to undertake extended and revised roles. Authors commented on:

- the limited flexibility within, and between, AHP career pathways, and their responsiveness to take on new and varied roles (DH 2008a),
- professional acceptance and specialisation as either a barrier or enabler for the implementation of revision of professional roles (Laurant et al. 2010), and
- resistance to change amongst AHPs as a possible contributing factor preventing role expansion (McPherson et al. 2006).

Although non-medical clinicians (i.e. AHPs, pharmacists, physician assistants and nurse practitioners) have been more willing to extend their roles than medically qualified clinicians (Laurant et al. 2010), resistance to change amongst AHPs may be a possible contributing factor preventing role expansion (McPherson et al. 2006). McPherson et al. (2004) highlighted that, although the literature regarding nurses in extended scope practice roles had grown enormously in the years leading up to their review, there was a dearth of research into the impact of these roles amongst AHPs.

Read et al. (2001) explored attitudes to changing roles, mainly from the point of view of GPs referring to specialists' services now provided by a nurse, hospital doctors and colleagues within the same profession who were still in a "traditional" role. The authors noted that:

"Where roles expanded and developed beyond the profession's domain of practice, there was little competition from other disciplines. However, where the domain of practice or line management overlapped with colleagues in the same profession, there was the potential for intra-professional tension." (p. 94)

The study was conducted in three stages. The first phase was a scoping exercise to identify the extent and location of innovative roles in England, which were compiled into a database. In this stage, 40 nurse managers (stakeholders) from the 25 Trusts selected by the researchers were also interviewed, using a 10-item topic guide. The Trusts were selected to represent 20% of healthcare Trusts in England - five Trusts in each of the eight English NHS Regions. The second stage of this research was a case study design exploring a variety of factors associated with these new roles. In this phase, interviews were conducted with therapy managers and post-holders themselves. From these interview and the interviews with the nurse managers in the

first phase, two questionnaires were designed for the third and final phase: a 27-item questionnaire for post-holders and a 23-item questionnaire for nurse and therapy managers. The questionnaires were multiple-choice with a small number of free-text areas for additional comments. In total, 614 of the 782 questionnaires posted were returned, giving an overall response rate of 78.5%.

In the second phase interviews with stakeholders, the authors identified “post-holder characteristics” (p. 140) as a barrier to effective working in the new roles. These characteristics included time management, interpersonal and negotiating skills, along with the failure to share information. Access to training was also cited as a barrier to new, innovative roles, with factors such as lack of time for training (74.9% of respondents), inability to cover post in absence (56.1% of respondents) and lack of funding for training (45.0% of respondents) cited as the most common factors preventing access to appropriate training. Exploring barriers to effective working in these new roles (rather than barriers to implementation), the authors described six themes that emerged for the data. These were:

- inadequate resources (lack of staff, insufficient funding, lack of secretarial support, lack of computers and no or limited space/office),
- time constraints,
- problems with relationships with other staff (lack of support from immediate managers, resistance to and non-acceptance of the post, inability of other staff to change, lack of role recognition and lack of understanding of the role by medical staff and peers,
- poor communication (i.e. with managers, lack of contact with others in similar roles or difficulty liaising with busy consultants),
- poor management (post-holders having to cover the wards when there were not enough staff, lack of cover for their role when they were on leave and lack of role clarity, political issues such as ‘red tape’ and NHS changes),
- excessive workload.

Although “resistance to and non-acceptance of the post” (Read et al. 2001, p. 219) are referred to in this research, this theme is not explored in any more depth, and neither was this the aim of the research. Furthermore, although the authors identify the six themes above, these themes emerge in the context of preventing more effective working, rather than as factors initiating, supporting or preventing role extension to occur in the first place. The authors also reported on other barriers to implementing innovative roles from the interview data, although not captured as main themes. These included opposition from key players (including medical and nursing staff, pharmacy,

radiology and laboratory departments) and reluctance on the part of the post-holder to relinquish non-specialist aspects of their role. Although issues of professional boundaries did arise, the focus of this report was on the practical barriers and enablers to these new roles (e.g. the availability of office space, training, good communication and role clarity, etc.), rather than the organisational/ sociological/ psychological barriers and enablers. Furthermore, their report did not integrate any existing theory from the organisational theory literature in order to better understand or overcome/ facilitate these barriers and enablers.

In addition to the barriers to effective working in innovative roles, Read et al. (2001) also identified job satisfaction as an important factor in the new and innovative roles described, although not necessarily in the context of whether this is a barrier, an enabler, or both. Of the post-holder survey responses received, 89.4% (549/614) stated that working in their innovative role had enhanced their job satisfaction. Factors associated with enhanced job satisfaction included autonomy, direct patient contact and holistic, enhanced care and enhancing and utilising skills and knowledge. In conclusion, the authors recommended that:

“...when establishing new roles or services, significant attention should be paid to the identification of clear role boundaries. Open and on-going dialogue with colleagues whose practice may be affected by the new service or role is critical.” (p. 117)

The later systematic review performed by Laurant et al. (2010) was part of the Health Foundation's Quality Enhancing Interventions Project, which conducts systematic reviews of peer reviewed and grey literature to assemble evidence on the impact of interventions designed to improve performance and quality of care. In this review, the authors propose a theoretical model linking the barriers, enablers and drivers of change. They suggest that: 1) payment systems, 2) professional regulation and training, and 3) professional and patient attitudes, all play a part in revision of professional roles. Under the theme professional and patient attitudes, they further identify acceptance, specialisation and teamwork/collaboration as sub-themes. Unfortunately, the authors do not link the constructed model to their review of the literature nor support the model with empirical evidence.

Having given an overview of the literature relating to extended scope practice in general, the review will now turn towards our knowledge regarding the feasibility of role expansion specifically within dysphagia care at the time this research was conceived.

## **2.20 Extended scope practice and dysphagia management**

The Royal College of Speech & Language Therapists (RCSLT) produced a competency framework in 2003, followed by the Skills for Health *Dysphagia-Specific National Occupational Standards* in 2004. In 2006, the *Interprofessional Dysphagia Framework* was developed in conjunction with the DH and the National Patient Safety Agency. All of these frameworks set out the competencies required to practice at varying levels of expertise. Neither framework stipulated which professional groups can or cannot manage the various aspects of dysphagia. The RCSLT-accredited post-qualification training courses are open to professionals from backgrounds other than SLTs and therefore, in theory at least, this area is not regulated to any profession.

There were only a few examples of role expansion within dysphagia practice in 2008. In the UK, one NHS Trust had employed a Dysphagia Nurse Specialist, who provided dysphagia assessment and care alongside SLT colleagues (Steve Davies, Gateshead NHS Foundation Trust, personal communication, August 2010).

Dietitians play a larger role in dysphagia screening in other countries (Robbins et al. 2007). For example, in Canada, dietitians routinely take on the role of primary dysphagia practitioner, with 26% of practising dietitians completing bedside swallow assessments and 86% making recommendations regarding texture and/ or fluid modifications in some areas (Lam and Butt 2005). In Canada, one research article describes the occupational therapist (OT) as taking the lead for dysphagia assessment and management plans (Runions et al. 2004). Training in oral motor skills, the key component of the first phase of a normal swallow, is part of the core competencies for Occupational Therapists (OTs) in the US, whereas this is not the case in the UK (Howard 2002).

As described earlier, the literature review revealed only two studies comparing dietitians to SLTs in dysphagia management (Brody et al. 2000; Huhmann et al. 2004). Both studies compared dysphagia screening by a dietitian to that of SLT and demonstrated that the dietitian can deliver comparable rater reliability to a SLT. Despite this, both were poorly designed in terms of homogeneity of measured outcomes and method of screening, which makes it difficult to draw firm conclusions about the feasibility of dysphagia screening and/ or assessment by dietitians. I will now describe the design and findings of both studies in turn.

In Brody et al. (2000), the primary objective of the study was to determine whether dysphagia screening by a dietitian in an acute care setting can accurately identify patients at risk of dysphagia and the need for SLT referral. The second research

objective was to evaluate the appropriateness of dietitian-recommended diet/ feeding regimens for patients at risk of dysphagia. The study was a clinical trial of 34 consecutive and eligible patients admitted to an urban neuroscience unit with a diagnosis of cerebral vascular accident, intracerebral bleeding, transient ischaemic attack, traumatic brain injury or brain tumour and/ or a diet order of a modified consistency diet over a 2 month period. All eligible patients were screened by a dietitian and then by a SLT, who was blinded to the dietitian's screening results. The dietitian used a screening tool developed as part of the study, which consisted of a range of questions to ask the patient, and clinical observations. Eating was observed *if* the physician had ordered a tray (e.g. a meal). The results did not report how many patients were observed eating. It is also unclear whether the SLT used the same pre-determined screening tool as the dietitian for the swallow screen, or whether the SLT observed or trialled diet as part of the swallow screen.

Dysphagia risk (determined by the need for referral to SLT for full assessment) and diet recommendations between dietitian and SLT were analysed using the k statistic. The sample size required to reach statistical significance was not calculated by the authors, neither did the authors report confidence intervals for the resulting k value for any of the 4 sets of data compared. The k agreement was calculated for: 1) dysphagia risk, 2) oral diet versus nil by mouth, 3) diet texture (regular, soft, mechanised soft, puree, NA if Nil By Mouth) and 4) liquids – no restriction, thick liquids, no liquids or NA if Nil By Mouth. The findings are presented below.

In the later research article published by Huhmann et al. (2004), the screening tool originally designed by Brody et al. (2000) was adapted and applied to patients with a diagnosis of stroke only. The aim of the research was to assess the level of agreement between dietitian and SLT in determining dysphagia risk and diet recommendations, and to determine the risk factors the dietitian can use to accurately screen for dysphagia risk. The study compared screening by a dietitian to assessment by an SLT in a convenience sample of 32 eligible patients admitted to a stroke team during a 6-month period. Of these, 19 had a diagnosis of stroke. Patients were screened by the dietitian using the adapted proforma screening tool and then assessed by the SLT, who was blinded to the dietitian's findings. The SLT assessment was considered "gold standard". The k statistic was used to compare dysphagia risk, oral diet versus Nil By Mouth, fluid and food consistency recommendations recommended by the dietitian versus SLT recommendations. Although the authors estimated that adequate statistical power would be achieved at 29 subjects, with  $p=0.05$ , it is unclear whether the power calculation relates to the k statistic of agreement, or the statistical modelling used to assess the different components of the screening tool. As in the case of Brody et al.

(2000), the authors do not report confidence intervals for the k value on any of the four sets of data that were compared.

The results of both Brody et al. (2000) and Huhmann et al. (2004) are presented in Table 2. Based on an interpretation of the k statistic proposed by Landis and Koch (1964 cited Kirkwood and Sterne 2003), where  $k > 0.75$  = excellent agreement,  $k 0.4 - 0.75$  = fair to good agreement and  $k < 0.4$  = moderate or poor agreement, then the results of both groups demonstrate excellent agreement between Dietitian and SLT for dysphagia screening, for most parameters. The exceptions are assessment of dysphagia risk and recommendations regarding diet consistency made by Brody et al. (2000). The authors suggested that the reduced degree of agreement in diet consistency recommendations may have been due to the dietitian relying more on personalised adaptations to the available textures according to individual patient needs. In contrast, the SLT usually opted for one of the uniform consistencies available. The authors do not report how many patients this applied to. The differences found may have been explained by either limited agreement between the two raters studied, limited agreement between dietitians and SLTs in the two professional groups as a whole, or limitations of the study design. In addition to this, and as discussed earlier, the dietitian observed mealtimes in some, but not all, patients. It is also unclear whether the SLT used the same screening tool or another form of assessment.

Despite more positive results in Huhmann et al. (2000), the dietitian used an adapted version of the pre-determined screening tool first used by Brody et al. (2004) in this study, along with observation at mealtimes. In contrast, the SLT used a full assessment, the details of which are not reported, but did include oral-peripheral examination, communication, feeding and swallowing, and trials of varying consistencies. The two independent assessments by both practitioners are therefore not the same, which allows us to draw only limited conclusions from the results.

	<b>Brody et al. (2000)</b>	<b>Huhmann et al. (2004)</b>
Dysphagia risk	k = 0.61	k = 0.80
Oral diet versus Nil By Mouth	k = 1.0	k = 1.0
Diet consistency	k = 0.61	k = 0.79
Liquid restrictions/ recommendations	k = 1.0	k = 0.83

**Table 1:** Rater agreement between dietitian and SLT for dysphagia screening

In summary, Brody et al. (2000) shows excellent agreement in relation to 'oral diet versus Nil By Mouth' and 'liquid restrictions/ recommendations' between Dietitian and SLT. Results for 'dysphagia risk' and 'diet consistency' are fair. This may be interpreted as due to overall poor agreement between professional groups. Alternatively, this may have been due to flaws in the study design. These flaws include practitioners not sticking to protocol, different approaches being applied to study participants in a non-randomised fashion and possibly different methods of screening used, depending on the practitioner. Although the later study by Huhmann et al. (2004) showed more positive results across all parameters, and a more rigorous study design of a homogenous study population, the dietitian screen was still compared to a fuller assessment by the SLT. This gives us therefore little information regarding the comparability of practitioners in relation to dysphagia assessment and management.

Whereas these examples suggest that it is feasible for clinicians other than SLTs, including dietitians, to extend their scope of practice into dysphagia management, there has to date been no rigorous assessment of this role expansion.

Although role expansion between dietitians, SLTs and other clinicians may present benefits to both the patient through more holistic management and the "system", it has not been widely adopted, and certainly not in the UK. Benefits may include reducing duplication, and thereby the availability of resources. Kayser-Jones et al. (1999) also demonstrated that dietitians are often referred patients for poor food and/ or fluid intake with undiagnosed dysphagia. Furthermore, they did not have the skills to assess swallowing ability, rendering their treatment ineffective.

It is possible that the willingness and motivation of the professionals involved in dysphagia care are barriers to change in the area. Dey (1999) suggests that:

"Thinking about how things work can be illuminated by examining how certain actions are made possible (or facilitated) while others are made impossible (or constrained)." (p. 179).

A survey of dysphagia screening by nurses in the UK identified motivation among nurses to take on the role, cultural beliefs amongst nurses about their role in dysphagia management, as well as lack of time for SLTs to deliver the training, as barriers to wider dysphagia screening by nurses in the UK (Head et al. 2003). A survey from Canada suggested that 85% of surveyed dietitians would have welcomed dysphagia therapy within their role, if the right training were available (Lam and Butt 2005). Dietitians in the UK do have access to appropriate training, through the Royal College

of Speech and Language Therapists (RCSLT) accredited courses, even though access to practical experience may be more difficult.

## **2.21 Research aim and research questions**

The **aim** of this study was therefore to gain an understanding of the enablers and barriers to role expansion in the area of dysphagia management, in order to contribute to theoretical knowledge about the barriers and enablers to adopting new and different ways of working in the National Health Service. The research focused on factors (or conditions) that could facilitate role extension, in order to propose practical actions that healthcare organisations could take to bring about change. The focus at the beginning of the research was on conditions rather than professional roles after taking the decision to use grounded theory. The focus of grounded theory research in the version described by Corbin and Strauss (2008), which I had chosen to use, is on causal and intervening conditions, the strategies employed by actors in the research setting and the consequences of those strategies. The relevance and importance of professional roles was not apparent at the beginning of the research and did not emerge until the research was in progress.

At the very beginning of my PhD, I had intended to compare dietitians and SLTs for outcomes in relation to dysphagia and nutritional assessment and management. The limited literature demonstrated that role extension in the field was feasible. The literature review had also highlighted issues of barriers to changes in clinical practice and it was this that I decided to study further. The literature review pointed to suitable starting questions, as detailed in the previous paragraphs. During the first phase of the research, skills and knowledge emerged as the core concept facilitating or preventing role extension in the area. Following the concept of theoretical sampling in grounded theory described by Corbin and Strauss (2008), I pursued the concepts arrived at in the first phase of the research in phase 2, as described in detail in Chapters 4 and 5.

Given the broad research recommendations proposed by review authors regarding professional and social barriers to change, I decided to research a broad set of research questions, specific to dysphagia care. For example, McPherson et al. (2004), without any further qualifying direction, proposed:

“Further investigation of ESP views about barriers to extending practice should be sought.” (p. 38)

As described earlier, Laurant et al. (2010) identified three main themes in their review of role revision: payment systems, professional regulation and training and professional and patient attitudes.

Read et al. (2001) explored the organisational barriers and levers which affected the implementation of new and innovative roles in 25 English NHS Trusts. Two of the research questions posed by the authors in the third phase of their research (questionnaires) are of relevance to this study, namely:

“2f) What factors facilitate effectiveness [in introducing these new roles]? 2g) What factors act as barriers to effectiveness?” (p. 274)

Although I was not directly intending to research the effectiveness of role extension in dysphagia care, given its very limited occurrence in the UK at the time of reviewing the literature, I felt that the broad scope of the questions posed by Read et al. (2001) could be transferred to my particular area of research. I felt that, given the possibility of role extension in dysphagia care, described in the little research available, that the “resistance to and non-acceptance of the post” (Read et al. 2001, p. 219) was the key area of research to explore which factors prevented or enabled role extension in the area. The research questions posed therefore mirrored those posed by Read et al. (2001), adapted to the area of dysphagia care.

As prior research (Read et al. 2001; McPherson et al. 2004; Laurant et al. 2010) focussed on the professionals themselves, rather than the role of the regulatory bodies, the focus of the research followed this lead, although it later emerged that the professional bodies had some influence at least on professional practice in the area. Professional body representatives were therefore included in the research questions posed in the second phase of the research, as their relevance became apparent in the first phase. Commissioners were included from the outset, as I had expected them to be drivers of change at the local level.

Having reviewed the literature, the following **research questions** were posed:

1. What are the barriers to extended scope practice in dysphagia management in routine clinical practice, in the acute and community care setting from the perspectives of:
  - a. clinicians providing care and their professional representatives,
  - b. service users,
  - c. those who manage and commission dysphagia services?

2. What are the enabling factors in adopting extended scope practice in dysphagia management in routine clinical practice, in the acute care setting, from the perspectives of:
  - a. clinicians providing care and their professional representatives,
  - b. service users,
  - c. those who manage and commission dysphagia services?

Having summarised the literature reviewed initially and posed the research questions that stemmed from this review, I conclude by updating the reader on developments in the field while the research itself has been in progress. This was not a systematic literature review as such, but rather I kept up-to-date with developments in the field by reviewing the literature using the search terms initially employed in the literature review, but narrowing the search to 2009 onwards.

## **2.22 Further developments in the area of extended roles in dysphagia care since initial literature review**

Dysphagia remains an area of concern for those with neurological disorders and continues to have serious consequences for health, from relatively benign coughing and discomfort on eating and drinking, through to aspiration pneumonia, choking (Kertscher et al. 2014) and even death (Cabre et al. 2010). Quite aside from the physical/ medical issues, dysphagia is still recognised as having a significant impact upon the person's quality of life (Miller and Patterson 2014). Whereas individuals may display variations of a normal swallow, an individual is classed as having dysphagia only when he or she shows signs associated with the sequela of dysphagia (such as aspiration and aspiration pneumonia, coughing and choking) or undernutrition from reduced intake (Groher 2010).

As the population ages, the risk of conditions leading to swallowing disorders rise (Miller and Patterson 2014), such as stroke (Kopey et al. 2010). This means that demands on swallowing services for assessment and management are on the rise (Kertscher et al. 2014). For example, it is now estimated that around 63,000 adults suffer dysphagia after a stroke each year (Marsh et al. 2010). Estimating the incidence of dysphagia is difficult, as different definitions and methods of measurement exist, but lie somewhere in the region of 11% to 40% of older community residents (Miller and Patterson 2014). The prevalence in nursing home residents is much higher, maybe in the region of 30-68% (Miller and Patterson 2014). With an ageing population, these estimates highlight the importance of finding effective (and compassionate) ways of managing dysphagia and the associated nutritional risk.

### **2.23 Dysphagia assessment**

Since the initial literature review, nurses have taken a greater role in dysphagia screening. Where there are doubts about a patient's swallowing function following a dysphagia screen by e.g. a nurse, the patient is still typically referred to an SLT for a more detailed assessment (Hines et al. 2011).

Instrumental examination techniques have developed in the six years since the initial literature review, particularly with the rise in fiberoptic endoscopic evaluation of swallowing (FEES). In this procedure, an endoscopic tube is inserted into the pharynx, usually through the nose, and pharyngeal swallowing and pooling can be observed (Miller and Patterson 2014). Nevertheless, practices regarding both videofluoroscopy (VFSS) and FEES continue to vary across areas and even countries (Miller and Patterson 2014). For example, Cocks and Ferreira (2012) found that UK SLTs rarely use instrumental techniques, such as VF or FEES, when making decisions on oral feeding.

This entails that much of the SLT assessment is still performed by the bedside, at least in the UK. Recent research by Kopey et al. (2010) suggests that the SLT bedside assessment may have a positive predictive value (PPV) of only 0.75 and a negative predictive value (NPV) of 0.70 in the research setting. In addition to this, many of the assessment modalities have been shown to have only low inter-rater agreement (Miller and Patterson 2014). The accuracy of dysphagia assessment and treatment modalities outside of research settings, in routine clinical practice, is likely to be less.

### **2.24 Dysphagia management**

Dysphagia treatment and treatment provided by SLTs falls into five broad areas (Speyer et al. 2010):

1. Bolus modifications and management (commonly referred to as compensatory techniques, such as altering the texture or temperature of the bolus/ food and drink),
2. Facilitation techniques (such as thermal and electrical stimulation of anatomical structures),
3. Swallow postures and swallow manoeuvres (such as chin tuck, head turns, supraglottic swallow),

4. Other interventions (residual category, including rehabilitative techniques such as vocal fold adduction and tongue exercises), and
5. Combinations of interventions.

Since the initial review, and the 1999 systematic Cochrane review demonstrating insufficient evidence to support specific therapeutic interventions for dysphagia, studies of dysphagia treatment remain elusive (Speyer et al. 2010). Recent, but as yet unconfirmed work, suggests that the increased risk of aspiration on one of the commonly used techniques compared to nectar or honey-thickened fluid, chin-down posture, may be due to the position itself having an adverse effect on other anatomical movements involved in swallowing (van der Kruis et al. 2011). Chin tuck (also known as chin-down) position is a technique commonly used to close off the laryngeal vestibule at the moment of swallow, thereby directing the bolus correctly into the oesophagus by closing off the airway to bolus matter (Macrae et al. 2014). Since the 1999 Cochrane review (Bath et al. 1999) of therapeutic interventions for dysphagia, a more recent Cochrane review (Geeganage et al. 2012) has been conducted. The authors of this demonstrated more positive findings with behavioural interventions, with dysphagia significantly reduced with swallowing therapy. It should be noted that, despite a significant reduction in dysphagia, treatments had a statistically non-significant effect on rates of pneumonia, length of stay and mortality. It is also worth noting that all dysphagia treatments (e.g. swallowing exercises, swallow postures and manoeuvres and texture modification) were all analysed together, due to a paucity of research. This makes it difficult to conclude which treatments are effective, whether singularly or in combination. This does raise questions about the use of many of these techniques in clinical practice, particularly if interventions have adverse effects. For example, thickening of fluids is often used to address difficulties swallowing thin (normal) fluids, but are typically less palatable and thus result in reduced fluid intake (Garcia and Chambers 2012).

### **2.25 Extended roles in dysphagia assessment and screening**

Although SLTs may have had, at least until the early 1980's, very little training in dysphagia management (Gaziano and Serrano 2012), the RCSLT is aiming to remedy this, by encouraging Higher Education Institutes (HEIs) to ensure adequate practical training while on undergraduate training placement (RCSLT 2014). Despite this, competency on qualification can be variable, with the RCSLT suggesting that:

“Individual levels of clinical competence in dysphagia at the time of entering the workforce will depend on the practical opportunities accessible during placements.” (RCSLT 2014, p. 7)

Though the SLT remains the main practitioner in the management of dysphagia, the use of dysphagia screening tools by other types of worker other than SLTs is now accepted practice, with only those “failing” the screening test then referred to SLT services (Kertscher et al. 2014). For example, the stroke sentinel audits demonstrate a reduction in the percentage of patients admitted to hospital receiving a SLT assessment of swallowing within 72 hours between 2010 to 2013 (Dorning and Bardsley 2014) – while this may reflect a reduction in performance (although SLT numbers in NHS settings have continued to rise in the same time period (Dorning and Bardsley 2014)), this is more likely to reflect a reduction in the number of patients admitted requiring SLT assessment as nurse dysphagia screening has increased.

Dysphagia screening tools continue to proliferate since the initial literature review (Hines et al. 2011). Dysphagia screening tests were first developed in the area of stroke (Daniels et al. 2012) and are increasingly used in a range of neurological conditions (Kertscher et al. 2014). Such tools may either be stroke-specific (Schepp et al. 2012), or applicable to broader patient populations (Hansen et al. 2011; Kertscher et al. 2014). The hunt for the “ideal” swallow screening tool continues (Kopey et al. 2010; Hansen et al. 2011; Daniels et al. 2012; Osawa et al. 2013; Suiter et al. 2014; Schepp et al. 2012; Kertscher et al. 2014), and the “best” protocol remains to be determined (Miller and Patterson 2014). Although the use of a swallow screening tool will result in false negatives (Drury et al. 2014), an ideal swallow screening tool is one that has sufficient sensitivity to accurately predict the presence or risk of aspiration and dysphagia to reduce the risk of pneumonia, poor nutrition and dehydration, while also being specific enough to not place already vulnerable patients Nil By Mouth (NBM) for prolonged periods. The ideal swallow screening tool should have similar inter-rater reliability, so as to be able to be performed by a range of clinical staff involved in the patient’s care, rather than needing to rely on skilled SLT staff (Daniels et al. 2012; Warner et al. 2013).

Dietitians continue to play a larger role in dysphagia screening in other countries (Garcia and Chambers 2012). In the US and Canada, they can routinely perform dysphagia screening and management planning, including advising on modified textures (Burton et al. 2012). Dietitians in the UK have started to expand their scope of practice into other dysphagia-related areas since the initial review, such as claiming professional jurisdiction in some areas over the care of feeding tubes (Stanley and Borthwick 2012). Although nurses are more commonly performing at least swallow screening since the initial reviews, as judged by the proliferation of swallow screening

tools and research, "...speech pathology professions appear to be in their infancy of extended scope roles..." (Saxon et al. 2014, p. 484)

## **2.26 Best practice in dysphagia care in stroke**

The National Sentinel Stroke Audits, which monitor NHS organisations against a set of key indicators, have continued since the initial literature review (2010). Initially conducted bi-annually, the reports are now generated quarterly and the Sentinel Audit data of all NHS Trusts are available as an interactive web tool (see <https://www.strokeaudit.org/results/national>). The 2012 RCP guidelines seem to have moved away from a focus on which professional performs the various assessments, and instead focusses on the specific actions that should be taken. For example, the guidelines state that patients should have their swallowing screened, using a validated screening tool, within four hours of admission to hospital, by a trained healthcare professional. Those unable to take adequate nutrition and fluids orally should have a comprehensive assessment of their swallowing function, performed by a specialist in dysphagia, with no reference to which professional group this specialist may belong. Following the NICE Quality Standard, the 2010 National Sentinel Stroke Audit targeted organisations with providing swallow screening by a specially trained healthcare professional (e.g. including nurses) within four hours of admission, an even shorter time frame from the previous 24 hours. As with the guidelines for dysphagia, the 2012 edition of the RCP guidelines recommend specialist nutritional assessment for patients who have required dietary modification for three days or more, with no reference made to occupational group.

NICE also published a set of Quality Standards for stroke in 2010, based on the recommendations found in the 2008 NICE guidelines and the 2008 RCP guidelines. The 2010 Sentinel Stroke Audit included audit against domains in these Quality Standards, as well as domains from the previous audits based on the RCP guidelines. More recently, guidelines regarding expected dysphagia and nutritional care have been captured in the NICE (2013) *Stroke rehabilitation: long term rehabilitation after stroke* guidelines.

## **2.27 Health policy change since 2009**

Since starting the PhD programme, the political landscape of health care has changed. In 2008, spending on health care was growing (Appleby 2013), and the expectation was of continued growth and development. For example, the Exploring New Roles in Practice (ENRiP) report (Read et al. 2001) was set in the context of health funding growth and a drive towards reducing waiting times, with the authors noting that:

“The primary intention of substitution roles should be to improve patient outcomes rather than to make financial savings.” (p. 114).

Despite these good intentions, a King’s Fund report in 2010 (Appleby et al. 2010) suggested that role demarcation was continuing, and that this was thwarting NHS efficiency efforts. The authors refer to the inflexibility of roles and the professions in the NHS as a barrier to providing efficient, patient-centred care (Appleby et al. 2010). They suggest there exists:

“... a tendency towards rigid role demarcation between different professional groups and grades, which can inhibit patient-focused care and be inefficient” (Appleby et al. 2010, p. 13)

They suggested that part of the solution to meeting the future “productivity gap” in the NHS is increasing staff productivity, in part through new ways of working and redesigning care pathways.

In December 2010 the consultation paper *Liberating the NHS: Developing the Healthcare Workforce* (DH 2010) was published. This document set out how the proposals in the White Paper would affect healthcare education and training. Following public consultation, the ensuing report in January 2012 (DH 2012) set out the new framework for workforce planning. The aims of the new framework included:

- Workforce planning that is better aligned with service provision, through service providers taking a greater role in supporting the continued education and training of existing staff,
- A diverse workforce, working in multi-professional teams,
- A flexible workforce that can respond to the needs of local patients.

Highlighted throughout *Liberating the NHS: Developing the Healthcare Workforce* was the need for a workforce that is responsive to the needs of service users, and is also flexible and can respond to the changing needs and demands of health care services:

“The new framework similarly provides these organisations with opportunities to work in new ways and collaboratively support innovation and improvement in education and training and working across traditional professional boundaries.” (p. 50)

A further emphasis of *Liberating the NHS: Developing the Healthcare Workforce* (DH 2010) and *Liberating the NHS: Developing the Healthcare Workforce* (DH 2012) was to create a diverse and flexible workforce, working in multi-professional teams, which can respond to the needs of local patients. Both the earlier *A Health Service of all the*

*Talents* (DH 2000c) and the recent *Liberating the NHS: Developing the Healthcare Workforce* (DH 2012) is the role of working across professional divides and between professional groups and sectors:

“Starting with a clear understanding of the service models best able to improve health outcomes, healthcare providers will be able to identify the specific competencies and skills needed at each stage of the patient journey and develop people they employ to provide these.” (p. 29)

Specifically, in relation to the role expected of the allied health professions, *Liberating the NHS: Developing the Healthcare Workforce: From Design to Delivery* (DH 2012), stated that:

“National Allied Health Professional Advisory Board is to work with the professional bodies representing the allied health professionals towards a shared framework for post-qualification learning to meet the needs of patients, employers and professionals alike” (p. 18)

If this is to be the case, then there is still a need for a greater understanding of the opportunities and barriers that exist for inter-professional working in this way.

A further strategic development relevant to this research is the drive towards adopting and spreading innovation throughout the health service:

“This means that simply doing more of what we have always done is no longer an option. We need to do things differently. We need to radically transform the way we deliver services.” (DH 2011b, p.4).

Adoption of innovation will include changes to working practice, roles and even locations of service. In this context, innovation is defined as more than simply adding a process or procedure, but includes ideas, services or products that are applied in a new way. A key thrust behind the innovation agenda is in discarding or de-commissioning:

“...incremental, cost-additive innovations, and focusing instead on innovation that increases and improves functionality or in other ways. This puts a premium on game-changing innovations that change patient pathways and traditional delivery systems, and that are implemented in a way that strips out the processes that no longer add value.” (DH 2011b, p. 8)

A further challenge in the adoption of innovation, and innovative ways of working, in the NHS is in replicating and spreading those innovations across the entire service.

The context the NHS now finds itself in is now a very different one, with a strategic drive towards greater efficiency and “doing more with less” (Appleby et al. 2010). Since then, the global financial crisis and growing demand on health care resources has led to an urgent need to find alternative solutions to health care delivery. It has therefore become even more important to understand the factors that will restrict and enable different ways of working in the national health care service. The NHS Five Year Forward Plan (DH 2014), which continues the focus on efficiency and service redesign, was written in 2014 under the Coalition Government. Since then the May 2015 General Election has introduced a Conservative-led majority government – it would now seem more unlikely that there will be any planned deviation from this strategic thrust for the next five years at least.

Achieving appropriate skill mix to achieve the new objectives of controlling healthcare costs remains as relevant as ever, and definitions remain just as elusive. Dubois and Singh (2009) use the terms “skill development” and “skill flexibility” (p. 91). According to Dubois and Singh, skill development refers to both role enhancement and role enlargement. Both of these involve the expansion of a worker’s tasks through new skills that are not taken from other professionals. In contrast, they refer to skill flexibility as both role substitution and role delegation. Both of these involve transfer of tasks and responsibilities from one type of worker to another. Substitution refers to the transfer of the task from one type of worker with equal status to another, whereas delegation refers to the downward delegation of a task, usually to non-professionally qualified staff. Others suggest that substitution always refers to inter-disciplinary change, e.g. a task moves outside the current professional boundary to another professional group (Martinez-Gonzalez et al. 2014). Nancarrow et al. (2010) use the term to refer to role overlap between qualified health and social care staff in their study of intermediate care services in the UK. In the organisational literature, the term job enlargement refers to adding additional task to a job, whereas job enrichment refers to increasing employees’ autonomy over how work will be executed (Parker 2014).

Despite interest in the range of role extension strategies, research in the area has remained of poor quality with a focus on process rather than outcomes (Martinez-Gonzalez et al. 2014). And despite continued interest in role extension, a recent systematic review of the literature focused on extended scope roles in three allied health professional groups (i.e. physiotherapy, occupational therapy and speech and language therapy), there is limited further research since McPherson et al.’s (2004) review (Saxon et al. 2014).

## **2.28 The process of literature review following construction of the theoretical model**

I had not anticipated that skills and knowledge would be the focus of the research before commencing data collection and analysis. I had therefore not systematically reviewed this field before constructing the substantive theory and model presented in Chapters 6-8 of this thesis. Therefore, after constructing the theoretical model, I returned to the literature to review existing evidence regarding the main constructs in the model. Using the Scopus database, I reviewed the literature relating to the core concept in the model. I used the terms “explicit skills”, “explicit knowledge”, “tacit skills” and “tacit knowledge” in my search. I also reviewed literature relating to the constructs in the model. I searched the terms “personalities” with “organisational change”, and also “vision” with “organisational change”. I searched the terms “professional boundaries” and “professional change”. I also used the term “professional control”. I used the term “organisational trust” and also “trust” combined with “change”. I narrowed the search to 2000 onwards, but I used “frequently cited articles” function in Scopus to review earlier literature. All abstracts of retrieved papers were scanned and the full article obtained for those which were deemed relevant.

In this chapter I have set out, through the limited literature available on the subject, our understanding of the feasibility and opportunity for role extension in the area of dysphagia care, as well as potential drawbacks identified from other areas of role extension. I have concluded that a greater degree of role extension is feasible, and indeed is occurring in a limited number of areas. With this in mind, I have posed two research questions that aim to elucidate the factors that may enable or prevent role extension in this area. In the next chapter I will describe the methodological approach taken to answer the research questions posed, followed by two chapters that describe the methods used to collect, analyse and present the research data.

## Chapter 3 METHODOLOGY AND APPROACH

### 3.1 Introduction

In this section of my thesis, the reader will be guided through the considerations leading to the decision to use grounded theory as the methodology that was used in the research study. The chapter includes a brief review of grounded theory, as well as critiques of the methodology. I will explore the role of the researcher in qualitative research, and the measures taken in this study to facilitate the production of a trustworthy piece of research.

### 3.2 A quantitative or qualitative approach?

At the start of my PhD journey, I initially considered an experimental study design, comparing each practitioner for a set of clinical outcomes related to dysphagia and nutrition, to test whether it was feasible for dysphagia and nutrition to be managed just as effectively, and more cost-effectively, by using extended scope practitioners.

This approach was abandoned when the literature review demonstrated that there was little evidence of clinical outcomes suitable for comparison for either professional groups and as such, positive outcomes of any service redesign would be difficult to measure quantitatively. Many of the interventions used in dysphagia assessment and management have limited or unproven efficacy, as presented in the literature review.

Further to this, and possibly of even greater importance, was the question of practitioner willingness, a crucial consideration in translating research findings into clinical practice. It was this that ultimately piqued my interest, as I felt that understanding the barriers and enablers to change in this area was just as important as understanding whether or not the roles *could* expand. With political change and a drive towards outcomes, efficiency and more personalised care provision along pathways (e.g. DH 2000c; DH 2008b; DH 2008c; DH 2010), one way in which the smaller professional groups may exponentially demonstrate benefit is by working “smarter” and combining roles (DH 2008a).

Although aligning roles to clinical conditions and associated care pathways, rather than professional groups, allows practitioners as providers of clinical services to “fit in” with the commissioning objectives, I was interested in understanding if practitioners would be willing to take on new roles and responsibilities, and even relinquish areas of their “speciality”? And if not, what would prevent them from making changes? I felt that barriers to change may have its roots in real clinical concern, reluctance to take on and/

or “let go” of clinical responsibility, or a combination of both. I also felt that there may be other, as yet unknown, reasons why practitioners would be unwilling to embrace a change in practice. It was plausible that different ways of working may have simply not been considered and would be welcomed, particularly if supported by evidence of comparable clinical outcomes in future quantitative research. This question has if anything become more pertinent as the current political direction moves towards integration (Humphries and Curry 2011; DH 2013a), and even medical training moving towards multi-skilled medical training to meet future population needs (Tooke 2008; Royal College of Physicians 2013; Greenaway 2013).

A review of the literature pertaining to role expansion had indicated a number of practical (i.e. annual leave cover), clinical (i.e. detrimental to patient care) and social/professional (i.e. “doing ourselves out of a job”) barriers to broadening skill sets and role expansion. It struck me that in some areas, for example in those used as case studies of good practice, these practical barriers had in some way been overcome, or at least managed or accepted (Heritage 2001; Davies et al. 2001).

I also questioned whether, from my own experience of trying to introduce role expansion between dietitians and SLTs, many of the clinical and practical concerns were in fact concealing social and/or professional concerns. It was this point that I felt the existing literature had so far not addressed adequately. Some places were changing their ways of working and introducing extended roles in dysphagia care (Heritage 2001; Davies et al. 2001). Several bodies (including the Department of Health, National Patient Safety Agency, the Royal College of Speech & Language Therapists and the Royal College of Nursing) had come together to publish the Inter Professional Dysphagia Framework in 2006 (Boaden and Davies 2006). These developments could surely point us towards factors that could facilitate such change. On the other hand, different ways of working may have simply not been considered and would be welcomed, particularly if supported by evidence of comparable clinical outcomes in future quantitative research.

**It therefore became necessary to identify whether role expansion was feasible and could provide any benefit to patient care. If so, what factors would enable adoption, and which barriers might have to be considered?**

A mixed qualitative/ survey approach was the method of choice leading up to my research ethics application. The aim was to first use qualitative research to allow the key issues to emerge from clinical practice, and then use these themes to develop a survey tool to verify the emergent issues, using the sequential, mixed methods

research design described by Creswell (2009). This initial approach is presented in my original research ethics application; a copy of the approval letter can be found at Appendix 2.

During 2010, I was fortunate enough to take part in a Clinical Leadership Fellowship programme. It became clear through reading related to this programme, that there was a body of literature from other sectors relating to organisational theory that was relevant to the health care sector. The relevance of much of this existing literature to the NHS had in many cases been only fairly recently considered. (See Greenhalgh et al. 2004 for a similar critique of innovation in the organisational literature). A deeper understanding of professional boundary issues, for example from the field of social sciences research, remains elusive in the NHS setting (Huby et al. 2014). As discussed in the previous section, the systematic reviews presented in the literature review section of this thesis regarding extended scope practice and role revision had not linked existing organisational theory literature to role revision in health care. It therefore seemed crucial to gain a deeper understanding of the cultural, organisational and professional issues affecting role expansion in dysphagia care, and the ways in which these can be overcome. This, I anticipated, had the potential to spark debate amongst dietitians and SLTs, their service managers and commissioners, with a view to considering the opportunities of changing practice in this area, further developing existing theory in organisational research.

### **3.3 Ontology and epistemology**

Quite apart from a desire to influence change in health policy and clinical practice, I also wished to explore the arena and the issues inductively, to gain an understanding of the social, professional and other workforce issues at stake. I had my own experience, gained from working in the clinical area, and my own position about why and how dietitians and SLTs should and could change practice. Setting up an experimental design, based on the assumption that this was the right way to develop services, would have been one possible option. I still felt that this would leave questions unanswered. It might be feasible for clinicians to extend their scope of practice in the area, and an experimental study would have contributed to the knowledge base in that respect. Nevertheless, I envisaged completing the study, demonstrating the feasibility of role extension, but practice still not changing in the area, as I would have missed the key social and professional barriers and enablers to role extension. I also felt that conducting what felt like a superficial exploration of barriers and enablers to new and different ways of working, and then testing the concepts that were constructed through a survey, would not allow a deeper

understanding of the issues. This brings us to the question of ontology and epistemology.

Ontology refers to the nature of truth, while epistemology refers to the role of the researcher in any study. I have summarised Denzin and Lincoln's (2005) and Creswell's (2009) propositions about ontology and epistemology in the table below. It could be said that Denzin and Lincoln and Creswell locate themselves as qualitative researchers in different positions in respect of their paradigms. Creswell (2009) identifies himself as a pragmatist, and often uses mixed qualitative and quantitative research methods, depending on which methodology, or combination of methodologies, is best suited to address the particular research question(s). Denzin and Lincoln, on the other hand, criticized mixed methods in the third edition of *The Sage Handbook of Qualitative Research* (2005) for placing quantitative research methods above qualitative methods in a hierarchy and risking not hearing the suppressed voices that qualitative research is intended to express, taking qualitative research out of its "...natural home, which is within the critical, interpretive framework." (p. 9). With this, they firmly position themselves within a critical, interpretive paradigm. Having said that, in the fourth edition of the *Handbook* (2011), they focus less on the differences between quantitative and qualitative research, and differences between different qualitative paradigms and methods, instead concentrating more on their similarities, and how the different research traditions can work together.

	<b>Denzin and Lincoln (2005)</b> (p. 22)	<b>Creswell (2007)</b> (p. 17)
<b>Ontology</b>	What kind of being is the human being? What is the nature of reality?	What is the nature of reality?
<b>Epistemology</b>	What is the relationship between the inquirer and the known?	What is the relationship between the researcher and that being researched?
<b>Methodology</b>	How do we know the world, and how do we gain knowledge of it?	What is the process of research?

**Table 2:** Philosophical Assumptions, adapted from Denzin and Lincoln (2005) and Creswell (2007)

The quantitative, empirical research tradition favours the pursuit of the identification of variables that predictably influence another variable under certain, known conditions.

Although this research tradition assumes that knowledge is always imperfect and conjectural, researchers seek to test a theory by rejecting, or not rejecting, a preconceived hypothesis (Creswell 2009). Qualitative, interpretive traditions favour the exploration of a problem or issue, to gain “a *complex*, detailed understanding of the issue” (Creswell 2007, p. 40, italics in original). Quantitative methods seek to remove outlying variables through the research design that may negatively impact upon the predictability of a model, whereas qualitative methods seek to understand outlying conditions, rather than present generalisable findings. In quantitative research designs, the researcher will seek to remove his or her influence on the findings (Creswell 2009), or the influence of the participants or contextual factors that are not under study (bias), by using methods such as blinding and randomisation. Reality, or the approximation of reality, is pursued through measures such as calculating sensitivity and specificity of diagnostic tests, hypothesis testing, confidence intervals and *p* values. Whereas the confidence interval identifies the degree of confidence that a “true” value lies within a given set of parameters, the *p* value, or level of significance, tells us the probability that a value has been derived at through chance, rather than representing the true population value.

In contrast, qualitative and inductive research designs seek to explore and/ or describe phenomena that are not always predictable, which is often true of social situations and perceptions. To put it another way:

“To level all individuals to a statistical mean overlooks the uniqueness of individuals in our studies.” (Creswell 2007, p. 40).

Qualitative research designs *usually* assume that reality is subjective and multiple, as seen by participants in the study (Creswell 2007). For example, a thermometer may tell us the temperature in a room and the thermometer may be calibrated to give us an accurate reading of the actual temperature within a given confidence interval. How you or I perceive the temperature of the room, however, may, or likely will, vary depending upon our individual perspectives and situations. You may be used to colder rooms than I am, or you may be wearing more clothing. Interviews, for example, give a perspective on a phenomenon or experience, but not necessarily the truth, as the interviewee provides an interpretation of the past event at the present time (Darlington and Scott 2002), rather than “an inner or authentic self” (Roulston 2010, p. 204) revealed through careful interviewing. According to Hammersley (2009):

“There is no method or starting point that can *guarantee* truth...” (p. 4, italics in original)

Whereas quantitative research methods attempt to eliminate the influence of the researcher on the research topic to avoid bias, the qualitative researcher assumes that the influence of the researcher on the research question that is chosen, the research methods, data collection and interpretation cannot be erased, although we can do much to allow the voices of participants to be heard, which I will discuss later in this chapter under rigor.

To summarise the discussion so far, my own ontological and/ or epistemological position is that there **are** multiple realities, and many interpretations of what constitutes knowledge in a situation. These realities are shaped by the perspective of the informants, whether these are interviewees or the perspective in written documentation of e.g. an official agency (Clarke 2005), the researcher and the wider positions, mood, trends or, as it is often called, “direction of travel” in society **at that point in time**. Despite this, research is a useful activity, in order to know **something** about the situation which we are studying. Even though we accept that the particular interpretation which is presented in this, or in any other, qualitative research study is but one interpretation, contingent on the circumstances on which this particular researcher chooses to research this/ these particular research question(s), it is nevertheless an exploration and a presentation of that world from **a** perspective. We may then know **something** about that world – others may choose to follow and explore and present a different view, which will of course be influenced by the passage of time also.

### **3.4 Which qualitative approach?**

The need for a deeper understanding of the cultural issues pertaining to different ways of working in dysphagia care, and remaining mindful of maintaining a manageable scope and focus for the research, led to qualitative research as the epistemological approach of choice. The next question was which research approach to use. Both ethnography and phenomenology were considered, and a case study approach was also given consideration.

Whereas an ethnographic approach would have addressed the research questions in terms of describing the behaviours, processes and roles, this approach was rejected on two grounds. Firstly, I was not looking at a deep understanding and description of the culture – but rather the “linkage” between the core themes and issues and the social processes of enabling or preventing new and different ways of working in the area. There was a further reason, and a practical one – as I was undertaking this research one day per week, I did not feel that I could immerse myself fully in the field to truly pay tribute to the ethnographic method.

Phenomenology offered the possibility of understanding the world views and experience of living with dysphagia or of being a healthcare professional involved in dysphagia care. I was, however, more interested in studying and understanding the social processes and interactions of the situation. Prior research (Jacobsson et al. 2000; Colodny 2005; Vesey et al. 2008) had explored different aspects of users' experience of dysphagia. Similarly, survey research had illuminated actual practice in the area, especially for SLTs (e.g. Smith 2007).

Overall, I decided to use a grounded theory approach, as the method is widely used to understand social processes within organisations, shaped by the views of those involved in the situation (Creswell 2007; Corbin and Strauss 2008). Grounded theory emphasises "action and process" (Charmaz 2000, p. 513), where process signifies:

"The flow of action/interaction/emotions that occurs in response to events, situations, problems." (Corbin and Strauss 2008, p. 87)

In addition to this, I felt that the method would allow me to follow leads as they emerged in the data (Charmaz 2007), while simultaneously giving me "more focus than many methods." (Charmaz 2006, p.14). This fits well with exploring the feasibility of role expansion and professional attitudes where the terrain is fairly uncharted. Grounded theory uses interviews as the main source of data and I felt this would allow me to explore participants' perspectives on the issue across a temporal dimension, as practice and policy has changed in the past and continued to change as the research progressed. Although other qualitative methods also use interview data, the ability to probe and clarify during interviews (Darlington and Scott 2002), and to follow leads to gain some understanding of the process and actions in the situation, fits well with a grounded theory approach.

Another reason for choosing the grounded theory method is its widespread use in health care research. Holloway and Wheeler (2009) suggest that this method appeals particularly to health care researchers, as it provides a systematic and organised way of data collection and analysis, by describing "the steps of the research process and provide[ing] a path through it..." (Charmaz 2006, p. 9). Thomas and James (2006) suggest that grounded theory appeals particularly to new qualitative researchers, as the "procedural rules" point to a "right way" to conduct qualitative research (p. 29). The method therefore provides a "safe" introduction to the field of qualitative research, while allowing me to develop theory-building and analytical skills in research.

### 3.5 What is Grounded Theory?

“The intent of a *grounded theory study* is to move beyond description and to *generate or discover a theory*, an abstract analytical schema of a process (or action or interaction) (Creswell 2007, p. 63, italics in original).

The method was developed from sociology by Barney Glaser and Anselm Strauss in the 1960's. At this time, quantitative methods (Charmaz 2006) had gained prominence in sociological research. Glaser and Strauss felt these methods, and the *a priori*, theoretical orientations in sociology that were prevalent at the time, were “often inappropriate and ill-suited” (Creswell 2007, p. 63) for the study of social or social psychological processes within a social setting. At the same time, previous guides for conducting field research primarily dealt with data collection methods and researchers' membership roles in field settings (Charmaz 2006) and so Glaser and Strauss's systematic strategies legitimised qualitative research as a credible methodological approach (Charmaz 2006).

Glaser and Strauss came from two very different epistemological backgrounds, and this was reflected in their methodology. Glaser brought the systematic approach of grounded theory methods, influenced by his rigorous quantitative research methods learned at Columbia University, to the method. Strauss, on the other hand, influenced the method with his background in Chicago school sociological field research methods and philosophy (Charmaz 2006). Glaser intended to codify qualitative research methods and advocated building useful 'middle-range' theories, grounded in data, as opposed to the 'grand' theories of mid-century sociology that had no foundation in systematically analysed data (Charmaz 2006).

Strauss adopted both symbolic interactionism and the Chicago legacy of ethnographic research. As Charmaz asserts:

“Symbolic interactionism assumes that people can and do think about their actions rather than respond mechanically to stimuli...” (Charmaz 2006, p. 7)

Strauss also viewed human beings as active agents in their lives and in their worlds and assumed that process, not structure, was fundamental to human existence. For Strauss, subjective and social meanings emerged through action, and the construction of action was the central problem to address (Charmaz 2006).

Glaser and Strauss's method held that theories should be "grounded" in data from the field, especially in the actions, interactions, and social processes of people, thus providing for the generation of a theory through interrelating categories of information

based on data collected from individuals (Creswell 2007). Glaser and Strauss proposed using procedures for generating theory that differed from those required for testing it, starting with a general problem or topic (Dey 1999). They elaborated on their ideas in a book called *The Discovery of Grounded Theory* (Glaser and Strauss 1967). The two authors ultimately disagreed about the meaning and procedures of grounded theory and parted company. Strauss went on to work with another researcher, Juliet Corbin, and together they published *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* in 1991. A second edition of *Basics* followed in 1998. After Strauss's death, Corbin went on to publish third and fourth editions of *Basics* posthumously with Strauss in 2008 and 2015. For his part, Glaser went on to research and publish on his version of Grounded Theory (1978), started the publishing company Sociology Press specializing in grounded theory methodologies and founded the web based organization Grounded Theory Institute.

By the 1990's, grounded theory had gained acceptance as a research method, but began to be accused of positivism, particularly as it was often used by researchers with only a superficial grasp of the method. The legitimacy of the methods appealed to qualitative researchers from varied backgrounds and was often used as the qualitative method of choice in mixed methods projects (Charmaz 2006). A growing number of scholars have moved grounded theory away from the perceived positivism in both Glaser's and Strauss and Corbin's versions of the method (Charmaz 2006).

“Strauss and Corbin's version of grounded theory...favors their new technical procedures rather than emphasizing the comparative methods that distinguished earlier grounded theory strategies.” (Charmaz 2006, p. 8)

Charmaz (2006) advocated for a constructivist grounded theory, while Clarke (2005) went even further, by suggesting that social situations should form our unit of analysis in grounded theory, developing yet another permutation with a focus on situational maps. In the procedures described by Strauss and Corbin (1990, 1998), the researcher seeks to systematically develop a theory that explains process, action, or interaction on a topic (Creswell 2007). Instead of embracing the study of a single process or core category as in Strauss and Corbin's (1998) approach, Charmaz emphasises multiple realities and the complexities of particular worlds, views, and actions, offering up a social constructionist version of grounded theory (Dey 1999). Constructivist grounded theory, according to Charmaz (2006), lies squarely within the interpretive approach to qualitative research, with developed theory very much dependent on the researcher's view. The focus is on “the views, values, beliefs, feelings, assumptions, and ideologies of individuals” (Creswell 2007, p. 66), rather than the methods of research. Research guidelines are flexible and “researchers can use

basic grounded theory guidelines such as coding, memo-writing, and sampling for theory development” (Charmaz 2006, p. 9).

The main differences between Strauss and Corbin’s (and later Corbin and Strauss’s) version(s) of grounded theory, and constructivist versions, are summarised in the table below, reproduced from Clarke (2005).

<b>TRADITIONAL/POSITIVIST GROUNDED THEORY</b>	<b>POSTMODERN/CONSTRUCTIVIST GROUNDED THEORIZING</b>
<i>*** All of the following should be assumed to hold only part and never all of the time/in all cases.</i>	<i>*** All of the following should be assumed to be followed by “if and as found in the data.”</i>
Positivist/realist	Constructivist/ relativist
Dualism of subject and object	Continuities of subjects and objects
Discovering/finding	Constructing/making
Correspondence theory of truth	Constructionist theory of knowledge production
Naive objectivity	Noninnocent subjectivity/reflexivity
(Over)homogenization; (over)generalization	Multiple positions; heterogeneous representations
A priori rejection of contradiction as possible	Representation of contradiction(s) as analyzed/interpreted
Simplification desired	Complexity represented
Seeks to be conclusive	Tentative, opening, jarring, troubling
Authority of author/”expert” voice dominant	Multiple voices, perspectives, intensities, reflexivities
(False/overdrawn) clarity	Ambiguity or representation
”Normal”/average plus ”negative cases”	Difference, range of variation, outliers, positionality
Tacitly progressive; linear	Doubtful; reads against the grain
Assumption of normativity	Assumption of positionality
Metaphors of normal curve	Metaphors of cartography
Goal: To delineate a basic social process (BSP) and formal theory	Goal: To construct processes, sensitizing concepts, situational analytics, and theorize

**Figure 2:** From Traditional/ Positivist to Postmodern/ Constructivist Orientations to Grounded Theory (Clarke 2005, p. 32)

For my own part, I started this research project with an assumption that a reality could be discovered, using the methods described by Corbin and Strauss. Throughout this journey, as I have experienced doing grounded theory, I have come to the conclusion that reality is an interpretation, constructed by the researcher and the “researched”, bound by contextual, temporal and geographical factors, as well as personal and professional experiences. Even the main findings in this study, presented in the findings chapter, are in interpretation of different ways of working in a clinical area, influenced in large part by history and the experiences of those in the different NHS Trusts.

Having said that, although I would like to identify myself as a constructivist, I find it difficult to tear myself away from assumptions that my findings are the truth, rather than a construction between myself (the researcher) and the participants that I interviewed. Using an interpretivist approach, we can accept that there are many truths, my truth being one among many. By being clear and transparent about my method the reader can judge the relevance and usefulness of my truth or account. Even then, I may only have touched the surface of their view on the subject matter and much may, or probably has, remained unearthed. I think that this is my training, in a quantitatively focussed field. I may have started to shed this mantle a little, as Charmaz’s attention to grounded theory as an interpretation of a situation and a construction between researcher and researched speaks to my own evolving interpretation, feeling and understandings of grounded theory. She states that (2005):

“Essentially, grounded theory methods are a set of flexible analytical guidelines that enable researchers to focus their data collection and to build inductive middle-range theories through successive levels of data analysis and conceptual development.” (p. 507)

Despite this resonance with the attention to construction and interpretation in developed theory, I have, as a beginning grounded theory researcher, relied on the research methods described by Corbin and Strauss (2008), precisely because of their systematic approach (Creswell 2007). Furthermore, I am no longer convinced that there is such a dichotomous position to the two interpretations of grounded theory, with even Corbin recently (2009) stating:

“I agree with the constructionist viewpoint that concepts and theories are constructed (they don’t emerge) by researchers out of stories that are told by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and themselves. Out of these multiple constructions, analysts build something that they call knowledge.” (p. 39)

I find some of the critiques of the method somewhat unfair and occasionally missing the point. For example, Glaser and Strauss's (1967), and later Strauss and Corbin's (1991, 1998) handbooks were an attempt to describe and explain, in written words, procedures that perhaps just "click" with practice. In the third edition, Corbin defends their methods and expands on her own changing position with experience, suggesting that:

“...even though any particular theory may become outdated as new knowledge comes to light, and even though theories do not represent ‘reality’, and even though theories are reductionist, they have over the years proven useful.”  
(Corbin and Strauss 2008, p. 55)

This is precisely the point, and in responding to the criticisms of, for example Dey (1999) and the meaning of theoretical saturation, that Corbin and Strauss were pragmatists. By their own admission, *Basics* was written as a handbook for qualitative researchers that could not be trained and schooled under the experienced grounded theory researchers. For this purpose, the method does describe adequately, for a novice researcher, what is meant by saturation and when this can be said to have been achieved, always for the purposes of this particular study and bearing in mind the imperfection and multiple meanings of truth inherent in any research. Saturation is explained in terms of linkage of the categories and their development in terms of their properties and dimensions. One can ask a researcher to explain what these are within a particular research project. Any interpretation of the methodology which allows a researcher to conduct perhaps 5-6 interviews and declare saturation, which has been the critique, is just poor research conduct rather than a flaw in the method. More recently, Corbin (2009) has expressed this point in the following way:

“Whenever a writer tries to put into words what he or she does when doing analytic work, it becomes rigidified and open to unintended uses. Yet, the actual research process is fluid, dynamic, and evolving...” (p. 50)

Despite these observations, the criticisms of grounded theory have no doubt been instrumental in moving the method along and further developing this, as is the purpose of scientific endeavour.

The reader will be taken through the precise research methods that were used in this study in the next chapter, but for now, I will explore briefly some of the key methods of grounded theory. These include:

- Coding
- Concepts and categories derived through constant comparison

- Theoretical sampling and saturation
- Theory

### 3.6 Coding in Grounded Theory

Coding is a central feature of grounded theory. Although Strauss and Corbin (1991, 1998) and later, Corbin and Strauss (2008) refer to three stages of coding, Charmaz (2011) suggests that:

“Those following Strauss and Corbin (1990, 1998) often adopt complicated coding procedures to generate themes... Grounded theory coding need not be complex.” (p. 370)

Charmaz (2006) prefers instead two phases of coding:

“1) an initial phase involving naming each word, line, or segment of data followed by 2) a focused, selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate, and organize large amounts of data.” (p. 46)

Dey (1999) takes issue with coding, suggesting that in practice, this often becomes a “code-first think-later’ approach” (p. 129) rather than an integration of coding and simultaneous analysis. I have tackled this particular critique in my coding and analysis by interspersing analysis with coding, i.e. analyse (listen through + mind maps) → code → analyse (refine mind maps + put on computer) → sort codes, which is described in more detail in the next chapter. Also, I am not sure whether, when a researcher is truly immersed in their data and the analysis, coding can become separate to the analysis. I certainly found that, because coding is a less demanding mental task using NVivo, it allows the researcher’s mind time to think about the text that you are coding, it’s meaning, and setting it within the context of your overall research. I also found that, having to make decisions about coding and the possible meanings of data, whether or not to give sections of data a new code, or to place them within an existing one, are in themselves analytical tasks.

### 3.7 Concepts and categories in Grounded Theory

Corbin and Strauss (2008) suggest that categories are “conceptual names” (p. 90) that the researcher places on groups of codes. Although Dey (1999) critiqued the use of categories in the 1991 and 1998 editions of Basics, Corbin and Strauss (2008) later suggested that:

“...though there are multiple interpretations that can be constructed from one set of data...generating concepts is a useful research endeavour.” (p. ix)

They go on to suggest that generating concepts increases our understanding of persons, their issues and how they resolve these. These understandings, generated through categories, can then be incorporated into an ever growing understanding and body of knowledge on a topic or issue. Dey (1999) suggested that Strauss and Corbin both treated categories as variables in quantitative research methods, and that the focus on one core category may exclude or underestimate other important issues. He proposes that:

“This is one area where the normal injunction of grounded theory – never to look for a fit in the data – seems to be suspended.” (p. 111)

One of the reasons for developing a core category, which Dey does concede, is the need to set boundaries to a research project which, without a focus on one central issue, could otherwise never reach a conclusion.

Constant comparison is another central feature of the grounded theory method:

“...making comparisons between data...and in doing so, deriving concepts to stand for those data...” (Corbin and Strauss 2008, p. 66)

The researcher compares data, codes and categories to “generate and inform ... ideas” (Charmaz 2006, p. 19). Memos are the primary tool for comparing data, and Corbin and Strauss (2008) provide us an example of using memoing to compare data derived from a project into the Vietnam War. In the accompanying memo, they begin to relate the section of data provided in the example to the broader concept of ‘locating the self’ that was developing in their project. These data also provide:

“...direction for the next set of data collection. Directing the next data collection is the question of how does being either a ‘combatant’ or a ‘noncombatant’ influence the war experience?” (Corbin and Strauss 2008 p. 193)

Charmaz (2006) too uses memos to make comparisons and the term “Theoretical Sorting”:

“Take a memo from your pile and compare it with another, then another....How do the memos compare? Does your comparison spark new ideas? If so write another memo....If it helps, take your related memos and form quick clusters with them.” (p. 117).

She advises further that the researcher should make “systematic comparisons between observations and between categories” (p. 182).

### 3.8 Theoretical sampling and saturation

Both Dey (1999) and Charmaz (2006) take issue with the term saturation. For example, Dey suggests that the term has overtones of quasi-quantitative comparison in an attempt to raise the legitimacy of grounded theory methods. It is not the concept of saturation *per se* that Dey takes issue with, but rather the phrase, with its quantitative overtones. He supports the concept of saturation:

“Otherwise, the constant comparison method would entail a sampling and data collection sequence of quite substantial proportions...” (p. 118)

He further contends that:

“...a decision not to collect further data can be no more than a guess (albeit more or less well grounded) that such an investment is no longer worth the trouble given the likely (theoretical) reward.” (p. 117)

Charmaz (2005) also questions theoretical saturation, but from the standpoint of the meaning of the term: “But what does saturation mean?” (p. 527). She is concerned with the use of only one criterion to justify the type, relative depth, and extent of their data collection and analysis, often to justify small samples. O’Reilly and Parker (2012) contend that in reality:

“...there is limited practical guidance or help to show researchers when saturation has been reached.” (p. 193)

Charmaz (2006) also warns against misinterpreting theoretical saturation for either gathering data from representative samples and/ or “...gathering data until they find the same patterns reoccurring” (p. 101). The former will produce “conceptually thin data” (p. 101), whereas the latter will merely describe “empirical themes in their studied worlds” (p. 102). Instead, the researcher should sample based on the conceptual categories that they have constructed early on in the research, sampling to develop these categories, and gathering data “toward explicit development of theoretical categories derived from analyses of their studied worlds.” (p. 102)

Rather than saturation, Dey (1999) prefers the term sufficiency rather than saturation, suggesting that:

“Theoretical ‘sufficiency’ would then refer to the stage at which categories seem to cope adequately with new data without requiring continual extensions and modifications...or ‘good enough’.” (p. 117)

Charmaz (2006) also prefers to use the term “sufficient”, and goes on to describe what might constitute sufficient data collection (p. 18 – 19):

- Have I collected enough background data about persons, processes, and settings to have ready recall and to understand and portray the full range of contexts of the study?
- Have I gained detailed descriptions of a range of participants’ views and actions?
- Do the data reveal what lies beneath the surface?
- Are the data sufficient to reveal changes over time?
- Have I gained multiple views of the participants’ range of actions?
- Have I gathered data that enable me to develop analytical categories?
- What kinds of comparisons can I make between data? How do these comparisons generate and inform my ideas?

Despite the validity of these arguments, rather than take issue with the term that is used, I have chosen to continue to use the language of Corbin and Strauss in the third edition of *Basics* (2008), and refer to theoretical saturation. Although I use the term theoretical saturation, I understand this in Charmaz’s (2006) terms as sufficient data collection. A researcher does have to conclude a research study, and different researchers may collect more or less data for a given project. Although sufficiency is a matter of interpretation, to me it means having gained a broad and deep understanding of the topic area. Exploring a range of views will add to the study’s depth, whereas “reveal[ing] what lies beneath the surface” (Charmaz 2006, p. 19) and understanding the central process, the conditions and context within which actors operate and impact upon the process add to the depth of a study. Whereas I understand the criticism that all too often grounded theorists use saturation to justify collecting insufficient data and concluding a study too early, I feel that I gained some tacit understanding, through the experience of conducting a grounded theory, of when further data collection is no longer adding substantially to the developing categories. As discussed earlier, Glaser and Strauss’s (1967), and later Strauss and Corbin’s (1991, 1998) handbooks attempted to describe procedures, including saturation, that the researcher can sense and feel, if one is wary to do justice to the data, by not concluding too early in order to be finished.

### 3.9 Theory

The development of theory from the research, whether one takes a constructivist standpoint or leans towards the original position of Glaser and Strauss, is the central aim of grounded theory. Corbin and Strauss (2008) suggest that both “substantive theory” (p. 40), e.g. theory that relates to a specific situation, or “middle-range theory” (p. 40), or theory that helps to explain a phenomenon beyond the very specific circumstances of study, can be developed using grounded theory methods. She suggests that initial theory can be used to develop middle-range theory and increasingly on to higher-level, more abstract, and general theories. More recently, Morse (2009) seems to suggest that grounded theory can develop “...mid-range theory that remains linked to these data, yet is generalizable to other instances and to future instances.” (p. 14), rather than higher level theory.

Corbin and Strauss (2008) suggest several techniques for refining theory developed through grounded theory, including:

- a) reviewing the scheme for internal consistency and for gaps in logic,
- b) filling in poorly developed categories and trimming excess,
- c) validating the scheme. (p. 109)

Although there are issues with the term and meaning of “validation”, which I will explore shortly, this list does point to some constructed meanings of theory and how theory can be developed. In the third edition of *Basics*, Corbin (2008) still uses the term, to suggest that the desired outcome of grounded theory is theory development, whether this be “middle-range” or otherwise.

### 3.10 Rigor in Grounded Theory

Questions of validity and reliability came to be asked of qualitative research during the “*crisis of representation*” (Lincoln and Guba 2005, p. 19, italics in original) between 1986 and 1990. Issues of reliability and validity surfaced during this period, as questions of how terms such as validity, generalizability and reliability could be applied to qualitative research arose (Lincoln and Guba 2005). At a policy level, movements such as the scientifically based research (SBR) movement in the United States, and the Research Assessment Exercise (RAE) in the UK (Altheide and Johnson 2011) arose, strengthening the quest of qualitative researchers towards finding ways of ensuring rigor in qualitative research that fits with the ontological and epistemological framework and assumptions of qualitative research itself (Altheide and Johnson 2011).

“A positivist view of validity works fine in a different social universe where there are not multiple perspectives, vastly different methods and materials with which to work, and myriad uses and audiences.” (Altheide and Johnson 2011, p. 593)

In the third edition of *Basics* (2008), Corbin and Strauss seem on the one hand to attempt to distance themselves from a more positivist approach to rigor, while on the other, continue to use terms such as validating, as referred to in the previous section. They suggest that a researcher can use the literature to confirm the findings and extend and validate knowledge in the field. They go on to say that:

“Another way to validate is to actually tell the story to respondents or ask them to read it, and request that they comment upon how well it seems to fit their case....participants should be able to recognize themselves in the story that is being told.” (p. 113)

They attempt to clarify their position by stating that their use of the term validating is “... not mean[ing] to imply that we are testing hypotheses in a quantitative sense”, but rather “refer[ring] more to a checking out of interpretations with participants and against data as the research moves along” (p. 48). They do not feel comfortable using the terms ‘validity’, ‘reliability’, nor ‘truth’, as “These terms carry too many quantitative implications” (p. 301), but instead prefer the term ‘credibility’, as it “indicates that findings are trustworthy and believable”, and “reflect participants’, researchers’ and readers’ experiences with a phenomenon” (p. 302), but “is only one of many plausible interpretations possible from the data.” (p. 302).

Charmaz (2006) takes a pragmatist approach to rigor in her exposition of constructivist grounded theory. One senses her emphasis on the need for the theory to stand up to its practical application one step further in asserting that:

“If the research findings are ‘credible’; that is, believable or plausible and ‘applicable’ in the sense that findings can be readily used because the findings provide insight, understanding, and work with diverse populations and situations to bring about desired change, then it seems to me all this philosophical debate about ‘truth’, ‘validity’, and ‘reliability’ is superfluous....the ‘proof is in the pudding’, If it ‘fits’ and is ‘useful’ because it explains or describes things, then what is all the concern about rigor...Rigor must have been built into the research process, or the findings would not hold up to scrutiny, would not fit similar situations, and would be invalidated in practice.” (p. 301)

Charmaz (2006) draws up a list of criteria for judging the quality of grounded theory research, which Corbin and Strauss (2008) refer to as “...the most comprehensive because they address both the scientific and creative aspects of doing qualitative research.” (p. 299). These ten points of Charmaz’s list are reproduced in the table below (p. 305 – 306):

1. Fit – do professionals “react emotionally as well as professionally to the findings?”
2. Applicability – “Can they (the findings) be used to develop policy, change practice, and add to the knowledge base of a profession?”
3. Concepts – “...density and variation.”
4. Contextualisation of concepts
5. Logical flow of ideas
6. Depth – “it is the descriptive details that add the richness and variation”
7. Variation
8. Creativity – “It is not that the topic needs to be new, but that new understandings of that topic are brought forth.”
9. Sensitivity – “Were the questions driving the data collection arrived at through analysis, or were concepts and questions generated before the data were collected?”
10. Evidence of memos

**Table 3:** Criteria (Charmaz 2006) for judging the quality of grounded theory research

Despite this more pragmatist approach to rigor, Corbin and Strauss (2008) warn against “... mix[ing] up different methodologies, or us[ing] only certain procedures and not others...” (p. 303), as this erodes credibility.

Although O’Reilly and Parker (2012) suggest that “there is no singular way to measure the quality of qualitative research because it is so diverse...” (p. 191) I have referred to the ten points of Charmaz’s (2006) list, as these are specific to grounded theory and appear to have been endorsed by Corbin and Strauss (2008). I will demonstrate how I have addressed these issues at the end of the methods chapter.

### **3.11 The role of the researcher in grounded theory**

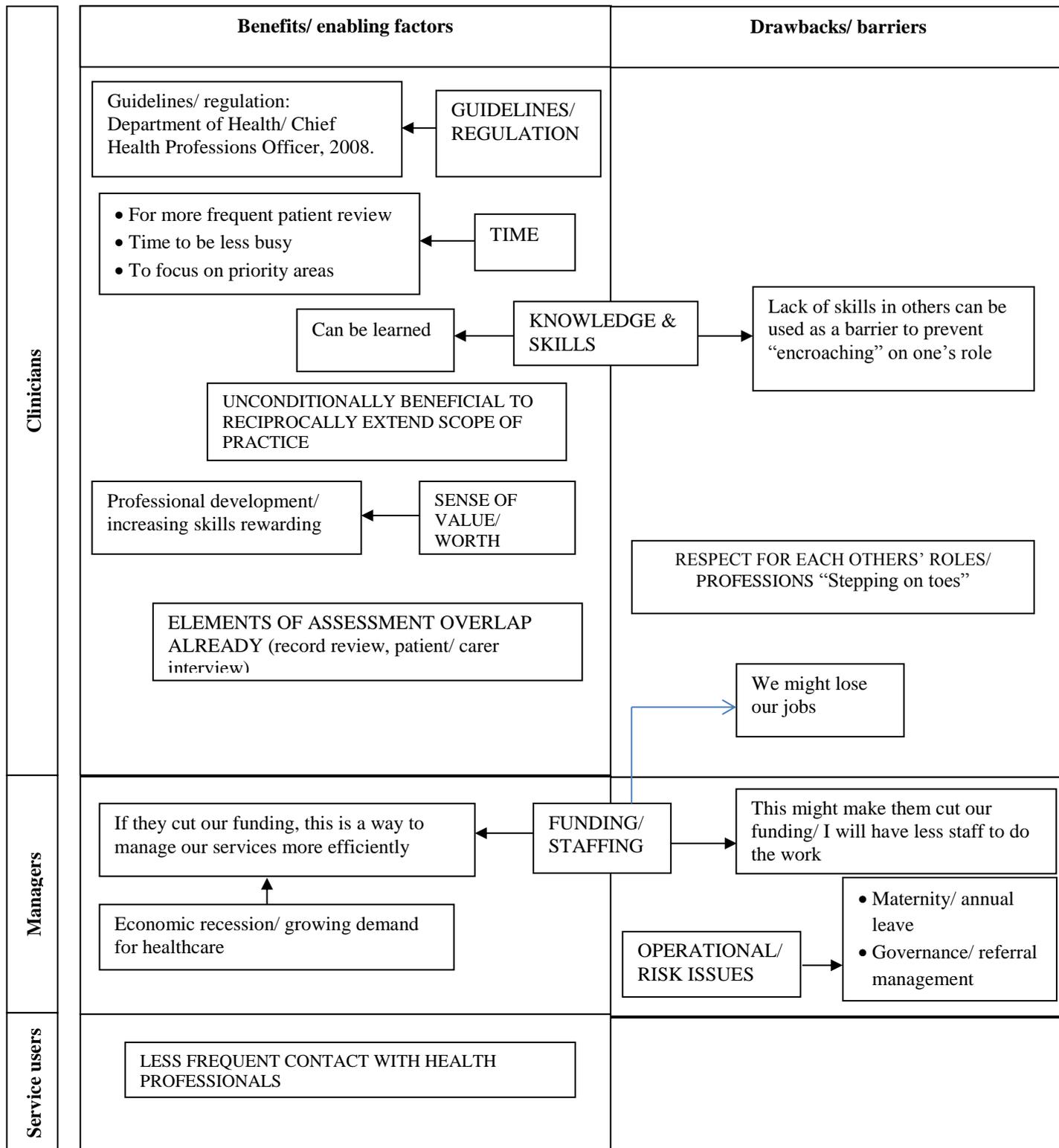
The role of the researcher in which data are collected and how those data are analysed and interpreted is influenced in part by the epistemological assumptions of the researcher and those reading and later using the research findings. Charmaz (2007) and Dey (1999) assert that the researcher is a fundamental part of the research process and that the findings of the research are the researcher’s interpretation of the world which is being studied. The researcher is central to qualitative research, as they influence which data are selected, how they are collected and interpreted (Finlay

2002). The assumptions and the past and present experiences that the researcher brings cannot be overlooked, nor put aside. Charmaz (2006) states that our conclusions are “an *interpretive* portrayal of the studied world, not an exact picture of it.” (p. 10, italics in original) and that (2011):

“...realities are multiple and the viewer is part of what is being viewed....Values shape what stands as fact.” (p. 366)

Strauss and Corbin, in the second edition of *Basics* (1998), suggested that “we know that we can never be completely free of our biases” but sought ways to move beyond these. Researchers are human beings, with prior understanding of human emotions and “their heads are full of notions” (Thomas and James 2006, p. 20). In many respects, a deep understanding of the subject area and the language that is used can be beneficial to the researcher and the research (Dey 1999). Thomas and James (2006) assert that *a priori* assumptions make a study both worthwhile and possible, as the researcher must possess prior knowledge of the field in order to be able to interpret actors’ actions.

In order to be upfront about my own expectations and assumptions before embarking on the research, I captured my assumptions about the benefits and drawbacks of role expansion in the area of dysphagia care in the form of a model, before starting the research. This was both for the benefit of future readers of my research, and my own, as I acknowledged, captured and constructively used these assumptions throughout the research process by writing reflexive memos, described in section 4.2.24. This model is presented in Figure 3 below. It should be borne in mind that this model is merely an attempt to capture my *a priori* assumptions about the enabling factors and barriers to role extension in dysphagia care before the start of data collection. This model is therefore a reflection of the assumptions that I brought to the research before embarking on data collection analysis, borne out from my own clinical practice and immersion in the area, as well as issues raised by the literature reviewed in Chapter 2. Other researchers would have brought very different assumptions to this research based upon their own experience and background. For example, as a busy, practising dietitian, I perceived less frequent contact to confer a benefit. This may have been a benefit to service providers, but service users may have viewed this very differently and instead valued frequent clinical contact.



**Figure 3:** Model of assumptions before the start of data collection

In this model, assumptions about the barriers or drawbacks to new and different ways of working are presented in the right hand column and assumptions about the benefits and enabling factors in the left hand column. Those factors which I expected could be either a barrier or an enabler are presented straddling the dividing line. The reader will notice, when comparing this model with the findings and the theoretical model that was

derived through the research that a few of my prior assumptions remain in the theoretical model. For example, fears over funding cuts and knowledge and skills appear in both models. Despite this, the final theoretical model that is presented in the Findings chapter, is substantively different from these initial assumptions. For example, operational issues featured much less as a key issue than my own prior assumptions, and the literature review, suggested. I had also assumed that health policy would play a much bigger role, and yet this was not the case. Despite my experience in the field, I was surprised at many of the concepts to emerge and the complexity of issues in the arena.

### **3.12 Summary**

Throughout my PhD journey, I have been enlightened by the world of qualitative research. Starting from a position grounded in the quantitative research paradigm, with little awareness of interpretive research traditions, I have explored and practised qualitative research methods. This has been an enjoyable, if challenging, journey. I end this particular research project in a different place from where I started at the beginning of the second phase to where I was at the beginning of the first phase, let alone when initiating the study design. This journey is reflected throughout this thesis, as I struggle to contend with many years of grounding in known “truths”, to exploring multiple truths. I recognise that I have a long way yet to go.

In the following two chapters, I will guide the reader through the research methods used, so that the reader may judge the credibility of the findings presented in Chapters 6 - 8.

## Chapter 4 RESEARCH METHODS – PHASE 1

### 4.1 Introduction

In this chapter I will outline the methods used in the research to address the research questions:

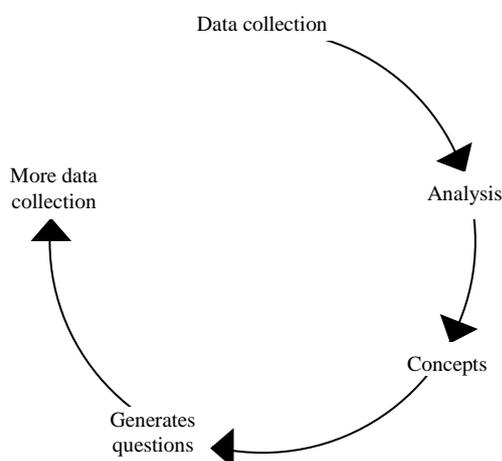
1. What are the barriers to extended scope practice in dysphagia management in routine clinical practice, in the acute and community care setting from the perspective of:
  - a. clinicians providing care and their professional representatives,
  - b. service users,
  - c. those who manage and commission dysphagia services?
  
2. What are the enabling factors in adopting extended scope practice in dysphagia management in routine clinical practice, in the acute care setting, from the perspective of:
  - a. clinicians providing care and their professional representatives,
  - b. service users,
  - c. those who manage and commission dysphagia services?

This chapter will describe the sampling strategy, research ethical considerations and how the research sites were accessed; data collection and analysis processes; consent and issues of research governance. This chapter will also describe theoretical development and provides examples of this: coding, memo writing, development of the concepts and identification of the core concept, modelling and theoretical sampling. Although the nature of the term theory in grounded theory is disputed (Thomas and James 2006) I will use this term throughout to put a name to the process of making sense of the data. I will finally “represent” (Creswell 2007, p. 147; Roulston 2010) and interpret (Thomas and James 2006), in the form of a model, the social process by which dietitians and SLTs enable or prevent new and different ways of working in dysphagia care, to understand “behaviour and process” (Charmaz 1995, p. 28).

### 4.2 Study design

The study used the grounded theory approach described by Corbin and Strauss (2008), while attempting to maintain a focus on the data, rather than constrict the data to the procedures, a critique of grounded theory (Thomas and James 2006). For example, whereas the theoretical model initially attempted to delineate the causal and intervening conditions, the strategies and their consequences, as prescribed by Corbin

and Strauss (2008), further development of the model followed and represented the data. The final model does therefore not explicitly identify the causal and intervening conditions, the strategies and their consequences. I used the constant comparative method of data collection, coding, memo-writing and theoretical sampling described by Corbin and Strauss (2008), while attempting to capture the assumptions and reflections of the researcher as an integral part of the development of theory throughout the research process. Early interviews formed the basis of subsequent interviews, and the developing model, generated during the first phase of the research, formed the basis of category saturation and the content of the second phase of interviews. As in the first phase, the theoretical model and the categories continued to inform subsequent interviews. This process of initial data collection and analysis, developing the initial concepts and identifying further sources of data (Corbin and Strauss 2008) is demonstrated in Figure 4 below.



**Figure 4:** Corbin and Strauss’s data collection and analysis model (2008)

Data collection and concurrent data analysis continued during Phase 1 until the core concept and main categories, or themes, were identified. This was captured as a working model, and gaps in this model were identified. Theoretical sampling was then used in Phase 2 of data collection and analysis to saturate the categories and to further develop the theoretical model. This is described in more detail later on in this chapter.

### 4.3 Data sources

Data were collected through semi-structured interviews, augmented by documentary sources. Data were collected and analysed in two phases. I will first outline the methods of data collection and analysis for the first phase of the research. I will then go on to describe the methods of the second phase of the research, where these differ, in Chapter 5.

The first phase generated the main theoretical concepts; the second phase developed these concepts and the theoretical model further, and also explored the credibility of the findings with participants.

During the first phase of the research, I interviewed 28 participants across two NHS Trusts. In the second phase, I interviewed a further 16 participants (total n = 44); some of these I had interviewed previously, others were “new” participants to the research. I will describe the rationale behind participant selection in the following sections.

In the first part of Phase 1, data were collected and analysed from 12 participants (Interviewees 01 – 12), and an initial theoretical model was constructed. In the second part of Phase 1, data were collected and analysed from a further 16 participants, i.e. Interviewees 13 – 28. As these data were collected and analysed, the developing theoretical model was modified. This model is presented within the main body of the text (p. 129) and also in Appendix 3.

#### **4.4 Sampling strategy – Phase 1**

Dey (1999) recommends sampling in two stages:

“This sampling process is presented in two stages, first including groups with minimal differences (to establish ‘the basic properties of a category’) and then those with maximal differences (to bring out the widest possible variation in categories). The aim, though, is not to use differences to negate established relationships but rather to recognize and incorporate new conditions.” (p. 171)

Charmaz (2006) recommends:

“For initial sampling, you establish sampling criteria for people, cases, situations, and/ or settings before you enter the field. You need to find relevant materials for your study whether that leads you to sampling people, settings, or larger structures such as government agencies or organizations.....” (p. 100)

Following on from these recommendations, the initial sampling strategy was to purposively select SLT and dietetic departments from two NHS Trusts. The departments studied were selected in order to generate new ways of thinking about the dysphagia arena from two varied perspectives (Walton 1992). The first two SLT and dietetic departments were providing dysphagia and nutritional care with the traditional role division of dietitians and SLTs. The second was a Trust where both departments had extended roles in dysphagia and nutritional management. Based on my prior knowledge of the area, I felt that this would provide a broad perspective and variation in the topic, and thus provide a rich understanding of the area.

I have called the NHS Trust using the traditional role division of SLTs and dietitians Billington, for the purpose of confidentiality. I have called the second Trust, where the dietitians and SLTs had extended their roles, Haslem. Billington and Haslem were located in England. Both provide dysphagia and nutrition care across acute and community, as well as rehabilitation – I felt this was an important element in the sampling strategy, as this would offer a wider perspective on the research questions, due to different patient needs during the acute and chronic stages of illness.

The initial participants fell into four main groups (Table 6), informed by my clinical background in the area. I anticipated that these would be the key groups of individuals involved in the management of dysphagia and therefore the richest sources of data in relation to the research questions.

Once in the field, informants for the first phase were identified initially through purposive sampling. My lead contacts in the field suggested the first participants. They had been involved in the R&D application and I therefore felt that they understood the research topic. They put me in touch with e.g. the stroke lead dietitian and the stroke lead SLT. In Billington, the lead person for this was initially the dietetic manager. Due to workload issues and then maternity leave, the research nurse later took the lead for identifying service users and nurses. She identified service users, as she had contact with each and every one who was admitted to the stroke unit. She also cascaded information about the study to the ward nurses, and it is through this that nurses approached me. As data collection progressed, further participants were identified through snowball sampling – “you need to talk to x” - a dietetic manager perhaps, or the stroke co-ordinator. In Haslem, the community SLT manager was the lead contact.

I started data collection in Billington, before progressing to Haslem. The intention was to generate the initial codes in Billington, before moving to Haslem to further develop these codes, as well as generate new codes. After the first interviews, I then went back and forth between both Trusts. In this way, I anticipated being able to explore perspectives on a concept or issue from different viewpoints, thus establishing the dimensions and properties of the categories as they developed.

#### **4.5 Identifying and accessing the research settings**

I will now describe how I identified and accessed both the “traditional care” SLT and dietetic departments and the “extended roles” SLT and dietetic departments.

#### 4.6 Identifying the “traditional care” SLT and dietetic departments

Corbin and Strauss, in the third edition of *Basics*, suggest that:

“...prior to beginning the investigation, a researcher can reason that events are likely to be found at certain sites and within certain populations.” (p. 157)

I was aware, from my professional connections and knowledge of the area, that role extension had not been trialled to any great extent in the South West of England before starting the research. Based on this, as well as for logistical reasons, I decided that sampling an NHS Trust in the South West should suitably allow me to start developing categories and contrast these with data from a dietetic and SLT department that had extended their roles. To this end, I obtained from the then Strategic Health Authority listings of staffing numbers, by grade, for SLT and dietetic departments in the South West. The intention was to select and approach SLT and dietetic departments at NHS Trusts with a fairly typical workforce profile. It became apparent during this exercise, that the historic structures and employment arrangements were particularly convoluted in SLT and dietetic teams. Very often (and most often for SLT services), services were purchased in to one organisation from a different one, through Service Level Agreements. This meant that the SLT and dietetic teams providing a service to a specific hospital or community Trust were employed by different organisations. I felt that including Trusts like these may impact upon the research findings, by introducing the issue of their particular service level arrangements (for example, “it would be difficult for us, because the SLTs/ dietitians are employed by another Trust”). The complex management arrangements of the Allied Health Professions were referred to be Read et al. (2001) also:

“Patterns of accountability and line management were difficult to uncover and were not always perceived in the same way by everyone involved.” (p. 168)

It concerned me that, if I were to include SLT and dietetic departments with complex employment arrangements, participants may have focussed more on the barriers and difficulties inherent in these employment and management arrangements, rather than focussing on the deeper organisational, cultural, professional and practical issues of role extension in this area. I therefore ruled out these Trusts.

I narrowed down my search to organisations in the South West employing both their dietitians and SLTs directly, and excluded the Trust where I worked. I approached the lead for both the SLT and the dietetic service at each Trust to enquire whether they would wish to be included as a potential research setting. At this initial enquiry stage, the dietetic and SLT departments at four potential NHS Trusts were willing and able to

take part (one community, one acute, and two joint acute and community). Once I started R&D applications, it became clear that only two of these Trusts would be able to commit in the timescales needed. One of these was a community Trust, the other a joint community and acute Trust.

#### **4.7 Identifying the “extended roles” SLT and dietetic departments**

In order to identify an SLT and dietetic department that had extended their roles in this area, I knew I would have to search further afield. I was aware of places where this was happening, through reading and keeping abreast of the topic. I had initially identified two potential Trusts and contacts: one was a Dysphagia Specialist Nurse in a teaching hospital, who was managing dysphagia alongside SLT colleagues. The second was a dietitian and an SLT who had both extended their roles and shared a stroke caseload in an acute hospital. Although initially interested, the Dysphagia Nurse Specialist was due to take retirement, and the replacement had her hands full in her new role. In the second Trust, one of the contacts went on maternity leave and the second changed jobs, ruling both of these potential participants out.

I now took a number of different approaches to identify the “extended role” research setting. I placed adverts in professional nursing, dietetic and SLT journals. I also contacted national centres, professional bodies and the universities providing dysphagia training. A contact in the RCSLT dysphagia Special Interest Group (SIG) also agreed to disseminate an electronic message to the group on my behalf. It was through this group and a number of subsequent telephone calls and contacts that I was led to the second research site. Specifically, a member of the SIG (another SLT) made contact and suggested I approach Haslem, as they were leading a programme of extending the role of nurses in dysphagia management. Here, the SLTs had over the years developed a nationally acclaimed programme of extended nurse dysphagia training. This training had initially started for nurses in the acute hospital, mainly on the stroke ward, a number of years earlier. In more recent years, this had been extended to nurses working in nursing homes and other community settings.

I approached the lead SLT in Haslem, who agreed to take part in the research. She also informed me that there were ongoing discussions amongst the dietitians and the SLTs at the time regarding dietitians extending their roles into dysphagia care. Both departments were also planning to provide joint training to care homes to skill up nursing home nurse to manage dysphagia and nutrition. Although these developments did not come to fruition in the time that this research was conducted, the dietitians were nevertheless actively pursuing upskilling of nursing and community nurses to take a greater role in nutritional management. In addition to this, they also employed dietetic

assistant staff to provide the majority of the nutritional care to stroke patients and staff training, unlike the first research setting.

#### **4.8 Ethical and research governance approval**

I made an application for ethical approval to conduct the research through the Central Allocation Service (CAS) of the National Research Ethics Service (NRES). As the research was to be conducted in NHS sites, using NHS staff and service users, application for research ethics approval through NRES was at that time mandatory. I anticipated that some service user interviewees might lack capacity to take part; nonetheless, I was keen that their voice was heard, through the experiences of their carers. To this end, I also sought approval to conduct the research with adults lacking capacity, which required application for approval to a “flagged” REC through the Central Allocation System (CAS). The study was considered at the South East Wales Research Ethics Committee – Panel D, and I attended the committee meeting. Approval for the research to take place was granted, after minor amendments, on 19<sup>th</sup> November 2010 - a copy of which can be found at Appendix 2.

#### **4.9 Ethical issues arising**

In preparation for my first REC application, I had considered the potential risks and burdens, to both service user (and their carers) and staff participants, as well as to myself and others indirectly involved or affected by the research. I compiled these potential, predictable risks into a table (see below), which I included for consideration by the REC. I had anticipated that talking about the topic, both for service users and for staff, might prove distressing – this was not the case once data collection was in progress. Although occasionally wary of the recording device for the first few minutes, overall, both service users and staff were very happy to talk about their experiences and views. Some staff participants commented that they enjoyed the interview. They said that they had spoken about issues that they had often thought about, but never articulated out loud. Some felt that it had made them think about the way in which they were working.

The most challenging aspect of the interviews, was keeping participants to the topic area. On two occasions, service user participants and their carers (Derek and Bill) made specific clinical queries of me. I suggested that they speak with their therapist or dietitian, as I was not able to answer their questions in my capacity as researcher, and they seemed satisfied with this.

#### 4.10 Confidentiality

The study adhered to all the principles outlined in *Confidentiality: NHS Code of Practice* (DH 2003) during data collection and analysis. A research number was allocated to each participant, which was then used to identify transcripts and memos. This code was also used in the NVivo software. Any data presented to third parties (such as academic supervisors) used the allocated research code. All results have been presented as themes and concepts and any directly quoted material is presented using a pseudonym.

#### 4.11 Data handling and storage

I used an NHS laptop throughout the study, both to analyse and code data in NVivo, transcribe and store interviews, as well as write memos. Data encryption software was installed and maintained on this laptop in accordance with my employing Trust's protocols throughout the study. I carried the laptop to research sites in order to write memos directly after each interview. The laptop was then either taken with me or stored in the boot of my locked car, in hospitals and other clinical site car parks under surveillance. Consent forms and the research code-to-participant key were stored in a locked filing cupboard in my home.

#### 4.12 Risk assessment

I carried out an assessment of the potential risks in the field to both myself and participants. A copy of this assessment can be found at Appendix 4. The potential risks and the control measures are summarised in the table below.

Potential hazard	Control measures
a) Breach of confidentiality/ loss of stored transcripts, interview sheets and/ or note review data collection sheets	a) All written and recorded data collection materials (notes, tapes, transcriptions) will be stored in a locked filing cabinet on secure NHS premises. Transport of such materials between research site and storage site will be in a locked case out of public site. Signed consent forms will be stored in a separate, locked, filing drawer from data collection notes.
b) Difficulties communicating during interview (service users)	b) It may be appropriate for aphasic individuals to participate in medical note review and carer interview only. An assessment of the patient's ability to participate, in line with professional opinion regarding communication ability provided in the medical, nursing or other care notes, will be made as part of the process of consent and assessment of capacity.
c) Risk of upset during interview	c) If the participant becomes upset during the interview, this will be suspended while the researcher confirms whether he/ she is able to continue and, if necessary, terminated or postponed. The interview

	room will be made available for 30 minutes after the interview should participants require a quiet space. The researcher will be present or available, depending on participant preference.
d) Risk of fatigue during interview (service users)	d) Participants will be informed that the interview is expected to take up to 60 minutes and they will be sensitively asked whether they are able to take part. The interview will be suspended while the researcher confirms whether he/ she is able to continue and, if necessary, terminated or postponed.
e) Time commitment in working day to participate in interview (staff)	e) Participants will be informed that interview is expected to take up to 60 minutes and it will be confirmed as part of the consent process that they are able to make this commitment.
f) Change of relationship with care professional (service users) and between colleagues (staff)	f) The researcher will not disclose nor discuss matters around individual care between participants, other than the further exploration of themes as per the grounded theory approach.
g) Expectations that participation in research may improve nutrition and/ or dysphagia and/ or care that is received	g) The participant information sheet makes clear that the purpose of the study is not to immediately effect treatment and care, but rather to explore issues around alternative models of care.
h) Unaccompanied domiciliary visits outside NHS premises (such as service user/ carer interviews in the home) to conduct data collection (researcher)	h) Most data collection will occur on NHS premises within working hours. While it is not anticipated that the service user group pose a high risk of threat to the researcher, any data collection occurring outside NHS premises where the researcher is unaccompanied, will be conducted following the domiciliary visit policy of the NHS Trust with responsibility for the patient's care. This will include notifying the Trust of the visit date and time of the visit, providing a mobile phone number and agreed alert code and notifying the Trust of the safe completion of data collection. The researcher will follow all local policies and procedures in relation to risk management, such as the control of infection, the safe handling of loads, conflict resolution and fire and safety. The researcher undertakes regular and statutory updates as required by her employing NHS Trust and has currently conducts domiciliary visits as part of her clinical role.

**Table 4:** Potential research risks and control measures during the research

#### 4.13 Gaining Research & Development (R&D) approval

I applied formally for R&D approval at both research sites before commencing data collection. Copies of the approvals can be found at Appendices 4 and 5.

#### **4.14 Research governance**

The study received research sponsorship from Bournemouth University. A copy of the sponsorship agreement can be found at Appendix 7.

#### **4.15 Service user involvement in the research design and participant information leaflets**

In preparation for Research Ethics approval, I worked closely with the southwest local Stroke Research Network. The network kindly disseminated a lay summary of the research proposal and the draft participant information leaflet to a panel of service users and their carers. Following this feedback, amendments were made where possible to the study design (e.g. the panel recommended including a medical professional in the study) and/or to the participant information leaflet. Some issues were difficult to amend, such as the use of research questions. Some felt that:

“The hypothesis is too closed, introducing the idea of “combined” work. This could influence patient’s responses. It almost seems that you are looking to make savings in staff.”

“I do not think that this research will improve the care pathway of the particular dysphagic sufferer and may cause more harm.”

Whereas others thought:

“Yes, for the sake of future dysphagia sufferers and for economy of health care professionals in both time and money.”

“I can see the benefits for the patient of simplifying the process of treating dysphagia.”

“Patients often say how tiring they find it repeating information and they don’t understand why different healthcare professionals can’t share information more.”

“Glaringly lacking what normally happens in hospitals and at home when a stroke leaves a patient with dysphagia and what role each health professional plays in the treatment of dysphagia.”

“There appears to be a desire to have a holistic approach..., taking in the whole medical history...and how [health professionals] can work together.”

For some issues, lay users had opposing views. Some saw the participation in the research causing: “Unexpected distress during the meeting” and “Embarrassment”, whereas others thought that: “You are making the assumption that some of the survivors and relatives/carers will be upset.” A full summary of the responses and feedback received can be found at Appendix 8.

#### 4.16 Informants/research participants

The initial participants fell into four main groups, outlined in Table 6 below. I stipulated the inclusion and exclusion criteria as part of the study protocol. Service commissioners and managers were included as well as front-line clinical staff. I expected that they would be more aware of the challenges facing the NHS at a strategic level, and they would therefore be able to provide an additional perspective. Professional body representatives were not included at this stage, as I had not anticipated the role that they would in the developing model. As Corbin and Strauss (2008) suggest:

“The full range of possible interrelationships between micro/macro conditions are not always visible to the individual research participants...” (p. 92)

<b>1. Those who experience the service directly (patients and/or their carers).</b>	
<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
<ul style="list-style-type: none"> <li>• Group 1a: survivors of any type of stroke, aged over 18, with newly diagnosed, ongoing or resolving dysphagia, who have been admitted directly to the acute stroke ward, or through the Accident and Emergency department to the acute stroke ward.</li> <li>• Group 1b: survivors of any type of stroke, aged over 18, with newly diagnosed, ongoing or resolving dysphagia, who are receiving rehabilitation for a recent stroke event on the stroke rehabilitation unit.</li> <li>• Group 1c: survivors of any type of stroke, aged over 18, with newly diagnosed, ongoing or resolving dysphagia, who are receiving rehabilitation for a recent stroke event at home or in a nursing facility.</li> </ul>	<ul style="list-style-type: none"> <li>• Stroke survivors not receiving ongoing support or follow-up by an SLT, dietitian, stroke nurse, stroke co-ordinator or other stroke therapy, whether on the acute or rehabilitation ward, or at home or in a nursing facility.</li> <li>• Stroke survivors unwilling to give informed consent.</li> <li>• Stroke survivors who lack capacity for whom a consultee withholds agreement to participate.</li> <li>• Stroke survivors unable to participate in a semi-structured interview of 60 minutes duration, whether due to fatigue, drowsiness, communication difficulties or other causes (although they may be included for medical note review and carer interview).</li> </ul>

<ul style="list-style-type: none"> <li>Group 1d: informal carers of survivors of any type of stroke, who ordinarily live with the individual and are involved in the day-to-day nutritional care of the individual (i.e. food shopping, meal preparation, assistance with feeding if required). This group will normally be a spouse or adult child, but may include siblings, same-sex or civil partners, or close friends living with the individual and providing domestic and/ or personal care.</li> </ul>	<ul style="list-style-type: none"> <li>Carers who provide care to the individual in a professional (i.e. paid) capacity, such as employees of a care agency.</li> <li>Carers who lack capacity to consent to participate, who are unwilling to give informed consent or who are unable to participate in a semi-structured interview of 60 minutes duration, whether due to fatigue, drowsiness, communication difficulties or other causes.</li> </ul>
<b>2. Practitioners directly involved in the nutritional management of dysphagia in stroke (dietitians and SLTs).</b>	
<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
<ul style="list-style-type: none"> <li>Group 2a: Dietitians employed by the hospital, from all grades, who provide care to dysphagic stroke survivors on the acute stroke ward or the stroke rehabilitation unit.</li> <li>Group 2b: SLTs employed by the hospital, from all grades, who provide care to dysphagic stroke survivors on the acute stroke ward or the stroke rehabilitation unit.</li> <li>Group 2c: SLTs employed by the hospital, from all grades, who provide follow-up care to dysphagic stroke survivors, either in the individual's home or in a nursing facility.</li> </ul>	<p>Dietitians and SLTs who provide less than two sessions (1 day) per week<sup>1</sup> of dysphagia related stroke care per week.</p>
<b>3. Clinical, nursing and medical staff directly involved in the dysphagia and/ or nutritional care of dysphagic stroke survivors.</b>	

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<sup>1</sup> The Manchester post-qualifying dysphagia course requires that candidates maintain two sessions per week of a dysphagia specific caseload for entry onto the course, and this requirement was therefore taken as a guide ([http://www.hpsc.mmu.ac.uk/dysphagia/PostBasicDysphagia/CRSINFO20\\_09.doc](http://www.hpsc.mmu.ac.uk/dysphagia/PostBasicDysphagia/CRSINFO20_09.doc) ).

<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
<ul style="list-style-type: none"> <li>• Group 3a: medical staff working on the acute stroke ward or stroke rehabilitation unit.</li> <li>• Group 3b: nursing staff working on the acute stroke ward or stroke rehabilitation unit.</li> <li>• Group 3c: other clinical staff working on the acute stroke ward or stroke rehabilitation unit in stroke-related roles (e.g. AHPs, stroke coordinators).</li> </ul>	<ul style="list-style-type: none"> <li>• Medical, nursing and other clinical staff who work with stroke survivors for less than 50% of their working time (e.g. bank and agency staff).</li> </ul>
<b>4. NHS staff who manage and/ or commission dietetic, SLT and stroke services.</b>	
<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Group 4a: Dietetic and SLT service managers.	Operational/ divisional managers of therapy and/ or rehabilitation services, which does not include stroke, dietetics or SLT services (e.g. musculoskeletal services).
Group 4b: Operational/ divisional managers of stroke, therapy and/ or rehabilitation services.	
Group 4c: Commissioning managers of stroke, dietetic and/ or SLT services.	

**Table 5:** Inclusion and exclusion criteria, Phase 1

Data were collected from 28 interviewees in the first phase of collection and analysis (Billingdon = 14, Haslem = 14). The table below demonstrates where each of the first 28 interviews took place.

	Billingdon	Haslem	Designation		Billingdon	Haslem	Designation
Interviewee 1	√		Staff	Interviewee 15		√	Staff
Interviewee 2	√		Staff	Interviewee 16	√		Staff
Interviewee 3	√		Service user	Interviewee 17	√		Service user
Interviewee 4	√		Staff	Interviewee 18	√		Service user
Interviewee 5	√		Staff	Interviewee 19	√		Staff

Interviewee 6	√		Staff	Interviewee 20		√	Staff
Interviewee 7	√		Staff	Interviewee 21		√	Staff
Interviewee 8	√		Staff	Interviewee 22		√	Staff
Interviewee 9		√	Staff	Interviewee 23		√	Staff
Interviewee 10		√	Service user	Interviewee 24		√	Staff
Interviewee 11		√	Staff	Interviewee 25	√		Service user
Interviewee 12		√	Staff	Interviewee 26		√	Staff
Interviewee 13		√	Staff	Interviewee 27		√	Staff
Interviewee 14		√	Staff	Interviewee 28	√		Service user

**Table 6:** Location of Phase 1 interviews

#### **4.17 Access to participants**

Service user participants (stroke survivors and carers) were approached by contacts in the field and provided with a written invitation letter (Appendix 9) and a copy of the participant information leaflet (PIL). Initially, I was expecting service user participants to make contact with me. In practice, this was often difficult, either due to communication difficulties or access to a telephone on the ward. In many cases, service users requested, via their SLT, dietitian, the research or ward nurse, that I make contact with them or make an appointment to see them on the ward. This was then communicated to me by the clinician, local contact or research nurse. Service users in their homes contacted me by telephone to make an appointment.

For NHS staff participants, individuals were usually identified and provided with an electronic version of the relevant invitation letter (Appendix 10) and PIL from the lead contact at the research site. Alternatively, some were identified as a potential informant by a clinician that I had already interviewed. In these instances, the first participant provided the invitation letter and PIL. Participants then contacted me by e-mail or telephone, and occasionally directly on the ward, if they wished to take part.

#### **4.18 Consent**

After contacting potential participants, I provided a verbal brief on the research in person (if on the ward), telephone or by e-mail (staff participants only). I also ensured that they had a copy of the relevant PIL. In the research ethics application, I had suggested at least 24 hours to consider if they would like to take part before interview. In reality, interviews were arranged at least one week in advance, allowing a much longer “cooling-off” period.

At the pre-arranged interview time, I confirmed that the participant had had the chance to read through the PIL. I invited and answered any questions or clarifications and then

took written consent. Two copies of the consent were signed; one for my research records, and one for the individual. For service user participants, a third copy was signed and included in their clinical records.

I had intended to make an assessment of capacity and document this in the research notes before taking consent if I had any concerns about the participant's capacity. Once data collection was in progress this was no longer required. None of the service user participants that I interviewed lacked the capacity to decide whether or not to take part.

A total of four PILs and four consent/ agreement forms were designed for this phase of the study. Copies of the PILs for service users and NHS staff can be found at Appendices 10 and 11. Copies of the consent forms for service users and NHS staff can be found in Appendices 12 and 13.

#### **4.19 Interviews**

The interviews were primarily conducted in a private room or office at the research site, although there were a few exceptions. I interviewed one service user in her own home; another preferred to be interviewed in the hospital garden. Two staff participants preferred to be interviewed in a quiet corner of the staff canteen, and another preferred to take a break from her work and instead was interviewed in the corner of a pub. Each interview was planned to take up to 60 minutes. Interviews ranged from between 40 and 70 minutes and were all audio-recorded. Participants were interviewed only once during this phase.

Interviews initially followed an Interview Schedule, with the aim of generating the first, broad codes and concepts pertaining to the research questions. Two interview schedules were designed in advance of data collection; one for service users and another for staff (Appendices 14 and 15). Charmaz recommends, when conducting interviews:

“For a project concerning organizational or social processes, I direct questions to the collective practices first and, later, attend to the individual's participation in them and views of them.” (p. 29)

I therefore started each interview with broad organisational themes before focussing down on the individual within the situation. Kvale (2009) recommends a debriefing after the interview when using “funnel-shaped” interview techniques that “gradually narrow down on the subject matter” (p. 71), to avoid giving the participant too much detail early

on. He argues that completely disclosing the rationale beforehand may limit the value of much qualitative interview research material, by framing participants' responses.

Given the broad area for research identified by McPherson et al. (2004) "Further investigation of ESP views about barriers to extending practice should be sought" (p. 38) and Read et al. (2001) "What factors facilitate...What factors act as barriers... (p. 274)), and the dearth of previous research into extended roles in dysphagia care, the topic areas included for Interview Topic Guide for Phase 1 of the research were necessarily broad. The main topic areas covered were:

- diagnosis and current situation in terms of dysphagia and nutritional care (service users)
- background and experience (staff)
- the process of dysphagia and nutritional care
- views on the current process and care pathway
- views on extended roles

The interview schedules served as guides at the beginning of data collection and helped by providing cues. As I was using grounded theory, I used the developing themes and concepts from previous interviews to identify areas and concepts to explore further in subsequent interviews (Kvale 2009). As Corbin and Strauss (2008) suggest:

"Once data collection begins, the initial interview or observational guides (used to satisfy committees) give way to concepts derived from analysis." (p. 152)

This is because:

"...these authors' experience that if a researcher enters the field with a structured questionnaire, persons will answer only that which is asked, and often without elaboration....Unstructured interviews...give respondents more room to explain what is important to them..." (p. 153)

This coincided with my increasing experience in interviewing; as Kvale (2009) states, becoming skilled is achieved through practice.

In preparation for each interview, I would start a memo with themes/ areas that I wished to discuss with this particular participant, in light of the developing theory. After each interview I would capture thoughts on the data collected on this same memo. This could include any immediately striking themes, as well as reflections on interview

technique and my role as research instrument. These memos served as both a learning tool and formed part of the analysis. Please see Appendix 17 for an example.

#### **4.20 Documentary sources**

Although Corbin & Strauss (2008) refer to the semi-structured interview as the primary method of data collection in the grounded theory study, Charmaz suggests that limiting data collection to interviews “delimits the theory we can develop” (Charmaz 2005, p. 527).

“Grounded theories may be built with diverse kinds of data – field notes, interviews, and information in records and reports.” (Charmaz 2006, p. 14)

Documentary data sources were included in the original research plan, as a means of triangulating data collection and gaining richer data in understanding the pathways. These sources included clinical record data (i.e. medical, nursing, SLT and dietetic notes), as well as Trust documentation, such as policies, flowcharts and training materials. In addition to interviews with key informants, I had therefore planned to collect data from documental data sources during the fieldwork, thus broadening and deepening the scope of data collection.

#### **4.21 Patient medical notes**

Entries in patient notes were expected to add further data to the emergent theory in relation to the professionals involved in the patient pathway, the specific input of individual professionals and the points in time of that input to the patients’ care. I had intended to use medical, nursing, other professional notes, bedside charts, ward charts and log books and include the date, time and designation of each individual clinician that assesses or provides care in relation to dysphagia and nutritional care. This would detail the specific contribution of each clinician, thus building a grounded picture of the dysphagia pathway. Such a technique of data collection through medical notes was used by Runions et al. (2004) in relation to the implementation of a dysphagia algorithm. The authors noted that body weight, a particularly clinically important piece of information, was not available in the medical notes and it was brought to the researchers’ attention only after the study that this was collected in a ward weight log.

I had expected that these entries would add further data to the emergent theory. My assumptions suggested that I would find data on issues such as duplication, communication and coordination of care. I therefore reviewed three sets of patient medical notes: Steven, Dorothy and Pamela. All three were the notes of service users whom I had already interviewed and who had given their consent to medical note

review (see Consent Form, Appendix 13). Relevant entries in these notes were transcribed verbatim and I attempted to incorporate this data into the analysis. Steven and Pamela were both service users on stroke wards, and so access to these notes was straightforward. Dorothy was, however, living at home. Although she had a few care and nursing notes in her home, her medical notes were kept by her GP surgery and in storage for the hospital.

Dey (1999) suggests that, in grounded theory:

“At the outset of the inquiry, these varied methods of collecting data were liable to be unfocused. Data collection at this point could therefore be fairly comprehensive and achieved largely through unstructured methods. As the study proceeded, however, ideas would become more focused, and the methods of data collection could correspondingly become more structured” (p. 6)

This assertion certainly rang true: After completing Pamela’s interview, it did not appear that the medical notes were adding data to the developing theory. Although Carlsson et al. (2010) demonstrated poor consistency in relation to dysphagia and nutritional care and discharge planning for stroke patients in the hospital in their study, this was not the case in the three sets of medical notes that I reviewed in this study. The notes that I reviewed contained regular records from dietitians and SLTs. In contrast to Carlsson et al.’s (2010) findings, the notes also contained a standardised weekly multidisciplinary team (MDT) review form, which contained several diet and dysphagia domains. These domains were:

- NBM (yes/ no),
- NG tube feed (yes/no),
- Fluid texture,
- Diet texture,
- Assistance with eating and drinking,
- Weight and Malnutrition Universal Screening Tool score.

These differences may be explained by the particular settings (e.g. hospitals) from which I reviewed three sets of notes, and the hospital where Carlsson et al.’s (2010) conducted their research, geographical differences (their study was conducted in Sweden) and/ or temporal differences, e.g. their study was conducted during 2003, whereas I reviewed the notes in 2011.

The medical notes that I reviewed described the processes of care, the professionals that were involved, and the recommendations of those professionals. Had the research

centred on the actual processes of care, then capturing these entries would have been valuable. However, as the focus of my research was on the perceived barriers and enablers to different ways of working, these did not contribute to the developing theoretical model. As my research question focused on the perceptions of service users and providers, collecting clinical data from medical notes did not help me understand either service users or providers experience of receiving or providing of dysphagia care. Clinical note review was therefore discontinued.

#### **4.22 Relevant local NHS Trust documentation**

I accessed relevant Trust documentation through staff participants in the field.

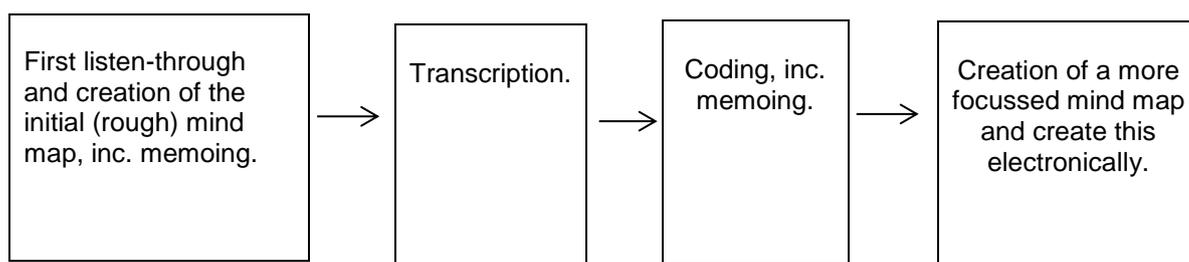
Permission to access this was included in the REC application worded as:

“In addition to interviews with key informants, data will therefore be collected during fieldwork from documental data sources, including patient notes, Trust policies and national guidance, thus both broadening and deepening the scope of data collection.”

It was difficult to know in advance the exact nature of the documentation that would be available, and whether or not this would add to the analysis. The most relevant and informative documentation, included in Appendices 17 and 18, was the advanced dysphagia trained nurse swallow screening tool used in the second research setting and the specific advice and guidance provided by the dietitian in the North, which codifies aspects of the dietitian’s usual assessment and advice. The screening tool in the second site (Appendix 18) demonstrates how the processes of the SLT bedside swallow assessment have been codified to facilitate assessment by other types of worker. I was made aware of the existence of relevant documentation as these were mentioned during the interviews. I then requested copies of these after the interview.

#### **4.23 Data Analysis**

The overall process of data analysis, which is described in more detail below, included a first listen through of each interview. Although I was going to be using NVivo qualitative data analysis software, I was mindful of Corbin and Strauss’s (2008) warning that the analysis “should determine how the researcher will use the computer program and not the reverse.” (p. xi). I created an initial mind map at the same time as the first listen through, before becoming too immersed in the detail of the interview. I then transcribed each interview, imported the transcript into NVivo and coded the interview transcript. A second mind map was then created by hand and this was then created electronically in NVivo. An example of a rough and a more focussed mind map, and then its creation in NVivo can be seen at Appendices 19 and 20, respectively. This process is summarised in the diagram below:



**Figure 5:** Data analysis process, Phase 1

As I had planned to use NVivo, I attended a two-day intensive workshop before data collection started. I also took advice from a selection of the recommended reading that dealt specifically with the process and practicalities of coding, both using NVivo and more generally in qualitative research (e.g. Bazeley 2007; Saldana 2009).

#### **4.24 Interview transcription**

Each interview was transcribed verbatim, including both interviewer and interviewee contributions. In the transcription, meaningful pauses, laughter, hesitations, ‘hmmm’s’ and ‘yeah’s’ were captured in the transcriptions. Grounded theorists differ in their opinions about the level of detail that should be included in the transcription (Morse et al. 2009). Some suggest that you “need to get a little bit above the data” (Phyllis Noeranger Stern, 2009, In: *Developing grounded theory, the second generation*, p. 192), while others that “the emotions are important!” (Charmaz 2009, p. 193). I choose to include this detail but, more importantly, wrote a memo after each interview about the feeling of the interview and the person being interviewed. Although this was always an interpretation, it helped remind me of the essence of the interview for the first listen-through of the recording. The transcriptions, as Word documents, were then imported into the NVivo data analysis software for coding.

#### **4.25 Documents**

PDF or scanned versions of documentary sources were stored electronically. I coded these sources using codes in the same way as for the interview transcripts, but with a necessary difference. For example, for flowcharts, or care pathways, the entire document might be coded under a code, e.g. “codifying expert knowledge”. Longer text documents, however, were coded in sections, in the same way as the interview transcripts.

#### 4.26 Coding

Both Charmaz (2007) and Saldana (2009) recommend initially coding data as actions (i.e. gerunds), to avoid conceptual leaps too early on. As Charmaz (2011) states:

“By using gerunds to code for actions, grounded theorists make individual or collective action and process visible and tangible... (p. 367). Gerunds enable grounded theorists to see implicit processes, to make connections between codes and to keep their analyses active and emergent.” (p. 368)

I also made use of “*in vivo*” coding (Charmaz 2006, p. 42), but avoided too heavy a reliance on this. Saldana (2009) refers to this as a common pitfall of beginning researchers. Whereas Charmaz (2007) recommends line-by-line coding, Corbin and Strauss (2008) appear to take more of a “lumper” (Saldana 2009) approach, by coding sections of text. My own method was to code sections that appeared to be relevant in some way to the research questions. These may have been a word, a few words, or a short section, where these sections represented a “specific act, event, activity, strategy, state, meaning, norm, symbol, level of participation, relationship, condition or constraint, consequence, setting” (Gibbs 2007, p. 47).

Corbin and Strauss (2008) originally conceived of three stages of coding, whereas both Charmaz (2007) and Saldana (2009) take a two-stage approach to coding. Corbin and Strauss (2008) follow the initial and second, selective, stage with a third, theoretical stage. In this stage relationships between the categories in the second stage are specified. Following these researchers, my own approach to data collection and analysis was to collect and analyse the data in three stages: i) initial, ii) focused (or selective) and then iii) theoretical sampling and analysis, described schematically at Appendix 22. The initial stage corresponds broadly with the first 12 interviews; the focussed (selective) stage with interviews 12 - 28 of Phase 1 and into Phase 2 of the research. Theoretical analysis is confined mainly to Phase 2 of the research. The transition between initial (open) and selective coding was led by the data, rather than at predestined points that I had decided upon in advance.

During open/ initial coding (interviews 01 – 12), smaller sections of data (ranging from a few words up to a couple of lines) of the interview transcripts were coded with free codes (or nodes, as they are called in NVivo). From the fifth interview, up to and including interview 12, I ordered the codes (or nodes) in NVivo under broader (Parent) nodes after coding each transcript. This served to retain some order and manageability in the large number of codes that were being generated. I found some aspects of NVivo were not as user-friendly as many other software programmes I am familiar with. Scrolling through and viewing the codes that I had already generated was particularly

difficult. This led to a large number of identical codes while coding, often with one word or a spelling difference in the name of the code, but with identical meanings. In these instances, I merged one of the identical codes into the other.

In all stages of coding, some sections of data were given more than one code. This was often because the data described the dimensions of more than one category, or more than one aspect of the process under study. This is commensurate with Dey's (1999) observation that:

“...’incidents’ initially could be coded under a multiplicity of categories.” (p. 7)

In some instances, some data were labelled with more than one code as I was initially uncertain how to interpret the data. These data were later assigned to one code only, or remained assigned to more than one, where the meaning was ambiguous.

As at 12<sup>th</sup> March 2013, I had collected and analysed data from 12 interviews and created 560 codes (nodes) in the process (Appendix 23).

After interview 12, I took a step back from data analysis to review the categories that had developed so far. There seemed to be similar patterns emerging in the Nodes, with some Parent Nodes collecting a large number of Child Nodes under their headings.

The analysis of the remaining interviews (13 - 28) was more focussed (selective coding), with larger sections of text (several lines) now labelled with a code. Dey (1999), taking issue with the distinction between open and axial coding in Grounded Theory, suggests that this distinction is more fluid and:

“...no more than a shift of emphasis from particular points in the string to the links between them.” (p. 105)

Although the boundaries between the phases of coding may not be clear-cut as one flows into the next, I certainly sensed a mind-set shift as I moved from initial, open-coding, into more focussed and selective coding.

After completing this analysis I took another “stock check”. This led to the Strength of Evidence and Gaps table (Appendix 24), a Substantial Amendment application to the REC, an Interview Topic Guide in preparation for the second phase of the research (Appendix 25) and a model of the theory so far. I will describe each one of these in more detail later on in the chapter.

#### 4.27 Interview 12 – Identifying the core concept

Corbin and Strauss (2008) recommend that:

“As the analysis moves along it is important that the analyst takes the time to sit down and write a summary of where he or she thinks the analysis is at this point.” (p. 120)

After analysing the data from the first 12 interviews, I started to get a sense that similar themes were emerging from the data. I therefore paused the analysis to take stock of codes and concepts developed thus far. This coincided with presenting a poster at a European Healthcare Management Association Conference in Milan, as well as presenting my research at the Bournemouth University Postgraduate Research Annual Conference. This was an important juncture in the research process, as preparing the posters and presentation, speaking to others about my research and thinking through the answers to their questions helped crystallize my thoughts about the data and the model that was developing.

Corbin and Strauss (2008) suggest that the researcher identifies the core concept in the following way:

“It [the central or core category] is the concept that all other concepts will be related to. ....A central category may evolve out of the list of existing categories. Or, a researcher may study the categories and determine that though each category (p. 104) tells part of the story, none capture it completely. Therefore, another more abstract term or phrase is needed, a conceptual idea under which all the other categories can be subsumed” (p. 105)

They go on further to suggest techniques to aid the researcher in identifying this core concept:

“There are several techniques that can be used to facilitate identification of the central category and the integration of concepts....writing the storyline, making use of diagrams...sorting of memos either by hand or by computer program...” (Corbin & Strauss 2008, p. 106)

I started to think about ways to organise these categories and used sticky notes and a wall space for this exercise, writing every main code and/ or theme on a light yellow sticky note. I then organised these into orange sticky notes for the codes and themes, pink for the major categories and bright yellow for the unexplained phenomena and gaps linked to each category or node (Figure 6 and 7 below). This helped my thinking, as sticky notes can be moved about a space as I reflected on the codes and categories. I then captured the developing categories electronically, transporting this “wall-map” into a Word document, so that it would not be lost (Appendices 25 and 26).

I had at this point identified training, skills and knowledge as major categories, but this did not explain the different processes that were taking place in the SLT and dietetic departments. The basic social process that seemed to fit the data that were emerging revolved around skills and knowledge, transferring these to other types of worker and the question of complexity. Specifically, the dietitians and SLTs in Haslem seemed to be teaching other types of worker, such as nurses and assistant staff, many aspects of their roles, which participants in Billington referred to as being “complex”.



**Figure 6:** Each main code and/ or theme is written on a light yellow sticky note



**Figure 7:** The sticky notes are organised into codes and themes, major categories, gaps links to each category or node

I now had to decide whether the core phenomenon that was emerging explained the other categories in the theory, and whether these linked together in a coherent story line. I organised the categories and codes into the main conditions referred to by Corbin and Strauss (2008). These are the causal conditions, the intervening conditions, contextual factors, the strategies by which the core category is brought to be, and the consequences of those strategies (Figure 8 below).



**Figure 8:** Linking the core phenomenon to the other categories and codes

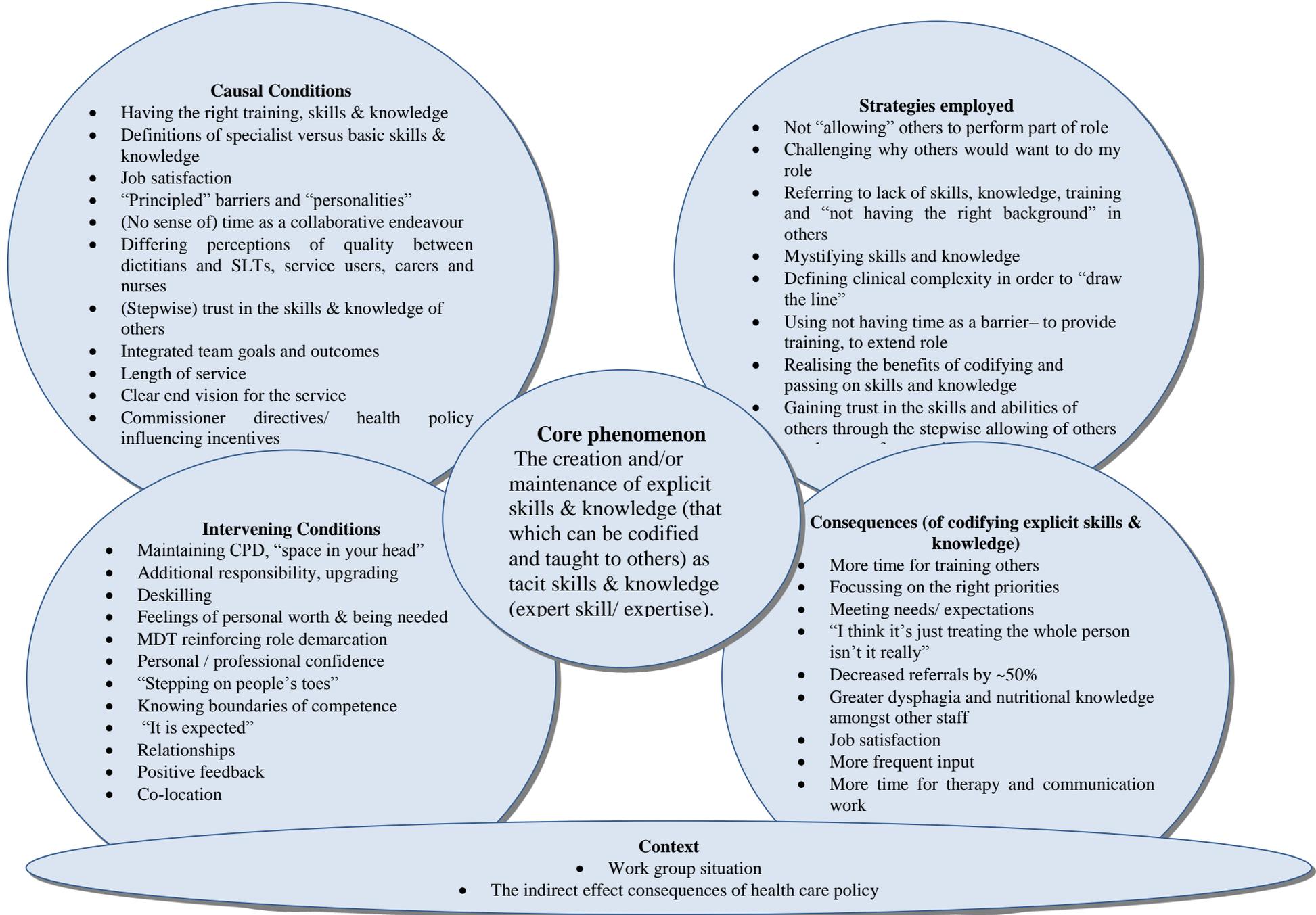
I describe this process further in a memo:

“Looking at all the sticky notes, I think what sticks out is that creating/ maintaining explicit knowledge as tacit knowledge, and the codification of explicit knowledge in Haslem, is the process that occurs. It seems to be the central/ core phenomenon around which all the other categories relate/ interact/ intersect. Examples of this process include, in Billington, the debate about SLTs assessing nutrition (i.e. food records) versus Haslem and the codification of dysphagia management in care homes and the ward, and in nutritional management in care homes, in Haslem. Although skills, training and knowledge, for example, comes up a lot from interviewees, it comes up in the sense that having, or not having, the right training, skills, experience and knowledge are a prerequisite/ barrier/ enabler to others or oneself performing tasks outside the usual scope of practice. The key questions and/ or gaps are therefore from this point on, what is it that makes that process occur in Billington (i.e. creating/ maintaining as tacit) but allows/ enables the codification and passing on to others in Haslem?”

Creating or maintaining explicit knowledge as tacit in Billington, and the process of codifying that same knowledge in Haslem, was the “recurrent pattern in the data” (Dey 1999, p. 111).

#### **4.28 First theoretical models**

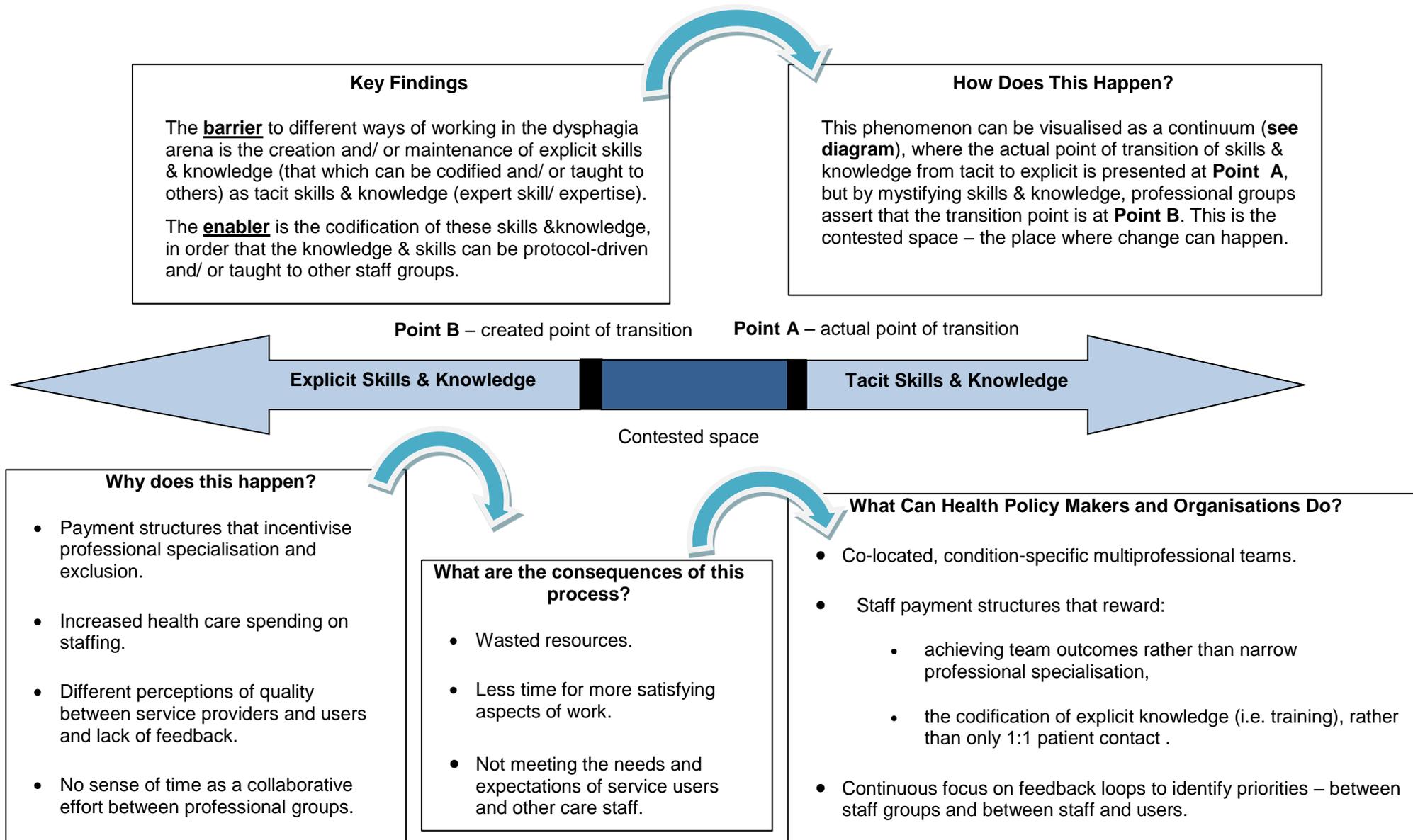
I was now in a position to create the first theoretical model, capturing and incorporating the concepts that had developed so far. The first iteration of the theoretical model appeared in May 2013 (Figure 9 below). The reader will note that in this first model, I have captured the categories as per Corbin and Strauss’s (2008) recommendation regarding causal and intervening conditions, strategies employed by actors and the consequences of those strategies, without interlinking these in a coherent story at this early stage.



**Figure 9:** The first theoretical model

In preparation for the 2013 European Healthcare Management Association, where I was due to present a poster of the research, it was necessary to link the categories in a coherent model. I had at this point started to conceptualise the core phenomenon as on a scale, with some clinical tasks transferred to other types of workers in Haslem which were retained by either the SLT or dietitian in Billington. Participants referred to “drawing the line” repeatedly, and there being a conceptual line between which tasks could be transferred and which could not. Perceptions of where this conceptual line lay differed between participants in Haslem and Billington. Definitions of this line were made with reference to having or not “the right training, skills and experience”. I therefore conceptualised a shifting line on a scale of transferability of skills and knowledge. Setting this phenomenon within the context of the research questions, the enabler was therefore shifting this line to the right, i.e. conceptualising a greater range of skills and knowledge as transferrable to other types of workers. The barrier lay in maintaining the line further to the left, i.e. maintaining a greater range of skills and knowledge, and thus clinical tasks, as of an expert nature and thus, not transferrable to other workers. I had started to set the categories identified through the first 12 interviews (in figure 9) within the context of this theoretical shift, but the reader will see that these were under-developed in comparison to later models.

In Figure 10, tacit and explicit skills and knowledge are presented on a continuum, indicating that any definition of whether a particular skill set, and the clinical tasks that flow from that, are contextual and fluid. Given this fluidity, Point A represents “the line” between skills and knowledge that had been drawn by participants in Haslem. To the right of this were the skills and knowledge which participants there perceived to be tacit, whereas to the left of this line were the skills and knowledge which they perceived to be explicit and thus transferrable to other types of workers. In contrast, participants in Billington had drawn the conceptual dividing line further to the right, thus defining a greater range of skills and knowledge as tacit. Possessing these tacit skills and knowledge, in the form of profession-specific expertise, was required to be able to carry out the clinical tasks which flowed from possessing these skills and knowledge. By defining the line further to the left, participants in Billington therefore held on to certain clinical tasks within the specific profession. These same tasks, such as offering food fortification advice by nursing home nurses and dietetic assistants, or prescribing a texture-modified diet by dysphagia trained nurses, were perceived as codifiable in Haslem. The space the two different lines that had been drawn, and the range of skills and knowledge that were therefore defined as either explicit in Haslem or tacit in Billington, is the contested space. This space in where the enabling factors can influence a shift – a shift in the conceptual line to the left, to define a greater range of skills and knowledge as explicit.



**Figure 10:** The theoretical model develops further

#### **4.29 Creating data “Sets”**

After mapping and modelling the existing concepts as described above, I had a sense of having identified the core concept that seemed to explain the social process that was happening in the data, along with some of the causal and intervening conditions, the strategies and the consequences of those strategies. It was now important to understand where the strengths and the gaps in the developing model were. To this end, I created Sets in NVivo to organise the codes. Although Dey (1999) prefers to use the term “strings” (p. 195) rather than sets, with connecting categories “conceived as particular points (or knots) on the string” (p. 105), I preferred to retain the term Sets for simplicity, as this is the phrase used in NVivo. Sets in NVivo are groupings of codes under a heading that does not interfere with the overall coding structure, e.g. it copies data that already exist into a new structure. This process allows the researcher to select several Nodes to be included in a particular Set and provides a short cut to the Nodes within that set. In terms of grounded theory methodology, this could be deemed equivalent to identifying the categories (Sets), with the dimensions and attributes of the categories (the Nodes within each set). This also helped in the management of the codes/ nodes that I had developed so far, as there were now 963 codes!

Creating these Sets enabled me to “see” which data existed within each Set and therefore, which Sets had an abundance of data, and those that were less well developed. For example, there were 48 codes/ nodes for “The creation and or maintenance of explicit knowledge and skills as tacit”; whereas there were only 3 codes/ nodes for “MDT reinforces role demarcation”. I interpreted the volume of codes as either gaps in the developing model, or as areas which may later turn out to be less central to the developing theory. This allowed me to raise these codes in subsequent interviews and see which generated a response and elaboration by participants.

In total, 27 Sets were created, each one named after each of the developing concepts in the model. The NVivo software does not have a function for users to export a list of Sets, and so I have listed these below:

- Clear vision, defined patient group and goals
- Co-location
- Codifying and or passing to others explicit skills and knowledge
- Creating clinical tasks as complex
- Differing perceptions of quality and lack of feedback
- Greater job satisfaction
- Having more time

- Health policy influencing incentives
- Increased funding that rewards specialised roles
- Job satisfaction from being an expert
- Maintaining control over clinical area
- MDT reinforces role demarcation
- Mystifying skills and knowledge
- No sense of time as collaborative
- Not having time for meaningful work
- Not meeting stakeholders' needs
- Opportunities
- Personal and professional confidence
- Personalities and principled barriers
- Realising the benefits/ time well spent
- Stepwise gaining of confidence in others
- The creation and or maintenance of explicit knowledge and skills as tacit
- The thing at the beginning
- Time as a causal condition and a barrier
- Trust in knowledge, skills and knowing boundaries
- Wasted or lost time
- Work dissatisfaction

#### **4.30 Interviews 13 - 28**

Data collection and analysis now continued in a more focussed (selective) way, exploring in more detail the concepts in the developing model. As I continued to collect and analyse data from the next interviews (13 – 28), I modified the theoretical model throughout. I had a refined version of this model in August 2013 (Appendix 28) and a version of this to highlight existing gaps in September 2013 (Appendix 29). This was adapted again as further analysis continued (Figure 11 below).

The continuum of tacit and explicit skills and knowledge remains in Figure 11, with a conceptual divide at Point A in Haslem and at point B in Billington and a contested space. While the core concept remained constant throughout this part of the analysis, the reader will note that this iteration of the model includes an attempt to capture the categories in terms of the process of change, e.g. a greater emphasis on shifting or retaining the conceptual line between tacit and explicit skills and knowledge. The contested space remains the area of knowledge and skills which can be manipulated by the enabling factors or the barriers, which are starting to be identified.

Compared to the model in Figure 10, I have also attempted to integrate the data to feature both enabling conditions and barriers. This became an important feature after member checking, through participant feedback events that I had organised.

I organised a total of four member-checking events: one with the dietetic department in Billington and one in Haslem, and then one each with the SLT departments in Haslem and Billington. Previous SLT and dietitian participants attended these events. Although managers, commissioners and other clinical staff participants were invited, none were able to attend, due to shift patterns or workload demands. Service users were not invited to attend, at the request of clinical staff, as these were undertaken as part of staff Continuing Professional Development (CPD) sessions or away-days. Each session lasted approximately 90 minutes, and consisted of a short presentation that I had prepared on qualitative research methodology and examples of grounded theory studies in health care settings, followed by an exercise in groups coding a short transcript on an unrelated topic (to demonstrate how different people will identify different codes and thus, there is not necessarily or right or wrong answer in any analysis). I then presented the core concept and each of the categories in turn on large pieces of flipchart paper attached to the walls. Participants were given a few minutes individually to write their initial thoughts on sticky notes and stick on the part of the model that the note related to, which I collected at the end. I then opened the session up to a group discussion, from which I took notes, but did not record, as I had not sought ethical approval for recording.

At these events, participants fed back that the initial model had “a negative focus”, e.g. a focus on the barriers. They reported that, from the perspective of the research being of benefit in clinical practice, it was important to place a much greater emphasis on enabling focus than I had until that point. This necessitated that I go back to the data and categories developed so far and review those in light of this feedback – the result was the model presented in Figure 11. The reader will also note that, at this point in time, I was still unsure how the concept of “Time” integrated into the model, although it was clear that it was somehow significant.

Below I present a memo; “...a short analytic narrative that begins to tie some of these elements together” (Clarke 2005, p. 270), to accompany the August 2013 model.

“To date, and although it is yet early in the analysis, the overriding core concept/ phenomenon generated by this project is the distinction/ use of tacit and explicit knowledge, in that the health care professionals in this arena

attempt to make explicit, or algorithmic and therefore open to codifying, clinical knowledge tacit and mystical, in order to retain control over the clinical area. They appear to do this to protect jobs and roles, but there are many underlying factors that affect this, including trust and support in the organisation in respect of clinical risk, personal confidence, having the right skills and training and job satisfaction from being an "expert" in one's field. Time, or lack of time, is used as a barrier, in that by not having or making time to acquire additional skills, one does not have to do so/ take on additional responsibility, and by not having or making time to train others, e.g. pass on the explicit skills and knowledge, one does not have to cede control over that particular/ substantive area."

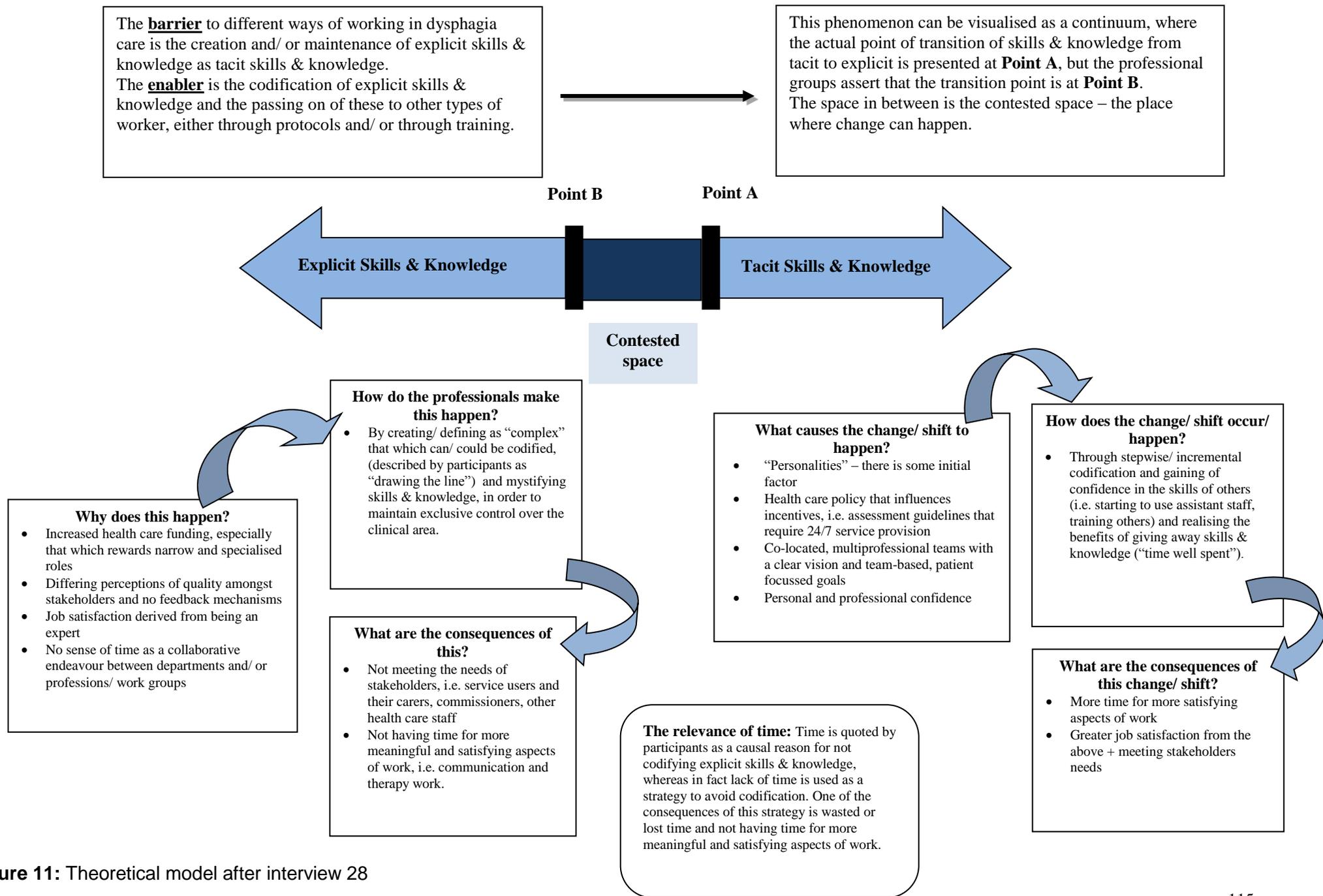


Figure 11: Theoretical model after interview 28

#### 4.31 Sampling strategy – Phase 2

After having conducted the first 28 interviews, I had a sense that I was now developing a coherent theory and model. Despite this, I was still left with questions and gaps. As discussed in the previous chapter, Corbin and Strauss (2008) suggest several techniques for refining theory, including:

- a) reviewing the scheme for internal consistency and for gaps in logic,
- b) filling in poorly developed categories and trimming excess,
- c) validating the scheme. (p. 109)

I had thus far reviewed the scheme for internal consistency and gaps in logic through the Strength of Evidence and Gaps Table (Appendix 24). Although I have only included the first three pages of this table in the Appendices to this thesis, the table totals 42 pages. I now needed to fill in poorly developed categories and trim excess, as well as explore the developing model for credibility, resonance and usefulness. I was not entirely sure that these questions could be answered by following the same line of inquiry, and speaking with similar participants. I realised that I needed to focus my interviews on concepts in the model, as well as identify participants outside Billington and Haslem to answer the research questions.

Both dietitian and SLT participants in Haslem referred frequently to colleagues in other parts of the country, from whom they had copied their own ways of working. I sensed that I would need to speak to these individuals to further extend the model and develop the categories. What, for example, was the condition that made them change the way that they worked at the very beginning? Was it something about the people involved in the situation, the circumstances, or both? What had been the consequences of working in these ways, both positive and negative for departments that had been working in these ways for longer than Haslem? To this end, I constructed a table capturing the strength of the evidence in my theory so far, as well as the gaps that remained (Appendix 24). This helped to identify the research settings, informants and topics for further data collection. For example, under the then emerging category “Personalities—there is some initial factor/ catalyst”, I have noted that I needed to explore further:

“What is it that makes some places & people extend their role and not others – the “at the beginning factor(s)”?”

I noted that I needed to speak with the following types of participants, outlined in the table below, and ask the following questions, in order to fill in the gaps identified in the model:

Sample	Why were they included?
<p>Group 1: Second (follow-up) interviews for participants who I had already interviewed. This group included:</p>	<p>These individuals had either contributed significant data to the emerging model, or we had only touched on issues that were now important to the developing theory in their first interview.</p>
<p>a) dietitians and SLTs who were actively involved in the codification of explicit skills &amp; knowledge and the training of other staff groups in these skills &amp; knowledge;</p>	<p><u>To address the issues:</u></p> <p>What is the line/ what constitutes complexity?</p> <p>Do you have any formal definitions of complexity?</p> <p>How do you perceive the role the professional bodies have taken in respect of complexity and “the line”?</p> <p>How could you gain the confidence in others?</p> <p>Previous participants have suggested that the codification of skills and knowledge allows time for other things (i.e. communication work for SLTs, training others, being able to concentrate on the more complex work) – what are your thoughts on this?</p> <p>Have you seen any benefits of extending skills and knowledge? Any downsides?</p> <p>How do participants perceive the impact/ influence/ effect of codifying skills &amp; knowledge on job satisfaction?</p>

<p>b) dietitians and SLTs who were instrumental at the beginning of these programmes;</p>	<p><u>To address the issues:</u></p> <p>Given the right training and support, what role does personal confidence play? Length of service?</p> <p>How do you respond to line that has been drawn in Site 2/ other places/ sites?</p> <p>Do you have any formal definitions of complexity?</p> <p>How do you perceive the role the professional bodies have taken in respect of complexity and “the line”?</p> <p>Previous participants have suggested that the codification of skills and knowledge allows time for other things (i.e. communication work for SLTs, training others, being able to concentrate on the more complex work) – what are your thoughts on this?</p> <p>What is it that makes some places &amp; people extend their role and not others – the “at the beginning factor(s)”?</p> <p>Previous participants in the site(s) where they have extended the role of assistants/ nurses further mention that they believe that it is a good thing and helps them, for example by letting them focus on more complex cases. What are your thoughts on this? Would this benefit you/ SLTs/ dietitians?</p> <p>Given the right training and support, what role does personal confidence play? Length of service?</p>
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	<p>What was the catalyst – why did you start doing this? How did you make this happen?</p> <p>You describe a very clear vision for the service (i.e. dietitians – move capacity from community hospitals into nursing homes; SLTs – initial ward nurses training, then nursing home nurses). Could you tell me a little more about this?</p> <p>Does this theme emerge in other sites that have codified skills &amp; knowledge?</p> <p>How has Agenda for Change, increased staffing and other health and professional policy changes affected role division and role expansion in recent years?</p> <p>How do participants who were in post before Agenda for Change and increased health care funding view this?</p>
<p>c) commissioning and operational managers who were or had been investing in these programmes and commissioned or managed the services which dietitians and SLTs provided in the research sites;</p>	<p><u>To address the issues:</u></p> <p>What is the line/ what constitutes complexity from a commissioner’s perspective?</p> <p>How do commissioners and managers in existing sites respond to the line that has been drawn in other areas?</p> <p>Site 1 and Site 2/ other sites have different ways of delivering their services/ different views on what constitutes complexity and where the boundaries between explicit and tacit skills &amp; knowledge lie. How can commissioners of these services influence this? What role do the commissioners play in this?</p>

	<p>How has Agenda for Change, increased staffing and other health and professional policy changes affected role division and role expansion in recent years?</p> <p>How do participants who were in post before Agenda for Change and increased health care funding view this?</p> <p>Job security; fear of “being done out of a job”. How do the commissioners view this proposition?</p> <p>How do commissioners perceive of the role of job satisfaction in this area?</p>
<p>Group 2: People who I had not yet interviewed, This group included:</p>	<p>These individuals had either been specifically mentioned by previous interviewees as potential, important contributors, or I had envisaged would otherwise add substantial data to the emerging model.</p>
<p>a) 2 – 4 NHS staff participants employed by 2 other NHS organisations, where nurses had taken a greater role in nutritional and/ or dysphagia management.</p>	<p><u>To address the issues:</u></p> <p>What was the catalyst – why did you start doing this? How did you make this happen?</p> <p>How can/ could we/ you make this happen in other places? What is preventing/ would prevent this happening in other areas?</p> <p>How have do you define complexity? How do these individuals perceive the role the professional bodies have taken in respect of complexity and “the line”?</p> <p>What is it that gives you the confidence in others? How could this be replicated in</p>

	<p>other areas?</p> <p>Previous participants have mentioned “not having time” as a factor preventing the codification of their skills &amp; knowledge and training others. What are your thoughts on this?</p> <p>Previous participants have suggested that the codification of skills and knowledge allows time for other things (i.e. communication work for SLTs, training others, being able to concentrate on the more complex work) – what are your thoughts on this?</p> <p>Previous participants in the site(s) where they have extended the role of assistants/nurses further mention that they believe that it is a good thing and helps them, for example by letting them focus on more complex cases. What are your thoughts on this?</p> <p>Given the right training and support, what role does personal confidence play? Length of service?</p> <p>How has Agenda for Change, increased staffing and other health and professional policy changes affected role division and role expansion in recent years?</p> <p>How do participants who were in post before Agenda for Change and increased health care funding view this?</p> <p>How do you address “giving away” skills &amp; knowledge?</p>
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	<p>How do you perceive the impact/ influence/ effect of codifying skills &amp; knowledge on job satisfaction?</p>
<p>b) “receivers” of explicit skills &amp; knowledge, e.g. dietetic assistants, ward and nursing home nurses.</p>	<p><u>To address the issues:</u></p> <p>How have you defined clinical complexity?</p> <p>Time: what are your thoughts on the time it takes to do the additional tasks involved in extending your role?</p> <p>How have you become/ what makes you confident in your extended role?</p>
<p>c) 2 - 3 participants who were representatives of the professional bodies that regulate the two groups of healthcare workers at the centre of dysphagia management in stroke – the British Dietetic Association and the Royal College of Speech &amp; Language Therapists (RCSLT).</p>	<p>How do the professional bodies define “the line” and complexity?</p> <p>Previous participants have mentioned that the professional bodies do not really understand extended roles. What are your thoughts on this?</p> <p>Previous participants have suggested that the professional bodies have not been supportive/ offered enough support in this area. What are your thoughts on this?</p> <p>What has been the vision of the professional bodies on role division and expansion in this area?</p> <p>How has any vision by the professional bodies translated to frontline services?</p> <p>Job security; fear of “being done out of a job”: How do the professional bodies view the codification of skills and knowledge in this context?</p> <p>How do the professional bodies perceive of the satisfaction of the job roles of the</p>

	<p>respective professional groups that they represent in respect of this question? How does a person actively involved in both the professional side and the professional body side view this issue/ question?</p>
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**Table 7:** Sampling strategy, Phase 2

The gaps identified in the Strength of Evidence and Gaps Table (Appendix 24), formed the basis of the Interview Topic Guide (Appendix 25) to inform Phase 2 of data collection and analysis. Commissioners remained an important sampling group at this juncture, as the commissioner that I had spoken with in Phase 1 had provided valuable concepts that had not been provided by other participants (e.g. “Agenda for Change”) that I had started to explore with other participants. I wished to explore perceived barriers and enablers to change with other commissioners, to add richness to the developing substantive theory and model. I had now also identified that I should collect data from professional body representatives, as several SLT and dietitian participants had referred to a lack of direction from their respective professional bodies as a barrier to further role extension.

I will now describe how data collection and analysis progressed in Phase 2 of the research, outlining also where this differed from Phase 1.

## Chapter 5 RESEARCH METHODS – PHASE 2

### 5.1 Introduction

This chapter outlines the methods used in Phase 2 of the study, where these differed from Phase 1. Consent and interviewing followed the same procedure as in Phase 1, whereas coding and theoretical sampling was more selective in this phase. I submitted a Substantial Amendment to the Research Ethics Committee, and sought R&D approval to conduct research in two further sites. I interviewed new participants, as well as re-interviewing some who had already taken part. I will describe each of these processes in turn. This chapter also describes how the concepts were developed further, as well as the modelling that was carried out in Phase 2 of the research.

The chapter concludes by considering the measures that were taken to produce a trustworthy piece of research and a credible theory in both phases of the research study.

### 5.2 Theoretical sampling and further data collection framework

Towards the end of the first phase of the research, it became increasingly clear that the line between explicit and tacit skills and knowledge, and where this line had been drawn by the dietitians and SLTs in Billington and Haslem, was the central concept in this study.

### 5.3 Informants/research participants

Corbin and Strauss (2008) suggest that:

“Toward the end of the research, when a researcher is filling in categories, he or she may return to old sites, documents, and persons, or go to new ones to gather the data necessary to saturate categories and complete a study.” (p. 155)

Following on from the Strength of Evidence and Gaps Table that I had constructed at the end of Phase 1, I identified that I would need to collect further data from two different groups of participants. These groups were:

Group 1: Second (follow-up) interviews for participants who I had already interviewed, who had either contributed significant data to the emerging model, or we had only touched on issues that were now important to the developing theory in their first interview. This group included:

- d) dietitians and SLTs who were actively involved in the codification of explicit skills & knowledge and the training of other staff groups in these skills & knowledge;
- e) dietitians and SLTs who were instrumental at the beginning of these programmes;
- f) commissioning and operational managers who were or had been investing in these programmes and commissioned or managed the services which dietitians and SLTs provided in the research sites;
- g) “receivers” of explicit skills & knowledge, e.g. dietetic assistants, ward and nursing home nurses.

Group 2: People who I had not yet interviewed, but who had either been specifically mentioned by previous interviewees, or who I envisaged would otherwise add to the emerging model. This group included:

- d) 2 – 4 NHS staff participants employed by 2 other NHS organisations, where nurses had taken a greater role in nutritional and/ or dysphagia management.
- e) 2 - 3 participants who were representatives of the professional bodies that regulate the two groups of healthcare workers at the centre of dysphagia management in stroke – the British Dietetic Association and the Royal College of Speech & Language Therapists (RCSLT).

Professional bodies were included in the second phase of the research, as participants in the first phase had referred specifically to the role and influence, or lack thereof, of the professional bodies in shifting the line between tacit and explicit skills and defining clinical complexity in their respective areas. Dietitians referred to the role of “the BDA” [the British Dietetic Association] and SLTs to the role of “College” [the Royal College of Speech & Language Therapy). I did not include Health and Care Professions Council (HCPC) representatives, as this body was not referred to by participants in Phase 1.

I drew up a table (Appendix 30) with a schedule for the second round of interviewees, taken from the gaps that I had identified in the Strength of Evidence and Gaps Table. In this schedule, I identified the specific individuals, or types of informant, that I should now interview, as well as any documental data that I felt was “missing”. This included e.g. examples of codification of skills and knowledge and definitions of complexity in dysphagia management.

In Phase 2, data were collected from a further 16 participants (8 new informants and 8 re-interviewees). In total 44 interviews were conducted throughout the research (Phase 1 = 28 participants, Phase 2 = 16 participants).

#### **5.4 Ethical approval**

As there had been changes to the requirements for ethical approval for research conducted in the NHS since my original application, I spoke to the main contact for the REC that had approved this (South East Wales Research Ethics Committee – Panel D). Specifically, I sought to discover:

- Should I submit a Substantial Amendment to add a second interview for some participants?
- Should I submit a Substantial Amendment as I now wished to add research sites?

I was advised that, although I would not be interviewing service users in this phase, and although REC approval was no longer needed to interview NHS staff participants only, it would be prudent to submit a Substantial Amendment as I had originally applied under the “old rules”. I could include the plan to add research sites as part of this submission. I was also advised that the REC would offer an opinion regarding the addition of interviewees in other sites too. I should, however, contact each of the “new” NHS sites and enquire whether R&D approval would be needed. This Amendment was duly submitted and approved by a Sub-Committee of the REC on 16<sup>th</sup> January 2014 (Appendix 31). The Interview Topic Guide (Appendix 25) was included as part of this application for consideration by the REC, as was a copy of the model as it stood at that point in time (Appendix 28).

#### **5.5 Gaining R&D approval**

I sought R&D approval at both “new” NHS sites and this was approved. I was granted Letters of Access (Appendix 32).

I interviewed the dietitian leading the training of nursing staff in the North of the country – the dietitian that informants in Haslem had often referred to. I also interviewed the SLT working in an NHS Trust in the Midlands – SLT informants in Haslem had referred to modelling their service in part on hers. She was pushing the line in transferring skills and knowledge in dysphagia care to nursing staff even further than Haslem were. I will call these two departments the North and the Midlands.

I was informed by the REC through the Substantial Amendment that R&D approval would not be required for the two professional body representatives. The REC was in a position to approve the addition of these two individuals in the Substantial Amendment as additional participants to the existing sites.

## **5.6 Access to participants**

Access to Group 1 participants in this phase was similar to Phase 1. For participants that I had not already interviewed previously, one of my known contacts in the field would send the participant my contact details, the invitation letter and the PIL electronically. They then contacted me by e-mail or telephone.

Group 2a) participants were contacted directly. It was necessary for me to do this, in order to ascertain whether or not they wished to take part, before I sought R&D approval from their organisation. Group 2b) participants were identified by contacting the main switchboard telephone number of each of the professional bodies. I outlined my query and then took the advice of the operator as to the best course of action. In both cases, the operator generated an electronic query with a copy of the invitation letter and PIL. This was then forwarded to the relevant person. This person contacted me by phone to discuss the research further and to make an appointment date.

## **5.7 Consent**

As in Phase 1, written consent was taken at the time of interview for all participants. I ensured that they had had the opportunity to read the relevant PIL, questions were invited and answered and then two copies of the consent form were signed. As in Phase 1, every interview had been pre-arranged with several weeks between initial contact and interview date, allowing the person a significant “cooling-off” period.

## **5.8 Data sources**

As in Phase 1 of the research, data were collected and analysed from semi-structured interviews, augmented by documentary sources.

## **5.9 Interviews**

The interviews were conducted in a private room or office on site, lasting between 48 and 80 minutes, and were audio-recorded. The interviews initially followed the Interview Topic Guide, but became ever more selective as the interviews progressed. Topics and themes identified in the proceeding interviews were picked up, as well as those related to the developing model. I attempted to “elicit... the participant’s

definitions of terms, situations, and events and try to tap his or her assumptions” (Charmaz 2006, p.32).

### **5.10 Documentary sources**

During this phase of the study, participants again referred to relevant documentary sources, which I obtained and included in the analysis. This included further processes of “codifying” expert skill and knowledge, such as care pathways, as well as professional body competency guidelines relevant to the passing on of skills and knowledge to other types of worker.

### **5.11 Coding**

Coding in Phase 2 was more theoretical, in that I was now specifically coding for linkages in the developing theory and model, as well as the gaps. I coded for more in-depth dimensions of the categories that already existed, rather than the open coding of the data in the initial stages. Entire paragraphs could be coded to a Node, usually an existing one, although exceptionally I did have to create another Child Node under a Parent Node. This was usually where the new Child Node had a different meaning from the Child Nodes that already existed.

### **5.12 Mapping during Phase 2**

During this phase of the research, I took to drafting clarifications and points to pursue directly onto printouts of the working model (Appendix 33). I did not want to continue amending the model more formally, as I was presenting this to research participants to get their reactions, feedback and thoughts. During this phase of the research, I felt it was important to integrate the barriers and enablers into a coherent model. I was aware that enabling factors had received less attention perhaps during the first phase of the research, following the feedback from member checking. I did feel, however, that by presenting the barriers and enablers separately in the model seemed disjointed. I was also mindful to maintain a focus on the social process itself, as per Corbin and Strauss’s (2008) position on the purpose and process of doing grounded theory research. The final model constructed through this research (Appendix 4) therefore focusses more on the process of change and sustaining this change than earlier models.

### **5.13 Theoretical sampling throughout Phase 2**

Theoretical sampling continued throughout Phase 2. For example, after interviewee 37, I realised that I needed to understand more about what could influence more junior

staff in their ways of working. Up until then, I had been interviewing mainly senior staff. Interview 39 and 42 then provided rich data on this topic.

#### **5.14 Focussed (selective) data collection**

According to Corbin and Strauss (2008):

“... [the] phenomenon stands for the topic, the event, the happening, the goal, or the major idea (category or theme) contained in a set of data. Process stands for the means of getting there...” (p. 101).

Taking this description, I now concluded that the core phenomenon had been the main conclusion to Phase 1. The core phenomenon was the way that a line had been drawn, in different places along a continuum, between explicit and tacit skills and knowledge in the different research sites. In Phase 2, I turned to explore the process by which the dietitians and the SLTs that had made the shift had done so. They had in effect shifted their definition, or perception, of this line and in doing so, were passing on more of the aspects of their role to other types of workers. I also focussed data collection on what it was that made, enabled or encouraged Haslem, the Midlands and the North to make the shift in the line that had been drawn between explicit and tacit skills and knowledge. This was the missing “at the beginning factor” that was found in the first theoretical models and appeared again in my gaps analysis. This analysis presented me with several key factors that had to be in place for the phenomenon to occur – in essence, the causal conditions. I also explored the consequences, both positive and negative, of this shift with participants. Given that the departments that had shifted the line between tacit and explicit skills and knowledge were categorical in the benefits that they perceived working in this way, I also wanted to explore the strategies that departments had used, and how they had made it work.

I visualised the phenomenon as something that “ignited” or “grew”. One or several factors caused the phenomenon to ignite in the first place. It started small (e.g. dysphagia assessment and management by nurses in stroke care) and then expanded into another area (e.g. dysphagia assessment and management by nurses across the whole hospital). The phenomenon then contracted back from areas where the benefits are not realised (e.g. every ward except stroke and the Intensive Care Unit (ITU)) and instead grew into other areas (nursing homes and other community areas). The phenomenon continues to grow and expand in the areas where the benefits are realised, while also seeking out other areas to grow (e.g. dementia care).

### **5.15 Scientific rigor during the research**

Toward the end of the research, when a researcher is filling in categories, they may return to old sites, documents, and persons, or go to new ones to gather the data necessary to saturate categories and complete a study. Even then, I will only have touched the surface of their view on the subject matter and much may, or has, remained unearthed. I think that this is my training, in a positivist focussed field, but I hope that I may have started to shed this mantle a little.

I discussed issues of rigor in the previous chapter. I shall not repeat these issues here, but instead I will summarise the measures that I took during this research that I hope will allow the reader to have confidence in the findings that are presented in the next chapter. These issues are summarised in accordance with Charmaz's (2006) list of criteria for judging the quality of grounded theory research referred to in the previous chapter (p. 77), and repeated in the table below for ease of reference. I shall now demonstrate how I have endeavoured to address each of these points in this study.

1. Fit – do professionals “react emotionally as well as professionally to the findings?”
2. Applicability – “Can they (the findings) be used to develop policy, change practice, and add to the knowledge base of a profession?”
3. Concepts – “...density and variation.”
4. Contextualisation of concepts
5. Logical flow of ideas
6. Depth – “it is the descriptive details that add the richness and variation”
7. Variation
8. Creativity – “It is not that the topic needs to be new, but that new understandings of that topic are brought forth.”
9. Sensitivity – “Were the questions driving the data collection arrived at through analysis, or were concepts and questions generated before the data were collected?”
10. Evidence of memos

**Table 8:** Criteria (Charmaz 2006) for judging the quality of grounded theory research

### **5.16 Fit and applicability - does the model and theory resonate with participants?**

Charmaz’s (2006) asserts that quality grounded theory research must hold up in practice, that it must make sense to those involved in the situation. She terms these concepts “fit” and “applicability” (p. 305). I felt it was particularly important to address these questions, both for scientific rigor, but also in the hope that the findings will be relevant, and helpful, to the professionals in the area. Did the concepts that were being generated by the data reflect participants’ own perceptions of the social process?

A key part of the research design was, during the early part of Phase 2, to go back to some of the people who had taken part in Phase 1. The purpose was to share the preliminary findings, to get their reaction to the developing model and to find out whether or not this resonated with their experience. This feedback helped refine aspects of the developing theory, whether theoretical gaps or clarification of the concepts to aid understanding.

I also presented participants with the developing theoretical model at interview in Phase 2. Although many of these participants reported that they had not thought of the

issue in a conceptual way, many felt that the concepts resonated with their sense of the situation. Several thought the model did resonate with how the process felt to them and how they experienced the phenomenon.

“Yeah, I think that makes some sense.” (65) (Michelle, hospital SLT manager, Haslem)

“So, yeah, yeah, but no that’s probably how we’d all see it, it’s just this kind of central...” (63 – 64) (Linda, SLT, Haslem)

“I mean that is sort of what I’d expect in the sense that yes, there are certain things that when you’re looking at dysphagia patients there are certain things that anybody can do for that person. And yes, there’s going to be the dietetics specifics, speech and language specific stuff at the other end and there’s always a grey area in the middle and it’s going back to that bit about you said ‘drawing the line.’ Some people draw it in one place and other people draw it in another and there could be a number of different reasons as to why that might be.” (36 – 41) (Phoebe, hospital dietitian manager, Haslem)

“Yeah, I would say, what you’re saying there, I would agree with all those things actually but never looked at it from a research point of view.” (61 – 62) (Cheryl, dietitian, the North)

“That sounds about spot on.” (25) (Carla, community dietitian, Haslem)

### **5.17 Applicability – “Can they (the findings) be used to develop policy, change practice, and add to the knowledge base of a profession?”**

Throughout Chapters 5, 6 and 7, where I present the findings of this research, I will link these to health care and professional policy in the arena, where such evidence exists. This is particularly the case in Chapter 7, where I will look at some of the conditions sustaining the change process. In order to address health and professional policy concerns, and represent a viewpoint beyond that of the professionals themselves, I specifically sought to sample from commissioners and professional body representatives, as well as other professionals in the arena.

### **5.18 Concepts - density and variation**

As described earlier in this chapter, the first phase of the study generated an enormous number of codes, and from those, 27 concepts. I have attempted to present the depth of the concepts explored and constructed with participants throughout the research with liberal use of interview quotes, which will be presented in the next chapters. I have attempted to explore the different concepts from more than one angle (for example, dietitian and SLT, or dietitian or SLT and nurse) and present differing perceptions and experiences. I have made liberal use of quotes precisely for the reader – although the

theoretical model and theory is my construction, I have attempted to convey how concepts and their interrelations have been arrived at, by the researcher, through the interview data, based on the direction that topics took, and to a degree where I led participants, during those interviews.

### **5.19 Contextualisation of concepts and logical flow of ideas - theoretical mapping**

Many grounded theorists treat creating visual images of their emerging theories as part of an intrinsic part of grounded theory methods (Charmaz 2006). They can help the researcher explore and connect ideas (Buckley and Waring 2013). Corbin and Strauss (2008) suggest that:

“...doing diagrams force a researcher to think about the data in ‘lean ways’; that is, in a manner that reduces the data to their essence.” (p. 125)

And:

“[In diagrams] ...the relationships proposed by the researcher are based on data and therefore can be said to have some grounding in the data.” (p. 127)

Charmaz (2006) suggests that theoretical mapping can be helpful “to chart the course with diagrams and maps that explain what you have and where you are going.” (p. 96). I certainly found this latter assertion to be true, and I used mapping throughout the research. More than recording the research process, mapping made it easier to make sense of large amounts of data and reflect on the complexity of the situation (Buckley and Waring 2012). In the early stages of the research, and as described earlier, an initial (“rough”) mind map was created on first immersing myself in the interview data. A second, simplified version of this map was then created after coding, so that it could be transported into the NVivo software. One mind map was created for each interview during Phase 1 of the research. During Phase 2, I no longer created a mind map for each interview, as I now had a developing theoretical model. Mapping, and certainly once I had the beginnings of a theoretical model, helped contextualise concepts, while allowing space to evolve existing concepts and develop new ones. The process of data collection and analysis unfolded in this order:

1. Preparation for the upcoming interview – go over existing data, listen once more to selected interviews (i.e. if interviewing a dietitian, I might listen to the last two interviews with dietitians) - reflecting on and thinking through the developing model, the gaps, where recent interviewees had added to the model or created further gaps to explore/ that I felt needing exploring further. Create the

beginning of the first interviewee-specific memo, which always starts with the specific data that I was hoping to gather from this particular participant (see Appendix 34).

2. Interview the participant. This always started with a brief introduction, questions relating to the PIL, consent.
3. Immediately after the interview, usually in my car, adding to the “Post-interview” memo, with my initial impressions.
4. Back home, importing this Word file into the NVivo software. Listening through the interview and creating the initial mind map, adding to the “post interview” memo as required.
5. Transcribing the interview and importing this into the NVivo software.

Throughout the process of data collection and analysis, I was continuously going back and forth between contacting, speaking with and arranging interviews; preparing for each interview, going out and conducting the interview, with immediate memoing post-interview; listening through the recording and drawing up the initial mind map, transcribing the recording and importing this into the NVivo software; coding the transcript, while also creating the “coding” memo, adding to or creating new “theoretical” memos and annotating the developing theoretical model as required by the new data; refining the mind map and creating this in the NVivo software. This process helped with the logical flow of ideas and to develop, hopefully, robust findings.

## **5.20 Depth – rich description**

In the three chapters that follow, where I present the findings of this research, I will expand on the concepts constructed during the research with rich descriptive detail. I also attempt to link this to existing literature, and to propose how the findings do, or could, develop, support or differ from existing literature. I will also present plentiful quoted material from the research, demonstrating in participants’ own words, the concepts that developed.

## **5.21 Variation**

Charmaz (2006) suggests that one of the main purposes of theoretical sampling is “to identify variation in a process.” (p. 107) and Corbin and Strauss (2008) suggest a number of techniques that may help the researcher move the analysis along if overwhelmed by his or her data, and to aid in theoretical sampling. These include techniques such as “The Use of Questioning”, “Various Meanings of a Word”, “Thinking in Terms of Metaphors and Similes” and “Looking for the Negative Case”. I, too, included many of these techniques throughout data collection, analysis and when

making decisions about further sampling, some of which will be evident in the findings that are presented in the next three chapters. For example, I use the participants' own metaphor of "drawing the line" to describe the central process enabling change. I explored with participants the different ways in which they understood, perceived of and defined this term, which is a central feature to the findings that will be presented.

While Charmaz (2006) warns against sampling "to find negative cases" (p. 100), amongst the other perils of theoretical sampling, I did, throughout data collection, attempt to play "devil's advocate", pitting concepts developed in one setting in another setting, in an attempt to draw out and extend the concept(s). This can be seen, for example, under the heading "Nutritional supplements as an example of clinical complexity", at p. 145 in Chapter 5.

Rather than conceive of variations on a concept as fundamentally negating the developing theory, Corbin and Strauss (2008) too, suggest that the purpose of theoretical sampling is precisely to uncover variation. If a case doesn't fit, they suggest that:

"For the most part, these outliers represent variations of the theory or present alternative explanations." (p. 114)

I have attempted to develop the properties of the categories that were developed, by pitting concepts against one another in the various research settings, and with the breadth of research participants, in a "ping-pong" fashion, taking into consideration Dey's (1999) thoughts on such negative cases, and as described earlier in this chapter under data collection and theoretical sampling:

"This sampling process is presented in two stages, first including groups with minimal differences (to establish 'the basic properties of a category') and then those with maximal differences (to bring out the widest possible variation in categories). The aim, though, is not to use differences to negate established relationships but rather to recognize and incorporate new conditions." (p. 171)

## **5.22 Creativity**

The developing model certainly sparked a new way of thinking about the issue to many of the participants interviewed in the second phase of the study. For example, it sparked Mavis, the stroke co-ordinator in Haslem, to think about the line between tacit and explicit knowledge, and the sharing of that knowledge, in terms of her own, advisory, role:

“...actually you can cover more ground if your tacit skills actually go through to being your explicit skills i.e. you work as an advisor rather than always as an actual person who has to be there, has to be involved.... (29 – 31) So actually that philosophy of working as an advisor, so people actually seek your information and you readily give it, is what you’re speaking about in terms of explicit skills and knowledge. (31 – 32) ... So advisory can be all sorts of different things, you know it can be mentoring, it can be helping, guiding people through, signposting people through. It can also be training as well. You might use some of your staff to actually do training...” (57 – 59)

Jenny, the commissioner in Haslem, was also able to relate the conceptual model to areas of skill mix that she too, was working on, a connection between withholding or sharing skills and knowledge that she had not made previously:

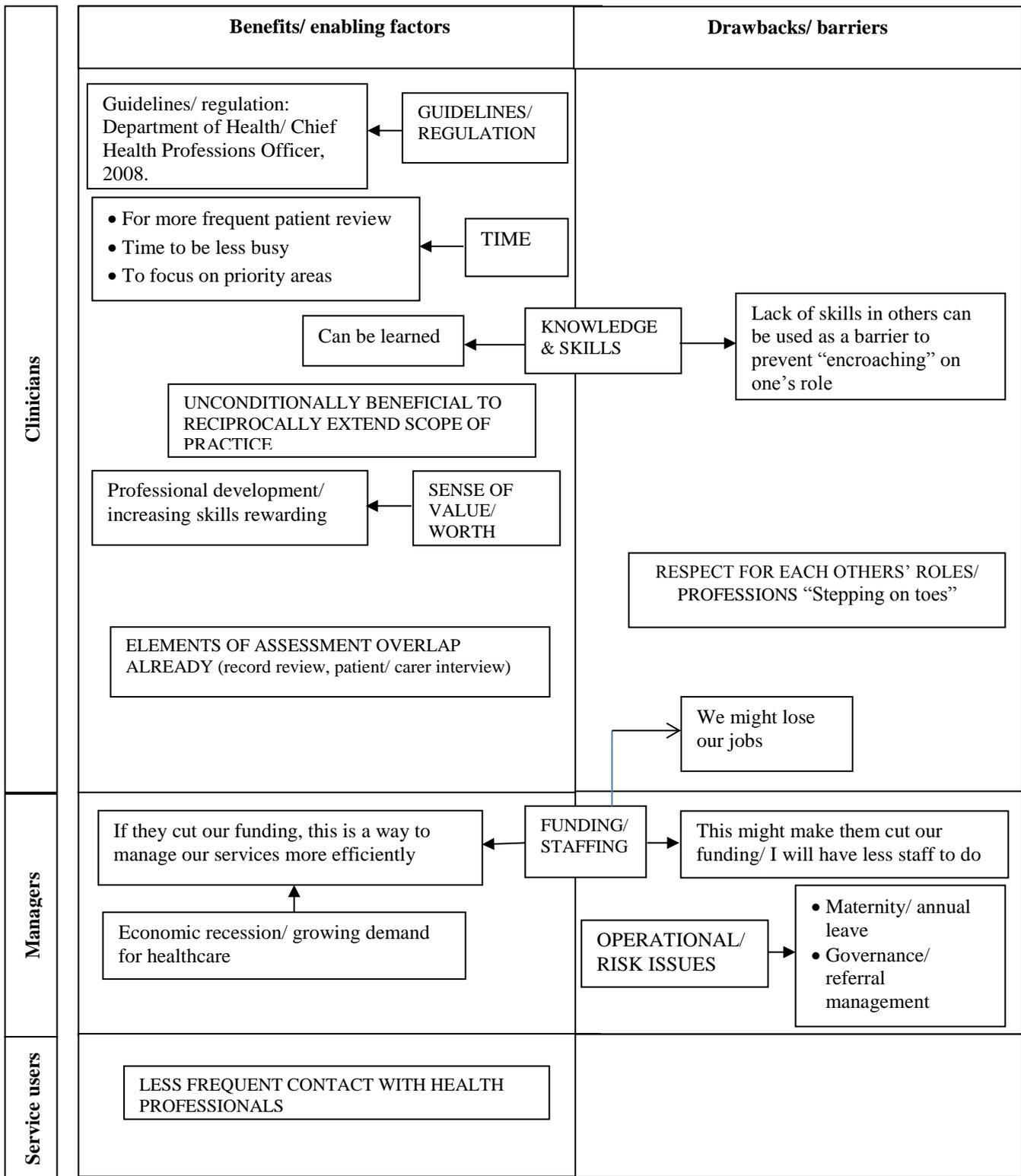
“Because I am aware that we’re doing other pieces of work about sort of generic working, I mean it’s like in, for example, intermediate care there’s a general desire that all professional staff in the team, there’s a [...] which if you like everyone can do up to the turning of level 4. So if you can teach, and bearing in mind we’re presuming that someone comes into that kind of unqualified post without any real background knowledge, learning potentially. So you are teaching them all those sort of tasks as opposed to, I suppose it’s this difference between that and the professional role where it goes along with a whole body of theoretical knowledge and experience in a very specific area isn’t it? So I’m guessing your explicit skills, is the contested area the bit where if you’re already a nurse or a therapist, would you teach them things that you wouldn’t teach somebody who’s a band 3 HCA?” (33 – 42)

The theoretical model presented to Carla, the community dietitian in Haslem, during the second phase of the research, also made her think about the steps in a clinical pathway in a new way:

“It makes perfect sense the word coding but it just wouldn’t, because that’s literally what’s been done – it’s been broken down, this and this, so it is like coding, it’s perfect, but it wouldn’t have been that phrase that would have... I don’t know how I would have described it really... probably more on the terms of a pathway or a plan.” (35 – 38)

### **5.23 Sensitivity**

As described in the previous chapter, I attempted to catch my own assumptions prior to starting data collection and analysis, reproduced again below for ease of reference.



**Figure 12:** Model of assumptions before the start of data collection

One of the key assumptions in this model is that these new and different ways of working, and role extension in the area of dysphagia care, is inherently a positive development. This assumption, based in my own experience of the frustrations of the clinical area, a positive disposition towards change and experience of service

improvement methodologies, resonates throughout this thesis. I have, however, attempted to remain open to alternative views and do present some drawbacks to these ways of working in the next chapter.

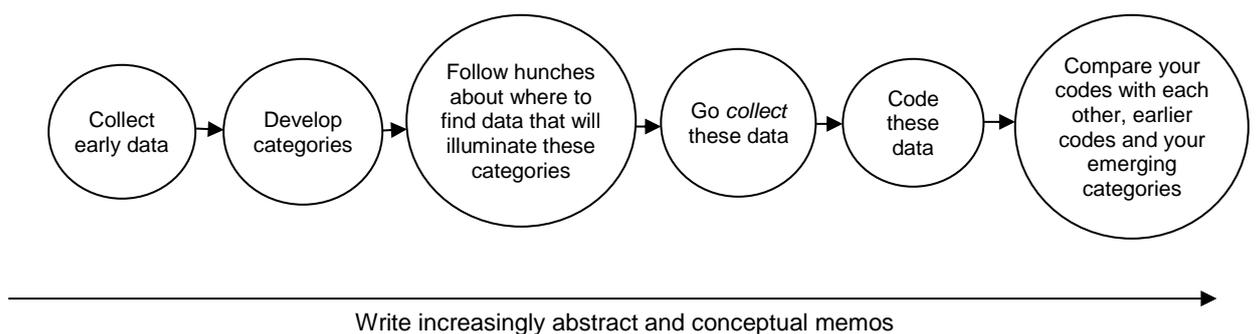
Other assumptions presented in the above model were those derived from personal experience in the area, and from the literature that I read prior to designing the research study. The reader may note that practical barriers and issues feature quite prominently – these were the main issues described in previous literature. As one will note from the findings in the next chapter, such practical issues were relatively insignificant in the process. Knowledge and skills are also present in this model, but in only a small way – before the study started, I was unaware that knowledge and skills would be the core concept and the importance that these would play in enabling, or preventing, role extension in the area.

#### 5.24 Evidence of memos

Memo writing forms an integral part of Grounded Theory research (Charmaz 2007, Corbin and Strauss 2008, Saldana 2009). Both Corbin and Strauss (2008) and Charmaz (2007) rely heavily on the use of memos as a tool for improving the credibility of grounded theory research. Charmaz (2006) tells us that:

“Memo writing leads directly to *theoretical sampling*...” (p. 103)

Specifically, Charmaz (2006) recommends the following relationship between memos and theoretical sampling:



**Figure 13:** The relationship between memos and theoretical sampling (Charmaz 2006)

According to this model, in grounded theory research, the researcher starts by collecting and coding initial data. From the analysis of these early data, categories will be developed by the researcher. The researcher then follows the gaps in these categories and, using theoretical sampling, collects data from places and participants, and by asking questions, that will develop these categories further. These new data

(usually interview transcripts) are then also coded. The codes derived from the data are then compared with each other, codes that have already been created and the categories that exist, so as to fill in the gaps in the categories and/ or link earlier categories. The role that memos plays in this process is in the beginning primarily to identify the properties and dimensions of categories (Corbin and Strauss 2008), gaps in understanding and identify further sources of data. As the research progresses, these memos become increasingly conceptual and abstract, with a focus on linking categories to create the coherent story line of a grounded theory, the "...short analytic narrative that begins to tie some of these elements together" (Clarke 2005, p. 270).

At the start of my research journey, I duly created memos with only a shallow understanding of their significance as part of the research process. As my experience and "theoretical sensitivity" grew, I have come to fully appreciate their importance. They are a valuable tool both for questioning the researcher and the decisions that you have made or are about to make, but also as a tool for propelling the analysis further. Memos also serve to document the progress of the research and therefore, add to the credibility of findings (Charmaz 2006). As such, I have come to enjoy periods of memo writing, rather than view this as only a necessary research process. Memos formed an important and intricate part of data collection and analysis and theory generation in this study, and as a tool for increasing, and demonstrating, scientific rigor and theoretical sensitivity. Richardson and Adams St. Pierre (2011) use writing itself both as data (i.e. writing about thoughts and feelings connected to their research) as well as a method of data analysis, i.e. writing helped them develop (analytical) thoughts about their data/ research:

"Thought happened in the writing.... I doubt I could have thought such a thought by thinking alone." (p. 970)

Writing memos helped shaped my thinking, and kept me asking questions of my data, such as: "Why?", "What if?", "What else?", "What is missing?".

In the 2<sup>nd</sup> edition of *Basics*, Strauss and Corbin broke memos down into several types – code notes, theoretical notes, and operational notes. In the 3<sup>rd</sup> edition, they describe wanting to get away from thinking about memos in a structured manner "As ...novice researchers" often become too concerned with "getting it right" (p. 118). Despite this assertion, I did create memos in such a structured way, as I found it helped to organise my thoughts and memos; neither did I find that organising the memos interrupted my analytical thinking.

I have used memos in the development of codes and categories, to capture reflective elements of the research process (see example appendix 35), for theoretical sampling (see example appendix 36) and to reflect on interview technique (see example appendix 37). Memos were captured electronically, and stored in an ordered manner. Within the NVivo data analysis software, the electronic folder “Memos” was created and sub-divided into “Methodological memos”, “Post interview” memos, “First listen through and creation of the mind map” memos, “Coding memos”, “Theory generation” memos and “Writing up” memos. Throughout the research process, this has resulted in over 120 memos, most with one or many more additions to each memo as my thoughts developed further on the topic of a particular memo.

Corbin and Strauss (2008) also recommend:

“Use a notebook or running log, separate from memos, to write up impressions of participant and researcher’s reactions during interviews or observations.” (p. 123)

I followed this recommendation, by creating and using separate “Post-interview memos” after each interview. Memos were used as my primary method of recording and reflecting on the research process. This enabled me to capture thoughts on interviews directly after each one. “On-the-go” memos were then transferred into NVivo once I was back at my desk. I did also use a hard bound research diary for hand writing notes when I did not have immediate access to my laptop – these were then typed into an electronic format at a later date. In effect, this means that for each interview conducted, there were three levels of memo writing for the specific interview, as well as memos regarding the development of the theory.

Having described the methods used to conduct this research, I will now present the findings of this research. Chapter 6 presents the conceptual model explaining the barriers and enablers to new and different ways of working in dysphagia care, as well as the conditions that sought to maintain the status quo. Chapter 7 explores the conditions that facilitated the change, while Chapter 8 explains how the change was maintained. I conclude the research findings with a discussion of their implications in Chapter 9.

## **CHAPTER 6 FINDINGS MAINTAINING THE STATUS QUO**

### **6.1 Introduction to the following chapters**

The following three chapters outline the findings and theoretical model constructed during this research. In this chapter, I will first describe the different ways of working in Billington, Haslem, the Midlands and the North. I will then explore the barriers to new and different ways of working and forces maintaining the status quo. In the next chapter (Chapter 6), I will go on to explore the change that occurred and the factors that enabled new and different ways of working to be adopted in Haslem, the North and the Midlands. In Chapter 7, I will conclude by exploring further the enablers to new and different ways of working, specifically the factors that helped maintain the change.

The reader will be presented with the overarching theoretical model constructed during this research in this chapter. I will summarise the main findings and model, before going on to explore each concept in turn. For ease of reading, I will repeat each part of the model as it is explored in the text in the following three chapters. The model is presented initially visually in its entirety. As I go on to explore each part of the model in turn, the aspect of the model that I will be discussing is highlighted, with parts of the model to be discussed later or already discussed are shaded out, to draw the reader's attention to the part under discussion. I will explore each of the concepts within the model in depth as the chapter proceeds, and in Chapters 6 and 7. Excerpts of quoted material include the line numbers from the original transcripts in parentheses at the end of, and within, the quoted text.

The findings and theoretical model will also be linked, where appropriate, to existing literature in the field, as described by Charmaz (2011):

“In conventional grounded theory practice, researchers develop their analyses first and then return to the literature...” (p. 373)

When reading these findings, the reader should bear in mind that I have constructed the findings based on the specific individuals that I interviewed, within the context of the research sites that I visited at the time that I visited them. I am aware that:

“...the findings reflect the ‘essence’ of what participants are trying to convey, or represent one logical interpretation of data, as seen through the eyes of this particular analyst.” (Corbin and Strauss 2008, p. 47)

The processes described here are thus contingent on both the researcher (Finlay 2002), the participants and the context within which the research was conducted (Maxwell and Mittapalli 2007). Given the variety of settings where data were collected, and the broad concurrence on the constructed model amongst participants in these various settings, I conclude that the findings may bear relevance and resonance to dietitians and SLTs working in other organisations than those studied here. The findings may also be transferable to other professional groups with overlapping scopes of practice. As an occupational therapist in the audience of a presentation that I gave stated: “You could be talking about physios and OTs.” Readers will be able, based on the context of the research settings which I will describe shortly, to judge to what extent the findings may be applicable to their own or other settings. As Dey (1999) states:

“To generalize beyond one population, we do not need to generalize to all populations. To generalize beyond one location, we do not need to generalize to all locations.” (p. 219)

I have used pseudonyms in presenting the findings, to protect the confidentiality of participants. Each interviewee is presented with their research participant number in the two tables below, along with their place of work and designation, as well as a pseudonym. I have presented participants in two tables – one for each phase of the research.

<b>Participant Pseudonyms – Phase 1</b>			
<b>Participant Number</b>	<b>Place of Work/ Interview</b>	<b>Designation</b>	<b>Pseudonym</b>
01	Billington	SLT	Heather
02	Billington	Dietitian	Harriet
03	Billington	Service user	Steven
04	Billington	Stroke nurse	Sarah
05	Billington	Dietitian	Rachael
06	Billington	Dietitian	Alexis
07	Billington	Stroke nurse	Margaret
08	Billington	SLT manager	Susan
09	Haslem	Dietitian	Carla
10	Haslem	Service user	Dorothy
11	Haslem	SLT	Betty
12	Haslem	Dietetic manager	Phoebe
13	Haslem	Commissioner	Jenny

14	Haslem	SLT manager	Lauren
15	Haslem	SLT	Karen
16	Billington	Doctor	Jonathan
17	Billington	Service user	Pamela
18	Billington	Service user	Derek
19	Billington	Stroke nurse	Amber
20	Haslem	SLT	Philippa
21	Haslem	Dietetic assistant	Lesley
22	Haslem	Dietetic manager	Sharon
23	Haslem	SLT	Emma
24	Haslem	Stroke co-ordinator	Mavis
25	Billington	Service user and carer	Bill and Carmen
26	Haslem	SLT	Linda
27	Haslem	SLT	Gail
28	Billington	Service user	Jennifer

**Table 9:** Participant pseudonyms, Phase 1

<b>Participant Pseudonyms – Phase 2</b>			
<b>Participant Number</b>	<b>Place of Work</b>	<b>Designation</b>	<b>Pseudonym</b>
29	Haslem	SLT	Michelle
30	Haslem	SLT	Linda
31	Haslem	Dietitian	Carla
32	Haslem	Dietetic manager	Phoebe
33	Haslem	Ward nurse manager	Rebecca
34	Haslem	Stroke co-ordinator	Mavis
35	Haslem	Commissioner	Jenny
36	The North	Dietitian	Cheryl
37	Billington	SLT managers	Susan and Olivia
38	Billington	Stroke ward nurse	Margaret
39	Billington	SLT	Julie
40	The Midlands	SLT	Poppy
41	Haslem	Dietetic assistant	Eve
42	Professional body	Representative	Grace
43	Professional body	Representative	Nina
44	Billington	Commissioner	Nelly

## **Table 10:** Participant pseudonyms, Phase 2

Before I present the model, it might be helpful for the reader if I first outline how the dietitians and SLTs work in the field of dysphagia in Billington, Haslem, the Midlands and the North, and how their ways of working differ. I will then summarise the differences in a table, for ease of reference while reading the next three chapters.

### **6.2 The context**

In Billington, both the dietitians and the SLTs take an approach to managing their caseload that my experience suggests is the traditional way of working in this area. Certainly, this is how we were trained as students to work, and this is how we train new students today. This is the way that we manage our patients where I work and where I have worked in the past. It is my impression, from speaking with colleagues, managing transfers of patient care and correspondence from other Trusts, and from reading our professional journals and periodicals, that this is how dietitians and SLTs work in most departments and Trusts in the UK. Departments that work in other ways, such as Haslem, the North and the Midlands, tend therefore to be presented as exceptional. If interested in the field, one will have heard about the new ways in which colleagues in the Midlands or in the North are working.

Specifically, in Billington, dietitians manage most aspects of nutrition and SLTs, most aspects of dysphagia. The introduction of the RCP (2008) clinical guidelines for stroke, which were later incorporated into NICE guidelines, has necessitated that nurses are trained to take on some aspects of the dietitians and the SLTs traditional role. Dysphagia screening within 24 hours has meant that nurses have had to be trained in recent years to perform a basic dysphagia screen, referring only those to the SLT who “fail” the screen.

“When the RCP guidelines and the Commissioners stepped forward and said we want water swallow screen training, it was the speech therapy team who designed the training...” (193 – 194) (Susan, SLT manager, Billington)

The dysphagia screening enables nurses to screen patients in or out of oral diet. For those patients which dysphagia screening identifies should remain Nil By Mouth (NBM), a referral must then be made to the SLT. For patients who are identified as being unsafe to swallow, a decision must be made, by a doctor, whether or not to provide artificial nutrition, through a feeding tube. Due to the 9-5, Monday-Friday nature of dietetic services, this has meant that dietitians have provided what is known as

“emergency feeding regimens” – a small amount of enteral feed that can be started by a nurse until reviewed by a dietitian. An online search will reveal a plethora of such emergency regimens in hospitals in the UK.

In 2006, NICE guidance recommended nutritional screening in the UK with the Malnutrition Universal Screening Tool (MUST) for all patients admitted to hospital and care homes, with regular review.

“Yeah so every patient would have MUST form completed and they do that on admission as well as weekly...” (255 – 256) (Rachael, dietitian, Billington)

This guidance later became incorporated into commissioning requirements, including Commissioning for Quality and Innovation (CQUIN) payments. The MUST screening tool was simple, and the intention was that any type of worker could be trained to perform it.

“...that’s one good thing, as time’s moved on (laughing) that we have got MUST, years ago when I first started I just used to have to somehow cobble something together to try and sort of suss out a nutritional assessment, whereas now we’ve got the nationally agreed one...” (159 – 162) (Alexis, dietitian, Billington)

Naturally, Billington uses this tool, and the dietitians accept referrals based, in part, on the results of this screen.

“Occasionally I will pick up patients from here too, ‘cause obviously if they’re carrying on using the MUST and screening patients... (147 – 149) I might then pick up a new referral from here, I did yesterday for a patient, because obviously they’d been screening...” (151 – 153) (Alexis, dietitian, Billington)

As per the official recommendations in the MUST tool, patients with a MUST score of 2 or above in Billington are then referred to the dietitian for assessment and nutritional management planning.

In Haslem, the majority of patients with a MUST score of 2 and above are managed by dietetic assistants, rather than dietitians. The dietitians in Haslem were also training the nursing homes to manage patients themselves, following a flowchart, and only refer to the dietitian if the actions in the flowchart failed to improve the patient’s nutrition. Similarly, the SLTs in the hospital had pioneered an extended dysphagia assessment programme for nurses a few years earlier. Starting with the stroke unit, this programme was now being used on the Intensive Care Unit (ICU), and was also being transferred into the community setting. The difference between this and the more basic dysphagia

screening was that nurses were trained and permitted to not only screen for the presence or not of dysphagia, but also to trial the patient on various textures of food and fluids. The end result of this extended screen was a recommendation, by a nurse, of oral intake (diet and fluids) or not, as well as which texture. In the community programme, community and nursing home nurses were being trained to review and manage patients with existing dysphagia, by assessing their progress and possibly “upgrading” the texture of their diet or fluids, i.e. recommending a more difficult texture to swallow if the patient was assessed as being able to manage this safely. These two aspects, nurses recommending a texture, and nurses reviewing and upgrading the texture, are fundamentally different from the more usual dysphagia screening performed by nurses.

The possible outcomes at each stage of the assessment or review, and the correct actions to perform in response to these results, were set out explicitly in the flowchart and associated training:

“And they have to work through the stages for that and at the end of each section there are points to look at. If the person fails on any of those points, it tells them what to do so they stop or they follow this line and it tells them to do what next.” (218 – 220) (Linda, an SLT, Haslem)

In the North, the dietitians were mostly handing all care for patients at risk of malnutrition on to community nurses, GPs and nursing home nurses, through a flowchart and resources. The role of the dietetic department here was focussed on training and audit, rather than advising individual patients, which is typically the role of the dietitian. Additionally, the training was provided almost exclusively by dietetic assistants, with the dietitians having more of an oversight role. More recently, they were developing an electronic and telephone system for monitoring patients, with their dietetic assistants providing oversight over the system and conducting telephone reviews.

In the Midlands, the SLTs were using a basic dysphagia screen as in Billington. They were also training nurses on selected wards and in selected community areas to provide comprehensive assessment and management planning for patients with non-complex dysphagia. In the Midlands, these nurses were providing assessment and advice in the same way as SLTs, for selected groups of patients.

The use of advanced dysphagia and nutritional assessment and management protocols and its associated training in Haslem, the North and the Midlands is a step

further in extending the role of other types of workers in this clinical area. So, too, is the provision of training to other types of worker by assistant staff, rather than professionally qualified workers. Advanced dysphagia training for, and assessment and management of dysphagia by, nursing staff, is also a step further than how dysphagia is managed in Billington.

	Basic nurse water swallow screen	Nurse swallow screen/ assessment and advice on various textures	Nurse swallow review and texture progression (“upgrading”)	Nurse nutritional screening	Nurse nutritional planning and review MUST > 2	Dietetic assistant nutritional assessment, planning and review	Dietetic assistants MUST training	Dietetic assistant nutritional assessment and planning training	Electronic and telephone-based nutritional review
Billington	√	x	x	√	x	x	x	x	x
Haslem	√	√	√	√	√	√	√	x	x
The North	N/A <sup>2</sup>	N/A	N/A	√	√	√	√	√	√
The Midlands	√	√	√	N/A	N/A	N/A	N/A	N/A	N/A

**Table 11:** Nutritional and dysphagia assessment, planning and review in the research settings

### 6.3 Theory and theoretical model constructed during the research

The process that was constructed from the interviews and analysis was a shift in the perception and definition of explicit and tacit skills and knowledge in the different research settings. Explicit and tacit skills and knowledge were conceived of as presented on a continuum, with explicit skills and knowledge on one end of the continuum, and tacit skills and knowledge on the other end, as described in the previous chapter. Explicit skills and knowledge were those that the clinicians had codified or transferred to other types of worker (such as assistant staff and nurses) by other means, i.e. through training and protocols. Tacit skills and knowledge were those that were not transferrable to other types of worker due to the complexity, and thus expert nature, of those skills and knowledge.

The boundary between explicit and tacit skills and knowledge was referred to by participants as “drawing the line” – participants referred to the need to draw a line somewhere between tasks that their own professional group would have to undertake, and those that could be relinquished to another group of workers, i.e. nurses or assistant staff.

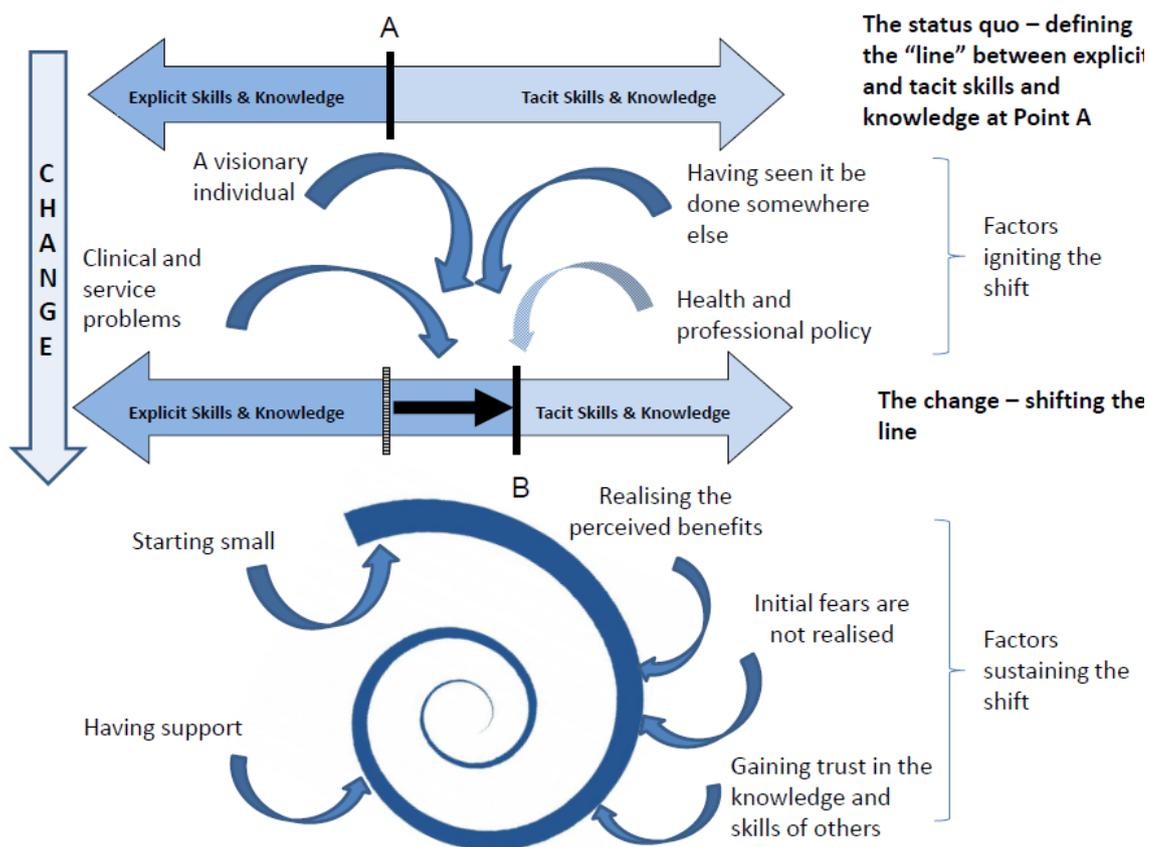
“So do you draw the line at purely food and fluid intake and modified consistency or do you go the whole hog and say well they could do tube feeds

<sup>2</sup> Data collection did not assess nutritional management in the Midlands, nor dysphagia management in the North.

and things as well, I don't really know. (419 – 421) ...I guess there would need to be a line drawn somewhere, it's just where." (444) (Rachael, a dietitian, Billington)

The difference in where this line had been drawn was the main barrier or enabler to working in new and different ways in this area. In keeping with grounded theory (Corbin and Strauss 2008), I visualised the phenomenon as a process. The theoretical model constructed through this research, representing this process, is presented below. This model uses the core concept presented very early on that was grounded in the perspective of early participants – the line between tacit and explicit skills and knowledge as either a barrier or an enabler to new and different ways of working in dysphagia care. As described in Chapter 5, I actively sought to present this core phenomenon as a social process, as described by Corbin and Strauss (2008). As a conceptual model, it also had to answer both research questions, e.g. be able to explain both the barriers and the enablers within one model. Thus, the barriers in the final model are the factors “maintaining the status quo”. The enablers are the factors igniting the shift. The concept of a shift igniting and then growing as participants realised the perceived benefits was an important factor in these data. These factors both sustained the shift in Haslem, but also continued to push the line even further, as was the case in the Midlands and the North. The model therefore captures the factors igniting the shift and those sustaining the change, both of which are therefore enablers in this research.

The core concept identified during Phase 1 of the research, namely that of a conceptual line between skills and knowledge that are explicit, and thus codifiable, and those that are tacit, and therefore retained by the professional group, remains in the final model. The concept of skills and knowledge presented on a continuum, and thus malleable, also remains, as does the definition of where the dividing line lies differing in the different SLT and dietetic departments. The skills and knowledge that have been defined differently, and the clinical tasks that flow from having (or not having) “the right training, skills and knowledge”, was the contested space identified in earlier models (Figures 10 and 11). I have attempted in the final model to retain the focus on the social process, or process of change, e.g. shifting this line, as the purpose of the research, in keeping with Corbin and Strauss's (2008) grounded theory method. Therefore, this model highlights instead how the process of shifting the line from Point A, where a larger proportion of skills and knowledge are considered tacit and this retained by the professional group, to Point B.



**Figure 14:** Theoretical model constructed during the research

Participants in Billington had “drawn the line” between explicit and tacit skills and knowledge at Point A in the model. Explicit skills and knowledge were those to the left of that line. In contrast, participants in Haslem, the North and the Midlands had defined the same skills and knowledge at Point B. The skills and knowledge in the contested space were being transferred to other types of worker in Haslem, the North and the Midlands.

In Billington, participants had not transferred these same skills and knowledge to other types of workers, as they felt that the skills and knowledge in the contested space, required to perform specific clinical tasks, were too complex for other types of worker to perform and required their tacit skills and knowledge, or expertise. By defining skills and knowledge as too complex to be transferred to other types of worker, professional boundaries were maintained in Billington. By perceiving of other types of workers as lacking “the right skills, training and knowledge”, specific to their professional domain, the SLTs and dietitians were able to maintain the status quo and professional closure over the clinical area.

For the shift in the line that had been drawn to occur in Haslem, the North and the Midlands, there had to be some igniting factor, some condition that caused this to happen. There were three conditions that were all essential for the shift to occur, namely:

1. A crisis or difficulty in managing the service, such as short staffing coupled with waiting time targets, an inability to fill vacant staff posts, or complaints,
2. An individual with a clear vision for the service,
3. Having seen it be done somewhere else.

None of these conditions were on their own sufficient (Dey 1999), but rather all three were necessary for the shift to happen. Health and professional policy played a role in influencing the shift, mainly through its impact upon incentives, but to my surprise, it was neither a necessary nor a sufficient condition igniting the shift.

Once ignited, the process of shifting the line started small (e.g. dysphagia assessment and management by nurses in stroke care) before expanding into other clinical areas (e.g. dysphagia assessment and management by nurses across the whole hospital, in the community and nursing homes), as participants perceived benefits to this new way of working. These perceived benefits sustained the shift and included direct benefits to participants and the service, such as having more time to focus on more complex patients. In addition to perceiving benefits, participants' initial fears, such as "being done out of a job" or those to whom skills and knowledge were being transferred "overstepping the mark", did not come to bear. Realising the perceived benefits and that initial fears were not realised further sustained the process, or shift, causing it to grow into other areas. "Gaining trust in the knowledge and skills of others" and "Having support" were further factors sustaining this process.

#### **6.4 Tacit and explicit skills and knowledge**

Tacit knowledge is sometimes referred to as "know-what", and explicit knowledge as "know-how" (Nonaka and Takeuchi 1995). The debate regarding eliciting and sharing tacit knowledge in the organisational literature centres mainly on capturing or codifying employee's tacit knowledge for the benefit of the firm (Chan and Chow 2008; Nonaka and von Krogh 2009; Argote 2011; Matzler et al. 2011; Chen et al. 2012) or the acquisition of tacit knowledge by competitors (Zander and Kogut 1995; Osterloh and Frey 2000; Chowdury 2005; Bock et al. 2005).

It is widely argued, from as far back as Polanyi's (1966) thesis, that all knowledge is rooted in tacit knowledge (McAdam et al. 2007) and even contextual in nature (Nonaka et al. 2014). Collins (2012) argues that the acquisition of explicit knowledge depends on the presence of ubiquitous knowledge. Thornton (2006) also suggests that explicit knowledge itself relies on a degree of tacit knowledge. Teaching nurses to perform dysphagia screening and/ or assessments rests on the nurses possessing the right tacit knowledge of the subject area. For example, in discussing the theoretical model arrived at in this research, Susan and Olivia, two SLT managers in Billington, elaborate on the contextual nature of where the line between tacit and explicit knowledge lies, depending on the skills of the individual:

"I think as a concept, it's a really good way of thinking about it. I can understand your grey area, I think it's a model that you could apply to any scenario where there are a range of people who could deliver the product. And I think because it's open to interpretation, unless you are absolutely categorical about, you know, like prescribing – either you can prescribe or you can't... (203 – 206) So how we would talk about something that would fall into that grey area might be completely interpreted in a different way by somebody else who also stands in that grey area." (213 – 215)

Renzl (2008) and Cabrera and Cabrera (2002) have suggested that both the degree of articulation (whether or not the knowledge can be codified, articulated or shared in some other way - see also Zander and Kogut (1995), and the degree of aggregation (whether the knowledge is located in the individual or in the group) as distinguishing tacit from explicit knowledge in groups. Knowledge is increasingly conceived as residing within social groups, rather than individuals (Currie and White 2012), referred to by Collins (2012) as collective tacit knowledge. In addition to studies focusing explicitly on knowledge *transfer* (Mowery et al. 1996; Tsai 2001), studies have labelled knowledge transfer processes in alternative but related ways. For example, studies have considered knowledge sharing (Hansen et al. 1999; Tsai 2002), knowledge flows (Gupta and Govindarajan 2000; Schulz 2001), and knowledge acquisition (Darr et al. 1995; Lyles and Salk 1996). Research into how knowledge is created and transferred is developing away from a one-way model of "source and recipient" (Renzl 2008, p. 207) towards a greater understanding of collaborative knowledge creation and knowledge sharing.

Interestingly, Nonaka and von Krogh (2009) assert that the conversion between explicit and tacit knowledge "should not be seen as separate entities but rather mutually complementary and based on the same continuum" (p. 640). Nonaka and von Krogh (2009) and Nonaka et al. (2014) also propose that tacit and explicit knowledge lie on a continuum, much like the theoretical model that I have arrived at here. They also

suggest that knowledge should not be considered fixed nor static along this continuum, but rather in a dynamic state of conversion.

The fluid nature of this continuum was articulated in the interview data; participants described the point of transition between tacit and explicit skills as being dependent upon the skill level of the individual. For example, Jenny, the commissioner in Haslem, an occupational therapist by background, said:

“I would expect that like the explicit skills or the things you can teach, how much is that dependent on what the person’s skills are already in the sense of and if you like their wider clinical confidence? (30 – 32) ...there’s a sort of part of the task, if you like, that is fairly straight forward and as long as people stay within fairly familiar norms that’s almost that bit isn’t it, because that’s what we’d expect, that’s what you know relatively normal. But as soon as you get anything that causes you to deviate off, that’s when you need somebody with either a body of knowledge, experience, a kind of understanding of the wider implications and be able to make I suppose judgements and decisions based on that...” (112 – 117)

Acquiring tacit skills is what we sometimes think of as being an expert, or having expertise (Feltovich et al. 2006). Turner (2012) suggests that a sign that knowledge is tacit is in the ability of some to perform the particular activity, whereas others cannot, even with verbal instruction. Stanley and Krakauer (2013) have pointed out that all skill ultimately starts as explicit rules that we then internalise. This is the case even if we cannot later tell how we once knew this. This does not necessarily make the knowledge tacit. The knowledge itself may be explicable and even codifiable, even if practice is then also needed to refine the skill. The same argument can be transferred to much skilled clinical practice. Ultimately, the student starts with theoretical knowledge and/ or instruction, proceeding then to refine their skill through practice.

Whereas some disciplines have come together to focus joint attention on the topic, such as psychology, linguistics and computer science, others remain at odds as to definitions and distinctions of tacit knowledge (McAdam et al. 2007) and how experts come to have the skills that they do (Dreyfus 2005). The tradition of focussing on the human in skill acquisition, rather than knowledge and skill itself (Collins 2010) continues with scholars with backgrounds in philosophy, such as Thornton (2006), Gourlay (2006a) and Fridland (2014). Findings in neurophysiology (for example Thomas et al. 2014; Shmuelof and Krakauer 2014) are adding to our understanding of how humans can better understand and accelerate knowledge and skill acquisition. Developments in social-psychological and behavioural research are also shedding light

(Chow and Chan 2008) on the social and psychological antecedents of knowledge and skill sharing.

### **6.5 Tacit and explicit skills and knowledge in this research**

Despite continued disagreements on definitions, it is generally recognised that a better understanding of tacit knowledge is needed, as well as clarity on the role of enablers and barriers to knowledge sharing (McAdam et al. 2007). The findings presented here are concerned more with how and why some professionals define the same skill and knowledge areas as tacit or explicit, rather than the nature of tacit knowledge.

Professionals from the same professional group, and dealing with the same clinical problems and tasks, consider the skills and knowledge in the contested space as explicit or at least, explicable. Although definitions of the explicitness of various aspects of both the SLT and the dietetic role and the tasks that those professional groups perform is of interest, it is enough for the purposes of this study to make the assumption that there are degrees of articulability of knowledge in the domain.

Although there is no clear-cut divide between explicit and tacit skills and knowledge, defining a line between tacit and explicit skills served the purpose in this study. It is a way of identifying knowledge and skills that can, or could, be taught to other types of worker who will possess the requisite existing tacit skills and knowledge, from those skills and that knowledge that could not be transferred or taught to these very same workers. Visualising the divide between explicit and tacit skills and knowledge also grounded the findings in the interview data – this was the term used repeatedly by participants.

The terms explicit and tacit skills and knowledge also demonstrate the purposeful demarcation of that line in an attempt to maintain professional ownership of the domain or knowledge area. In essence, I am referring to the imparting of skills and knowledge that are usually held as tacit by one expert area, but which could conceivably be imparted or transferred to another, but nevertheless are not. The meaning in the context of this study is turning tacitly held information, information that could be made explicit through codification of that knowledge, into explicit knowledge. Of course, in the process of utilising the acquired explicit knowledge, those “receiving” such skills and knowledge are creating further tacit knowledge in managing swallowing disorders and associated nutrition.

Role extension in these findings refers to both delegation and assignment (Mackey and Nancarrow 2005). The dietitians in Haslem had assigned nutritional screening to nursing home nurses – they had also delegated nutritional assessment and

management to their assistants. The SLTs had assigned a large proportion of dysphagia assessment and management planning to nursing home and ward nurses. Participants used the terms “shared care” and “transfer”. The excerpt from Emma below, an SLT who trains nursing home nurses, demonstrates the degree to which knowledge and skills were being codified and transferred in Haslem. The point up until teaspoons and sips of water will be included in the basic water swallow screen – anything beyond that is pushing that line further.

“...the algorithm that we developed for assessing the swallow. It’s a flow chart which starts with your basic information an oromotor assessment... and then you start with something similar to the basic water swallow test. (61 – 62) ...it’s sort of teaspoons of water and feeling for laryngeal elevation. So you start with that and the flow chart then directs you that if they’re OK on teaspoons of water, you then move onto sips of water. The things you are looking at are – the speed of the swallow, whether you can feel laryngeal elevation at all, the voice quality so you’re looking at gurgle on the vocal chords and you’re looking at coughing, you know the obvious sort of things. And you’ll look at those for each of the sort of tests that you do. So if they are OK on teaspoons of water, it’s syrups because if they weren’t OK on teaspoons of water you begin to see a problem then you can try them with a custard consistency and that’s kind of the new bit. (62 – 72) We do train them to use a review schedule for people where you are just looking at thickness of drinks or the type of diet if that person’s stable.” (86 – 87)

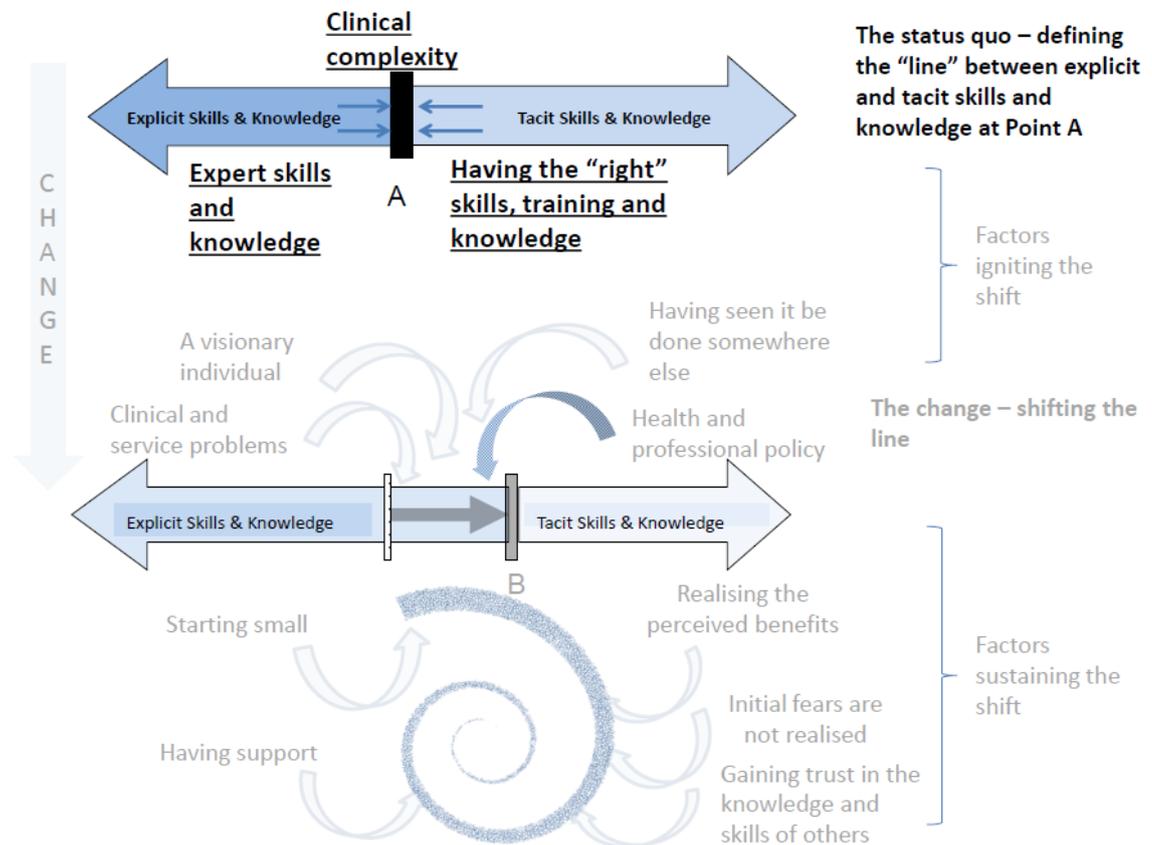
## **6.6 Maintaining the status quo in Billington - “Drawing the line” between explicit and tacit skills and knowledge**

Dietitian and SLT participants in Billington outlined in detail the various clinical tasks that were discreet aspects of their roles in the dysphagia pathway. In Haslem, the North and the Midlands, many of these discreet parts had been “codified” and made explicit, and then taught to other types of worker, such as nurses and assistant staff. Elements of the dietitians and/or SLTs roles were transferred as a protocol (such as a nutrition support pathway in the North) or were being taught to others (e.g. dysphagia management and review).

The line at Point A in Billington was drawn at this point by reference to the specialist skills that they had and the complexity of the clinical tasks in question.

“The speech and language therapists having assessment of nutrition? (267) So, look at food record charts to see how someone is doing, but you still need our input, because obviously it’s a more specialised thing that we do, compared to what they’d do... (274 – 276) I don’t think they would be able to look at a food record chart and estimate how much calories were in, were in that particularly.” (Harriet, a dietitian, Billington) (289 – 290)

This line, and thus professional role demarcations and the status quo, was maintained by reference to the lack of the “right” skills and knowledge in other types of worker, and by the tacit and expert nature of the skills and knowledge used by SLTs and dietitians in performing certain tasks, as depicted in the model below:



**Figure 15:** Maintaining the status quo in Billington

The barriers presented to shifting the line between tacit and explicit skills and knowledge in Billington, centred on the lack of appropriate skills and knowledge of other types of workers to perform those clinical tasks. This was captured in the theoretical code “Having the right training, skills and experience”. As Heather, an SLT and my first interviewee, stated:

“...I also think there is a reason why people go in to doing what they do as their profession and they have lots of training to do that.” (664 – 665)

## 6.7 Expert skills and knowledge

Margaret was a stroke specialist nurse, working on the acute stroke unit in Billington. Rather tragically, her mother had had a stroke, about a year before the interview took place. Although her mother was on the road to recovery, Margaret could still recollect her experience as a close family member. She had been treated in a different hospital

to the one where Margaret worked and was initially Nil By Mouth and fed through a nasogastric feeding tube. Her mother had been overweight prior to the stroke and lost a lot of weight during her illness and recovery. Food had played an important role in her mother's life prior to the stroke and once persistent vomiting resolved, it took a long time until her mother regained her appetite for food. Margaret was not as concerned about her mother's lack of nutrition during this time as she was with her ongoing vomiting. In describing her thoughts on her mother's nutritional state during this time, she highlighted the skill that many lay dieters have in estimating the calorie content of food. This stood in stark contrast to Harriet's position on whether or not SLTs would be able to estimate the calorie content of a patient's diet.

"I think we all quite sort of know quite a bit about food and calories as well, we're all a bit weight obsessed in my family so..." (866 – 867) (Margaret, stroke nurse and carer, Billington)

This is an example of what Collins (2010) describes as "ubiquitous knowledge" - knowledge that exists broadly within a population or group of people, whether or not this knowledge is explicit or tacit. Harriet, by referring to the specialist skills of dietitians in caloric assessment, was attempting to maintain this knowledge as "esoteric" (Collins 2010; Adler and Kwon 2013), or knowledge that is held by a specialist group. According to Currie and White (2012) esoteric, or "component" (Currie and White 2012, p. 1336) knowledge can play a role in maintaining segmented and hierarchical uni-professional boundaries in professional bureaucracies.

In contrast to the position taken by participants in Billington, participants in Haslem, the North and the Midlands valued the importance and contribution of a broader skill base in workers to whom they were transferring skills and knowledge – in effect, their own esoteric tacit knowledge. For example, Poppy, the SLT in the Midlands, suggested that, whereas SLTs acquire their skills in dysphagia care in a linear upward manner, nurses can enter this upward ladder vertically at any point, precisely because they have the requisite ubiquitous knowledge and/ or esoteric skills and knowledge. These skills and knowledge are obtained through years of working with stroke survivors and working clinically more generally (especially, perhaps, in the area of nutrition, eating and drinking), albeit obtained in a different way to SLTs. This is referred to as "relational tacit knowledge" by Collins (2010). He claims that individuals can gain a certain amount of knowledge in a field through conversing in the language of the field and experiencing the field, without necessarily having had direct experience of tasks and actions in that field. In this instance, nurses possess relational expertise in the field of dysphagia even before they undertake their dysphagia training. They have worked with SLTs and

observed safe eating plans, amongst other relational contact. They therefore understand the language and the principles of the field before they embark on their dysphagia training. They will have a degree of tacit knowledge in the management of dysphagic patients, achieved over several shifts and having observed and assisted many patients at mealtimes and with drinks. Poppy says:

“Speech therapists come at it in a linear fashion, in a sense we’re undergraduates, we then come into our first jobs and we get a bit of general awareness don’t we and then you might go and do some post-graduate training which takes you up to that point in a linear fashion. (Holding one hand up and moving the other hand upwards to meet it.) The nurses who come on the course come at it this way (moving the second across to the first laterally) and they come at it this way because the nurses that we train at foundation level, at the screening level I’m talking about here, are experienced nurses...(323 – 328) ...they’ve been around dysphagia for a long time.” (330)

Participants in Haslem also seemed to value the tacit skills that nurses already possess. As Gail, one of the SLTs, says:

“And you think well if you’re an intelligent nurse and you know that this person can’t manage lumps and we need to blend her food, you don’t need me to come out and rubber stamp that. (177 – 179) ...you know, nurses have that skill... (184) You know that’s why they’ve put people on stuff already. (184 – 185) ... And in fact this is what a lot of nurses do, they decide whether somebody has progressed or regressed, they make the decision and then they make a referral.” (210 – 212)

Cheryl, the dietitian in the North, purposely appoints dietetic assistants who have previously worked in the care setting, as she has seen the benefits of their previous experience:

“But when they first start with us, all of our DAs we have a remit, they don’t have to have any nutritional knowledge but they have to have worked in the care set and they need to have worked in a care home. Now I can go in as a dietitian and deliver training and they’d think who the hell she think she is, she’s a pompous so and so, she’s never worked in here, she doesn’t know the stresses; one of my team members goes in and if they kind of get that bit of a response they turn around and say ‘Oh yeah I used to work in a care home, seven years as a carer de de de de,’ woah the respect of that person goes through the roof, they’ve been there, they know what it’s like...” (860 – 866)

A lack of acknowledgement around the skills and knowledge of nursing staff by allied health professionals has been reported by other researchers. For example, Pryor (2008) noted a similar issue in her grounded theory study of nurses’ role in rehabilitation units. In this study, Sarah, one of the stroke ward nurses, airs the frustration that nursing skills and knowledge are not recognised:

“...as the nurses we are there with them for 24 hours so I know more than what this patient is doing speech wise or swallow wise...” (112 – 113)

She then goes on to state that she will often go through the motions, refer to SLT, or the dietitian for supplements, when she has already started these:

“We used to, legally we have to wait until they’ve prescribed it, but if the patient is like um, if I have a patient, um who doesn’t like a yoghurt and if he asks me like, can I have that pudding which is special, because I can’t eat too much, um, I’m happy enough to give that to the patient. If I know it won’t harm them, it’s high in nutrition...” (234 – 237)

Rachael, one of the dietitians in Billington, perhaps saw that the knowledge of calorie content was not necessarily esoteric, and yet still needed to create this core part of her role as a specialist skill set:

“... they [SLTs] would...kind of eye ball whether they think somebody’s managing enough kind of based on what you’d eat every day not really any sort of evidence based knowledge but more just common sense...” (381 – 384)

The need to create or maintain boundaries around areas of skills and knowledge was repeated by other interviewees in Billington:

“I think you have to be quite careful in terms of what you do and what you don’t do, so that there are still some boundaries between your own professions.” (666 – 668) (Heather, a SLT, Billington)

The presence or absence of the “right” skills and knowledge was frequently used to determine which areas could or could not be relinquished.

“I think in terms of our expertise, obviously that’s, that’s one of our skills that we can do whereas the nurses...they have thorough training but they don’t have anywhere near the level of training that we have...” (517 – 519) (Philippa, a SLT, Haslem)

## **6.8 Having the “right” skills, training and knowledge**

Some participants did recognise that it would be possible for other professional groups or types of worker to learn the “right” skills and knowledge to be able to perform a specific clinical task. In the first quote below, Rachael considers the possibility of training others, given the right conditions. In the second, Susan seemed to mock the notion that this was feasible:

“But I suppose that’s where the support comes in isn’t it, if you have support and you have the right training then you shouldn’t be making those mistakes.” (393 – 394) (Rachael, a dietitian, Billington)

“I think you can teach a plumber to be a dysphagia specialist as long as that plumber has done the same training that anybody else has, there’s no reason why not.” (1171 – 1172) (Susan, an SLT, Billington)

The reference to skills and knowledge is perhaps not surprising, given that having skills development and training have been shown to increase “role breadth self-efficacy” (Axtell and Parker 2003, p. 113), e.g. the belief that one can effectively undertake new aspects to one’s job role. Rachael, a hospital dietitian in Billington, identified the lack of training in dysphagia management as a barrier to her taking on a greater role in the area: “...they’ve done training, I don’t know what I’d start with.” (459) Harriet, one of her dietetic colleagues in Billington, suggested that having training might improve her confidence in her ability to take on a greater role in the area:

“...they’ve had specific training. I suppose just because I haven’t had that training, perhaps I would change my mind, if I had been given the appropriate training...” (618 – 620)

Axtell and Parker (2003) also demonstrated that “job enlargement”, e.g. greater decision making influence and involvement, rather than just a greater breadth of tasks to be performed, influenced role breadth self-efficacy. Merely increasing the range of tasks that workers were expected to perform caused a deterioration in their belief in their ability to carry out the additional tasks. Dubois and Singh (2009) refer to this phenomenon as “role and skills drift” (p. 95), as tasks are no longer owned by a specific type of worker. Carla, the community dietitian in Haslem, refers to the reservations of the dietetic assistants that she manages expanding their roles further into dysphagia management:

“It’s, it was an extra responsibility that they themselves were not keen on, taking on board. (672 – 673) “They really were not keen and I mean it wasn’t suggested, I just threw it to them, how would you feel and they were no, no...” (681 – 682)

Despite recognising that it is feasible to teach one’s skills and knowledge to others, participants in Billington still felt that clinical tasks in the contested space could not be taught to other types of workers by reference to the deep knowledge and training required to perform those tasks. Susan, an SLT manager, had had good experiences in the past with teaching nurses on the stroke rehabilitation ward to move patients through the dietary consistencies (“upgrading”), without the need for review by the SLT.

In more recent years, the care pathway had reverted to review and change of consistencies by SLTs only.

“...in fact my experience when I trained the nurses is that when it worked well it worked really well, we didn’t kill anyone, people did get better sooner, people did go through the consistencies quicker...” (1312 – 1314)

Despite these positive experiences, she pointed mainly to the downsides of any transfer of skills, and thus clinical tasks, to other types of workers in her interview.

Some of the workers who may have taken on expanded tasks perceived them as too complex and skilled. In discussing whether they would be able to take on an even greater role in dysphagia management, two participants in Billington, a nurse and a dietitian, had this to say:

“I don’t think we could because I think the speech therapists train for so long to do their role, I think it would be wrong to assume that the nurses could be trained to upgrade diet and fluids, really.” (1181 – 1183) (Margaret, a stroke nurse, Billington)

“Yeah so they’ve had a four year degree or whatever on the swallow, I know nothing about how the swallow works and what’s safe and what’s not and I’m not sure how I’d then be able to judge whether somebody was managing the consistency, if I don’t know anything about somebody’s swallow.” (438 – 441) (Rachael, a dietitian, Billington)

In contrast, participants in Haslem, were more open to the possibility of other types of workers learning the skills and knowledge required, as long as staff had “...the skills and time so that it was done in the right way.” (854) (Betty, SLT Haslem). For example, Lauren, the community SLT manager in Haslem, says:

“I don’t see why you couldn’t [...] you know, train other people could train to do dysphagia assessments. It’s about making sure that they get the appropriate training and reach the relevant competence.”

## **6.9 Clinical complexity**

Clinical competence and complexity were used to maintain professional boundaries, as demonstrated in the following quote by Rachael, a dietitian in Billington:

“I think it would always be a worry that it wasn’t my role, so it’s whether you had enough training, whether you had enough background or whatever.” (329 – 330)

These boundaries were understood by other professionals. Rachael goes on to say:

“I suppose it would be a discussion with the MDT [Multidisciplinary Team] wouldn't it to see how they felt about it also... (342 – 343) Yeah make sure you're not stepping on other professionals' feet as well, you know you weren't doing someone else's job and they weren't too happy about it.” (352 – 353)

If an individual or professional were to overstep these mutually acknowledged boundaries, it might be necessary to actively challenge this in order to maintain those boundaries:

...you would need to challenge that. I think people would start getting upset...it's like 'well, that wasn't really what you trained necessarily to do, or have you had training in that?'" (804 – 806) (Harriet, a dietitian, Billington)

Some participants in Billington identified professional boundary setting as one of the main issues at stake.

“I suppose it just, I guess the worry would be would they get it right, but then if they've got enough training then why wouldn't they? And I guess does it eradicate your role from the team if somebody else can do your role?” (386 – 389) (Rachael, a dietitian, Billington)

Although tacit knowledge may be difficult to “tell” (Polanyi 1967), results show that people do have a sort of “rudimentary meta-knowledge” (Herbig et al. 2001, p. 688) of their tacit knowledge, e.g. they can explain that this has been used. Feltovich et al. (2006) suggest that research has demonstrated that experts “are able to give detailed accounts of their thought processes” (p. 59).

Some participants in Billington were aware that they were using complexity to retain professional control over a clinical area. Olivia, the community SLT manager, seemed to identify that the way that they were currently working, in an attempt to protect their role, was detrimental to patient care, and not necessarily serving SLTs well either:

“I think that this feeling that we have to be masters of the subject area because it's been perceived by them and us to be totally relevant to what we practice...I mean because there aren't enough of us to go round and we don't fall into Cochrane standards of you know sort of evidence based for what we do but we all know that we do things that make a difference and all of that; that I think we've become quite protective of what we do and how we do it and where we do it.” (326 – 334)

Where both dietitians and SLTs actively sought to maintain these boundaries of knowledge, they would demonstrate to other staff groups why they did not have the

requisite skills and knowledge to perform the tasks in question. Amber tells us how SLTs used videofluoroscopies to demonstrate how complex dysphagia is:

“...certainly when you see things like the videofluoroscopies, we’ve seen a couple, um, that the speech therapist have always be involved in, people that we, we’ve never realised were aspirating, people who you know, who aspirate silently, um, but when you watch it on that investigation it’s amazing really and it does just go to show why we, we’re not qualified to do any more than we do.” (1183 – 1187) (Amber, a stroke ward nurse, Billington)

Heather, one of the SLTs, talks about the skills that SLTs have that nurses do not:

“So you try to say to people ‘well, have you felt their laryngeal elevation?’, and they’re going ‘hmmm, what?’” (453 – 454) (Heather, an SLT, Billington)

Mackey and Nancarrow (2005) found a similar trend when conducting focus group research with occupational therapists just starting to work with assistant staff. In their data, accountability was created as a barrier to exert control, or “power” (p. 336) over the professional domain. Nancarrow and Borthwick (2005) refer to this as “the creation and maintenance (p. 901) of exclusive rights” (p. 902). Claims to areas of specialist expertise may confer a defence to a clinical territory (Currie and White 2012). Adler and Kwon (2013) also refer to the importance of expertise and perceived complexity in the spread of innovations and the power professional groups can exert over the codification aspects of their expertise.

### **6.10 Complexity and clinical risk**

Clinical risk was used to maintain ownership over the clinical area, but also to expand one’s professional group.

“I think the reason that they [SLTs] were able to eventually get their speech therapy sort of numbers improved was through completing AIRS forms [clinical risk reporting forms], you know because there were... (426 – 428) ... perhaps even like the number of referrals they’ve received and not being able to get to see somebody soon enough and the implications of that... (433 – 434) AIRS forms, soon focuses people’s minds really.” (438) (Alexis, dietitian, Billington)

“We’ve done several things in our Trust; one is, um, to highlight it as a risk issue (288) ... the number of speech and language therapists are, is, is almost directly related to outcome (293 – 294) ... we’ve had increase in number of staff in the past months, or 12 months.” (302) (Jonathan, consultant stroke physician, Billington)

Susan, the SLT manager in Billington, identified other potential risks of codifying their skills and knowledge. In discussing the risk of patients not being followed up if other

types of worker were to take a greater role in assessing dysphagia, she had the following to say:

“And when somebody leaves the stroke service and they are still dysphagic, you still need to hand on to somebody to be able to manage that dysphagia. (1531) ...you’re going to have a mass of people wanting to assess, cos its clever and its useful and it’s this, that and the other and then the patient is left high and dry, or all of a sudden they all come back onto the speech therapists’ caseload...” (1536 – 1538)

In contrast, Michelle, the SLT manager in Haslem, sees the issue of picking people up for follow-up neither as a risk nor a barrier, but rather as an inevitable occurrence.

“And also perhaps from our point of view, although they might do the initial assessment they’re not very good at then following that up. We often end up picking it up and then managing the situation after that anyway...” (387 – 389)

Connelly et al. (2012) introduced the term “knowledge hiding” (p. 64) to describe instances where employees intentionally withhold knowledge. Although their research centres on knowledge sharing between two individuals, this concept could conceivably be expanded to include knowledge hiding in order to maintain the uniqueness of one’s knowledge and thus, position. Referring to the knowledge and skills as “complex” provides a way to prevent sharing skills and knowledge that is difficult to deconstruct. Take for example Susan’s account of the lack of skills in nurse that have been trained to manage dysphagia screening, and therefore the potential to miss important clinical cues:

“So for instance with dysphagia, yes if somebody does the basics like the water swallow screen you need to have them awake and this is why, you need to have them sitting up and this is why, you need to be aware of what a larynx should do to know whether it has done it. So you’ve got all that, and then you stick to, OK, I’ve been trained to consider those issues, therefore I will practise according to those issues. A speech therapist is also going to be listening to the quality of the voice. If somebody’s talking like that (interviewee talks in compressed, creaking voice) they’re immediately going to think hello, we’ve got maybe vocal chord issue and we are trained to listen to the quality of the voice to know whether that’s likely to be vocal chord palsy which is going to affect your ability to swallow or bowed chords which potentially isn’t.” (1191 – 1206)

In contrast, Linda, a SLT who was training nurses in Haslem, felt that nurses did have the ability to provide a basic assessment and management plan, even though they did not have the knowledge and skills of a SLT:

“The skills they’ve got involve them doing a basic assessment/screening and basic management (677) ...they can’t make the judgements that you make,

they haven't got the theoretical background and they haven't got the knowledge base that you've got after three years of training. So they do something differently, but they're supported by you, so no we're not suggesting that nurses are speech therapists... (680 – 682) But I think we're saying a small part of dysphagia management is within a nurse's competency to do it and it's better for the patient if they are skilled to do it, so therefore let's support them to do it." (693 – 695)

Although Haslem also had to manage the potential clinical risk posed by transferring dysphagia skills and knowledge to DTNs, this was not perceived as a barrier to codifying skills and knowledge there. For example, Karen identifies the pressure that their DTNs could be put under to work outside the training and knowledge:

"...they are often put under pressure to see patients that are outside their scope of practice and it's a continual battle then with the consultants and we often have to go in and fight the dysphagia trained nurses cause." (Karen, SLT, Haslem)

Ownership of the clinical area was retained in Billington, even when some aspects of the role had been transferred to nursing staff. For example, Susan, the SLT manager, was providing some dysphagia screening training to nursing staff. Despite this, she was keen to maintain control over the boundaries of their practice and the unique role of the SLT.

"What a lot of the recipients of the training have wanted it to be is permission to assess and we're saying it's not permission to assess, it's permission to recognise." (254 – 256)

### **6.11 Nutritional supplements as an example of clinical complexity**

The use of nutritional supplements provides us with an illustrative example of how clinical complexity and skills and knowledge are defined in the various research sites.

Nutritional supplements were used by dietitians to set the boundaries of nutritional skills and knowledge. Although nutritional supplements are not prescription-only items, they were presented in this way to other staff groups.

"...then we've got these prescribable supplements that we [the dietitians] would write up and then we'd write that on the drug chart." (1034 – 1035) (Alexis, a dietitian, Billington)

There was a list of specified options available that dietitians allowed the nurses to offer without their authorisation, for example outside of dietitians' working hours:

“So we’ve got that...the supplements that they can just use at ward level which is Build Up soups and the Build Up milkshakes...” (1031 – 1033) (Alexis, a dietitian, Billington)

The dietitians had control over the prescribing of nutritional supplements, a negotiated boundary of control that they were not ready to relinquish.

“Um, I would say if the person is being provided with supplements...then I would say that needs to be left to (coughs) the dietitian so that...the dietitian would sort of make the, um, assessment as to whether...supplements needed increasing or decreasing or whatever.” (707 – 710) (Phoebe, dietetic manager, Haslem)

Control over nutritional supplements was maintained in part by reference to the lack of relevant skills and knowledge to be able to correctly prescribe these items. In discussing the feasibility of SLTs recommending supplements, the dietitians in Billington thought that they lacked the right skills to be able to do this correctly.

“I guess potentially they could be the wrong supplements they [SLTs] can give too many calories, they can give too little. From a refeeding [syndrome] point of view as well...” (522 – 528) (Rachael, a dietitian, Billington)

Nursing staff were similarly considered to lack the right skills and knowledge:

“So, you know, we do get often where nursing staff will just go and pick up a supplement drink and just give it to them, and maybe that wasn’t the right one to give them... (836 – 838) You know, it might not be the right consistency, or it might be, you know, they’re diabetic and they’ve got high blood sugars and you know, all sorts of things you that need to go, into consideration, you’re can’t just pick up...” (844 – 847) (Harriet, a dietitian, Billington)

The specialist nature of the knowledge and, flowing from the knowledge, the authority to prescribe supplements was clear to other types of workers.

“...because they can, they are the ones prescribing...legally we have to wait until they’ve prescribed it... (234) ‘Cause they are the one authorized to do that and without authorization I am not supposed to do anything without authorization”. (170 – 171) (Sarah, a stroke ward nurse, Billington)

Although control over nutritional supplements was maintained by reference to the lack of relevant skills and knowledge in other types of worker, “receivers” of skills and knowledge seemed to possess the skills and knowledge to enable them to use supplements correctly.

“I will check...whether they’ve got allergies to some special stuffs, some patients have gluten free and ...vegetarian...” (238 – 239) (Sarah, a stroke ward nurse, Billington)

Creating roles and tasks as more complex than they are is in keeping with some previous research. For example, Van Wijk et al. (2008) suggests that knowledge ambiguity (including conceptions of tacitness and complexity) both protects knowledge from being transferred to competitors, but also serves as a detrimental barrier to knowledge transfer within and between organizations.

### **6.12 Management of nutritional supplements in the North**

In Haslem, where the line had been shifted to assistant staff, the dietitians were happy to relinquish the monitoring of supplements to dietetic assistants under their direct supervision, although not the actual prescribing.

“And if they’re on supplements we would monitor that... (368) ‘Cause in our department dietitians always advise on the supplements, that’s a boundary that I wouldn’t cross.” (515 – 516) (Eve, a dietetic assistant, Haslem)

In the North, this line had been pushed even further. Here, nursing staff predominantly managed nutritional supplements, with the guidance of protocols devised by the dietitians.

“...so we’re saying first line if you need supplements you start with Complian... Give them a week’s worth, if they don’t like it try another product which is overleaf... But every month you need to be reviewing the patient, it doesn’t need to be a dietitian. (345 – 348) ...if they’re not compliant, try another product, you don’t need to refer to dietitian for that.” (351 – 352) (Cheryl, a dietitian, the Midlands)

Although control over nutritional supplements was maintained in part by reference to the lack of relevant skills and knowledge in other types of workers, participants who had pushed the line viewed this differently. Cheryl, the dietitian in the North, was training nursing home, practice and community nurses to be the main health care workers to manage supplements. She had this to say about the perceived lack of clinical knowledge and skills in nursing, and other, staff:

“What?! I’m sorry, but in regards to coeliac disease pretty much every single product out there is gluten free...If you have a milk allergy your GP’s not an idiot, they’re not going to prescribe them Complian... diabetes, if they’re not eating and they need a supplement for goodness sake, you put them on a supplement, you can increase the diabetes medication.” (376 – 385) (Cheryl, dietitian, the North)

In fact, Cheryl has codified much of this explicit nutritional knowledge, in the form of leaflets and other information on how to use supplements, and which ones to choose. This knowledge was made publicly available on their website and actively given out to patients and other types of workers. Nurses had been left with an unprecedented amount of responsibility to manage the supplements. Dietetic assistants had been left almost solely in charge of delivering the training and working with the nursing homes.

“We don’t do anything in the care homes anymore, they [dietetic assistants] recruit the homes, they sign them up, they can set the homes to consent... They do all the evaluation, they do all the training, they do all the marking, they do everything in the homes; very little that we get involved with.” (205 – 209) (Cheryl, dietitian, the North)

### **6.13 How other participants perceived complexity**

In Billington, the focus on the profession-specific esoteric skills and knowledge in the area, and a lack of acknowledgement of the broader skills and knowledge of the nursing staff, led to frustration for some of the nurses. There were instances when these boundaries were practically flaunted in order to get timely care to a patient.

“And if I am confident enough, if there is no dietitian available and if I am confident enough, ok this patient hasn’t had any refeeding syndrome and I can check the blood results and I can just tell doctors I feel like I’m sure these blood results are fine, are they happy that if I go to upgrade, upgrade the thing, ‘cause we have to...” (212 – 215) (Sarah, a stroke ward nurse, Billington)

From a patients’ point of view, it seemed irrelevant who held control over the clinical area.

“As far as I’m concerned, it doesn’t make any difference who’s doing the assessment, it’s just as long as they’ve got the experience levels and know what they’re talking about, that’s the important thing. (852 – 854) You don’t care who drives your bus as long as they can drive your bus, or who services your car as long as they can service your car.” (960 – 962) (Steven, a stroke survivor, Billington)

Commissioners were aware that professional groups were attempting to maintain control over clinical areas by creating these as complex.

“We’ve just been involved... a thing called Functional Mapping. ...where you take the activity and you kind of break it down, but sort of begin to say well could this be done, at what point moving up the scale could it be done by anybody and at what point does it need a specific professional? (62 – 68) ...you had one sort of group of people who were really taking it down to the minutest detail and then another group who were kind of slightly more bulking up the activities. I mean it was very obvious that it was the personalities who were in

those groups affected how you did it.” (78 – 81) (Jenny, a commissioner, Haslem)

The way in which commissioners were allowed to commission clinical services did not facilitate a focus on transferring skills and knowledge, as Nelly in Billington describes:

“It’s very difficult, well it’s in the service specification, so in the service specification you can’t be specific about grades of stuff, so you have to word it so that it does say skill mix with the ability to achieve these outcomes. ... There was a lot of discussion, it took a long time to get them round to thinking that we might be able to employ band 4 speech and language therapy assistants.” (119 – 124)

Despite Jenny’s hands being tied in terms of her influence and ability to prevent the professionals from creating this area as complex, she felt that it would be incumbent on professionals to identify work that really is complex from that which is not in the future.

“Because we’re in a world where we’re not going to get increase in resources so it is around looking at ways where we can both improve quality of care but also if you like stretch elastic for want of a better expression... (187 – 189) I think professionals have got to have a bit of wakeup call on this because we’re moving away from a world where, it sounds awful, but professionals could do exactly what they like when they like.” (555 – 557) (Jenny, a commissioner, Haslem)

#### **6.14 Skills, knowledge and professional closure**

Renzl (2008) concluded that quite aside from the complexity and ambiguity of the knowledge itself, “the *willingness* of the parties involved” (p. 216, italics in original) to share their knowledge was of perhaps even greater importance, particularly where the cost of acquiring that knowledge was high (Perez et al. 2014). This latter point was repeated by several participants and captured in the code “It’s taken me x number of years” of training to perform their role. For example, Rachael, a dietitian, pointed out the effort in obtaining her professional qualification:

“No it’s difficult [to know where to draw the line] because it’s taken me like four years of a degree to know what I’m doing, so how quickly can another professional know what they’re doing in your role...” (417 – 419)

Phoebe, the hospital dietitian manager in Haslem, refers to the skill and knowledge acquired by dietitians during their professional training as unique and not easily transferable to SLTs. This is despite her extensive use of dietetic assistants.

“I think it is around, um, having the correct knowledge and skills to do it and, um, maintaining those competencies, um, ‘cause in a sense I suppose what I’m thinking is it, it takes us four years to train as a dietitian, um, to get all the

information that we need to be able to do things. You're not going to be able to give that same degree of, of knowledge and skills to somebody, um, in a short period of time to take, take on some of that role. Um, so I think that's perhaps where I'm, I'm coming from." (587 – 592)

The unwillingness of employees to share knowledge, even in competitive markets where organisational practices encourage sharing, is well documented in the organisational theory literature (Connelly et al. 2012). In addition to this, professionalization itself can be viewed as “a process ... to secure and protect exclusive areas of knowledge, skills and expertise” (Khalili 2014, p. 93), resulting in “turf wars” (p. 93) or “turf protection” (Oelke et al. 2008, p. 65) where scopes of practice overlap. More recently, SLTs have sought to expand their own scope of practice into other clinical areas – knowledge and skills is the mechanism that is used to justify this role expansion (Gaziano and Serrano 2012). In their paper, titled “Transferable skills in the field of speech language pathology”, the authors suggest that SLTs are ideally placed to play a role in a variety of conditions, including Rumination Syndrome, an as yet rare disorder. The authors state that:

“Many SLPs are well versed in these breathing techniques, behaviour modification strategies, biofeedback modalities, and the requisite basic knowledge of swallowing anatomy and physiology.... their skill set may be useful in an interdisciplinary setting to optimize management.” (p. 157)

### **6.15 Professional role demarcation and knowledge sharing**

Conflict along professional boundaries and threat to professional identity has been found to negatively impacting upon both team effectiveness and knowledge-sharing (Mitchell et al. 2010). On the other hand, Huby et al. (2014) found that conflict along professional boundaries sparked service development, although the authors admit that professional and organisational hierarchy also played a role in their findings.

It is doubtful whether, in the face of professional identity issues, organisations themselves can have much influence over knowledge-sharing between professional groups, as “the process of professionalization” (Currie and Suhomlinova 2006, p. 22) can reinforce normative professional pressures. Certainly for AHPs, Larkin (2002) suggests:

“...professional identities have been forged across decades precisely through stratagems of demarcation and status differences” (p. 131).

The following excerpt from Susan’s interview, the SLT manager in Billington, demonstrates the protection that complexity affords the professional. She is describing

some of the potential difficulties of transferring her skills and knowledge to nurses in nursing homes:

“Somebody can watch me go out to a nursing home, ten people have been referred that are coughing when they drink and they will watch me put some of them on thickened fluids. So there is now this if somebody coughs give them thickened fluids. However, I know that you really, really shouldn't do that for certain types of patients. So there is this I've got a small amount of knowledge and I'm going to overuse it and that I think, again, is this grey area.” (218 – 222)

Participants in Haslem had made a distinction of complexity, and would not expect their dysphagia trained nurses to manage complex patients.

“We're not expecting them to be able to manage everything, we're expecting them to sort of screen your simple dysphagias and offer some early management. And then if it's more complex we're not expecting them to do that and I don't think they'd want to do that.” (448 – 451) (Linda, SLT, Haslem)

The difference between definitions of complexity in Billington and in Haslem was in how complexity was considered. In Billington, complexity was used as a barrier, whereas in Haslem, participants had taken considerable efforts to make distinctions about what constituted complexity. This enabled them to identify where the line between codifiable, and transferrable, skills and knowledge lay. This classification was initially used for newly-trained SLTs, as described by Philippa, one of the stroke-specific SLTs:

“Right...it's a little bit of a grey area in that in acute, um; they'd class complex and non-complex as slightly different to what we would in community...So, in acute, newly trained dysphagia therapists would see people with motor neurone disease, multiple sclerosis, all of those things where as in community they'd be classed as complex and it's not so much complex in terms of the actual swallow but it's in terms of the overall dysphagia management because these are patients that are likely to need alternative feeding at some point and discussions in terms of end of life and the bigger picture is more complex. The actual dysphagia assessment isn't always...I mean it can be really complex but it's not always that that's bit complex on its own; it could be the bigger picture of managing that persons, um...whether it be end of life of whatever the issues are that come up, um...So in the hospital they'd class the complex patients as people that as I say, um, on oxygen for a start... Um, because that in itself impacts on the swallow. They'd say people, um, with a tracheostomy are complex... So less complex would be, yeah stroke, dementia; usually the newly trained therapists would be put on the, um, on the elderly care wards which is a lot of dementia, strokes, Parkinson's disease... They do see MND, MS; all those things but it's generally dementia, um, strokes, those kinds of things, yeah.” (875 – 935)

Their definitions of complexity were also being used to identify where the line for their dysphagia trained nurses lay.

“Um, in terms of I think who the DTN [Dysphagia Trained Nurse] can screen they’d class complex as anybody who hasn’t got a diagnosis because like, just going back to what I said about us perhaps picking up signs from their speech and swallow that could help to form a diagnosis. (902 – 904) Nurses would perhaps be less able to pick up on those features from their speech and swallow, um, so that people with no diagnosis in acute would be classed as complex.” (908 - 909)

Linda, one of her colleagues, also points to “a written list of ‘these are the patients that you can’t see.’” (107). Philippa goes on elaborate on how these definitions are made in relation to dysphagia management:

“Um, in community the complex ones are more the, the ones that are going need quite (pauses), an intense management approach in that, in conditions like motor neurone disease, communication can be really severely impaired as well although cognition usually stays intact so it might be that the person’s not able to tell you what they want and in terms of decision making you need...it’s a more difficult approach rather than going to review somebody who’s, who’s had a stroke and their swallows going to rehabilitate, you know in those conditions that the swallows going to get a lot worse.” (913 – 919)

These definitions had been made explicit through a set of guidelines.

“There are some set guidelines that they create as to who’s classed as complex and non-complex but off the top of my head I can’t remember exactly what they are...No its local guidelines that when KH<sup>3</sup> and LO<sup>4</sup> who trained me, they; when they were developing our training they put together guidelines as to who is complex and non-complex, um, so that newly trained therapists and other therapists were aware of who was classed as complex to see who, so that nobody’s felt out of their depth or, yeah...” (954 – 962) (Philippa, SLT Haslem)

Since starting the scheme several years earlier, dysphagia patients had become more complex. Michelle, the hospital SLT manager in Haslem, points to this increasing complexity below:

“And I think also that the environment’s changed, I mean certainly now the acuity of the kinds of people that are coming through are completely different to the sorts of patients we were dealing with 10-15 years ago.” (182 – 184)

Rather than pull the management of these patients back into the remit of the SLTs, they had continued their way of working and developed the scheme even further, to allow the nurses to continue to manage these patients.

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<sup>3</sup> Pseudonyms for identifiable persons referred to by participants.

<sup>4</sup> Idem.

“So we’ve had enhanced training for the DTNs working there dealing with some very complex patients.” (191 – 192)

Whereas complexity of even explicit knowledge can inhibit its transferability (Law 2014), complex and non-complex aspects of the SLT role had been codified in Haslem. In Billington, the SLTs were maintaining the same skills and knowledge as too complex for nursing home staff to be able to learn. Control over the clinical area through reference to skills and knowledge was also maintained by reference to the potential disastrous effects of relinquishing clinical areas.

“So not only is it an issue about safety and fundamentals, well survival, you don’t want to choke them to death.” (1151 – 1152) (Susan, an SLT manager, Billington)

### **6.16 Drawbacks in transferring skills and knowledge**

I have thus far presented the barriers to new and different ways of working in dysphagia care constructed in this research, as those factors maintaining the status quo in definitions of explicit and tacit skills and knowledge. There can, of course, be drawbacks to clinical tasks being pushed into the realms of another professional group, particularly if that group does indeed lack the requisite training and skills. Although the use of protocols specifically in dysphagia screening has been shown to improve accuracy in predicting pneumonia (Lakshminarayan et al. 2010), both Sharp and Shega (2009) and Vitale et al. (2011) have referred to poor knowledge amongst SLTs in the outcome of enteral tube feeding insertion in patients with dementia. They both found that SLTs were likely to recommend tube feeding inappropriately, due to a lack of knowledge about its outcomes and consequences.

Another area of potential concern in the transfer of skills and knowledge from one type of worker to another is in the creation of new knowledge in the field. New knowledge, particularly new tacit knowledge, can be created from explicit knowledge, in a process Nonaka calls internalization (Nonaka 1991). Over time, as SLTs and dietitians have assessed patients and devised management plans, they have expanded their knowledge in the field, thus creating further knowledge. By transferring a large part of this knowledge to other types of worker, such as assistant staff or nurses, it is then the assistants or nurses who will continue to develop further knowledge within the skill set that has been transferred to them. Where transferring skills and knowledge is a one-way communication channel, there is a danger that the new knowledge created by e.g. assistants and nurses, will not be transferred back to SLTs and dietitians. The depth of their own skills and knowledge, particularly as regards these less complex patients, may then be lost. This may further impact upon the skills and knowledge that they are

transferring through the training and other resources that they provide. As Olivia, the community SLT manager in Billington, puts it: “It’s also evolution of professional knowledge as well.” (830)

### **6.17 “Drawing the line” between explicit and tacit skills and knowledge in summary**

The theoretical model highlights how two groups of clinicians practising in this same field define the line between explicit and tacit skills and knowledge in different ways. The accompanying analysis also demonstrated how the contested space can be manipulated in order to retain professional authority over the clinical area. Having explored the forces in action that maintained the status quo in Billington, I will now turn towards the conditions that ignited the shift defining the line between tacit and explicit skills and knowledge in Haslem, the North and the Midlands. I will follow this by presenting the factors that sustained the change in Chapter 8.

## CHAPTER 7 FINDINGS

### MAKING THE SHIFT

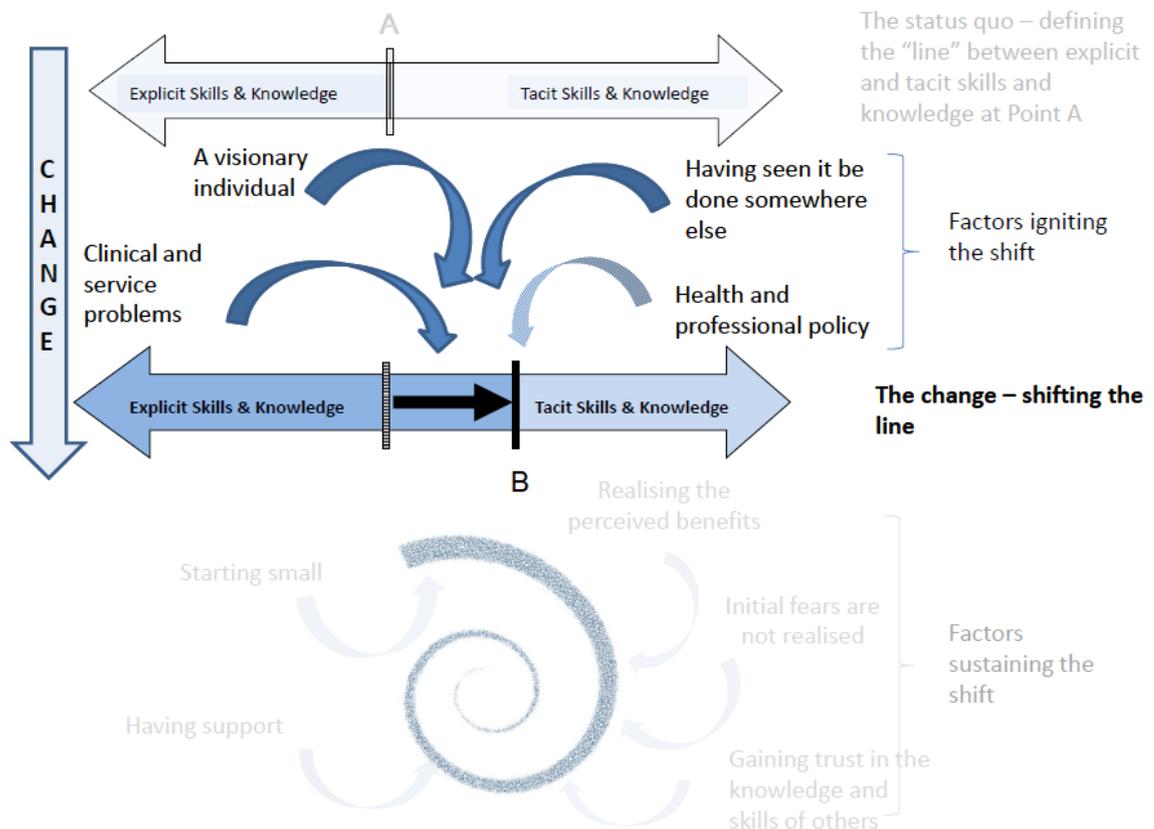
#### 7.1 Introduction

Having explored the conditions that maintained the status quo in Billington, I will now turn towards those factors that ignited the shift in the line that had been drawn between explicit and tacit skills and knowledge in Haslem, the North and the Midlands. As described in the previous chapter, the social process that occurred in these data was the shift in the line from Point A, with a greater proportion of skills and knowledge defined as tacit, to Point B. I will now describe the conditions or factors that enabled this initial shift in Haslem, the Midlands and the North. These enabling factors influenced the professional groups to re-define previously held tacit skills and knowledge as explicit, and thus not codifiable and transferrable to other types of workers. These skills and knowledge included those required to perform dysphagia assessment by nurses in Haslem and the Midlands, nutrition management by dietetic assistants in Haslem, and nutritional management by nursing staff in the North and the training of those staff by dietetic assistants.

There were four conditions igniting the shift in where the line between explicit and tacit skills and knowledge had been drawn in this research, depicted below. As described briefly in the previous chapter, for the shift in the line that had been drawn to occur in Haslem, the North and the Midlands, the following three conditions had to all be present:

1. A crisis or difficulty in managing the service, such as short staffing coupled with waiting time targets, an inability to fill vacant staff posts, and complaints,
2. An individual with a clear vision for the service,
3. Having seen it be done somewhere else.

Health and professional policy, the fourth condition, played a facilitative role in influencing the shift, primarily through its impact upon incentives for the SLTs and dietitians - it is therefore depicted as a dashed line.



**Figure 16:** The conditions that caused the shift to happen in the line that had been drawn between explicit and tacit skills and knowledge in Haslem, the North and the Midlands

## 7.2 Professional regulation of dietitians and SLTs in the UK

In the UK, both dietitians and SLTs are regulated by the Health and Care Professions Council (HCPC). The HCPC regulates members of both professional groups' fitness to practice and has the power to remove registrants or place restrictions on their ability to practice.

The HCPC, under its former name (The Council for Professions Allied to Medicine) was established following the 1960 Professions Supplementary to Medicine Act (Larkin 2002). The Council initially regulated seven professional groups, including dietitians (Larkin 2002). SLTs joined the register 2001 (Health and Care Professions Council 2015). In 2014, there were 8,528 dietitians and 14,992 SLTs registered with the HCPC (Health and Care Professions Council 2015).

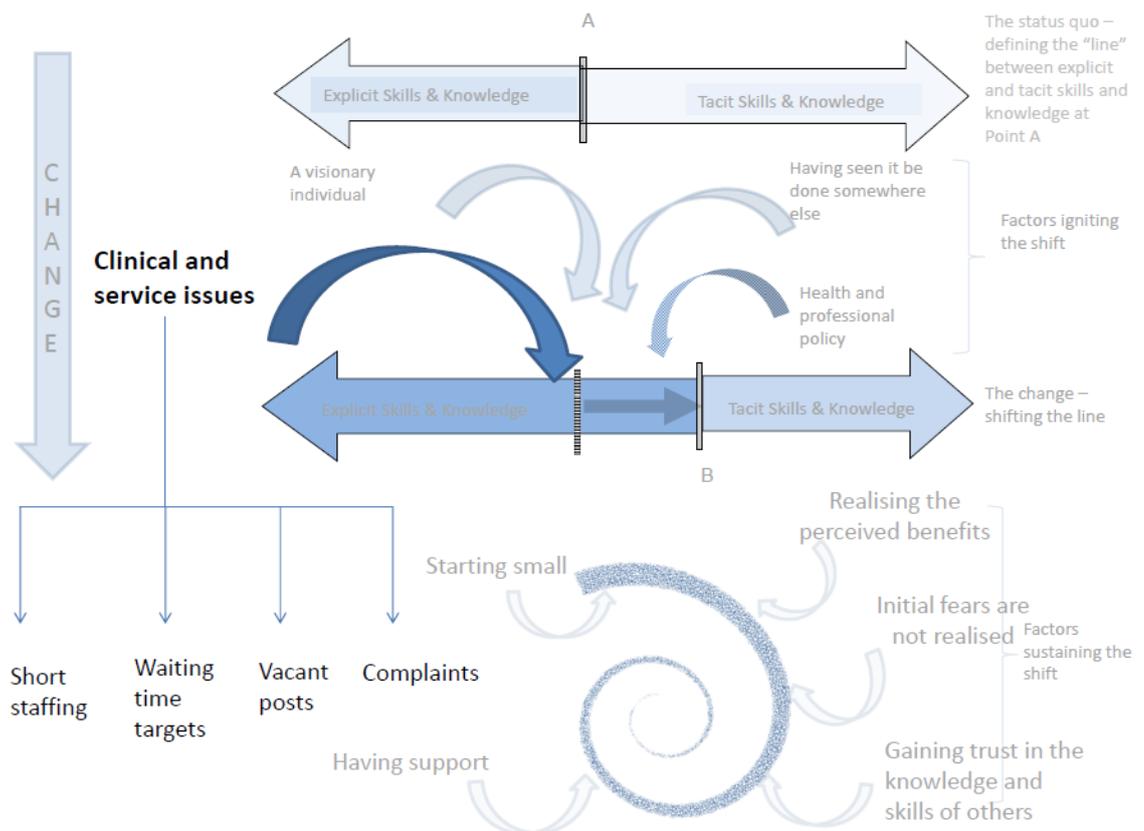
Both dietitians and SLTs have their own professional bodies. Dietitians have the British Dietetic Association (BDA), which is the "professional association and trade union for

dietitians” (BDA 2015). For SLTs, the RCSLT is “the professional body for speech and language therapists in the UK” (Royal College of Speech & Language Therapists 2015)

The RCSLT also provides a Trade Union function similar to that of the BDA. When referring to the professional bodies in this thesis, I am referring primarily to the BDA and the RCSLT, as these two bodies are referred to by participants as providing professional direction and are tasked with “providing leadership and setting professional standards” (Royal College of Speech & Language Therapists 2015).

### 7.3 Clinical and service issues

In both the dietetic and the SLT departments in Haslem, participants had started the shift towards codifying their skills and knowledge in response to a crisis within the service. The crisis revolved around clinical care and issues of managing the service, as depicted in the diagram below:



**Figure 17:** Clinical and service issues causing the shift in the line that had been drawn

The issues or crisis could be a short term one, such as short staffing or meeting waiting time targets.

“No money so OK I had to wait for a vacancy and then I skill mixed to get dietetic assistants...” (142 – 143) (Sharon, community dietitian manager, Haslem)

“...we were getting so many referrals and we couldn't cope with them...” (439) (Karen, SLT, Haslem)

“And so we have, I mean a couple of our dietetic assistant posts we got because two people had gone on maternity leave, both working full time, both wanted to come back part time, so we had some extra hours. So we thought the work still needs to be done in that area, but do we need exactly what was left? Do we need a band six?” (308 – 311) (Phoebe, a hospital dietitian manager, Haslem)

“...we had at the time a huge number of referrals and not enough staff.” (161) (Linda, an SLT, Haslem)

The crisis could also be a longer term problem, such as an inability to fill vacant posts, or ongoing demand management.

“...demand is increasing so it was a way of looking at managing that...” (534 – 535) (Lauren, community SLT manager, Haslem)

“...as a community therapist being asked to go out there, you know and travel half an hour to get there and you know set up a new case... (198 – 200) There is a huge demand for assessing and reviewing and care planning for dysphagia.” (352 – 353) (Emma, an SLT, Haslem)

“The pressures are basically to treat more patients with the same number or fewer staff, because our reference cost is too high so our price per contact is too high and we are not going to be replacing staff that leave with qualified staff, we're going to be replacing them with no staff or unqualified staff. We've got to cost cut across the next five years, like everybody has. We've got to cut 4% from our budget in the next five years. (220 – 224) ...we are seriously going to be putting in place moves to establish DTNs in every nursing home.” (227) (Gail, an SLT, Haslem)

Van de Ven (2008) suggests that an innovation does not spark out of a single event, by a single person, but rather a string of events that provide the “shock” needed to initiate the innovation. Watzlawick et al. (1974) suggest that, for Second Order Change (system change) to occur, the organisation or system usually needs to face a threat to the existing system itself. Nancarrow and Borthwick (2005) suggest that both horizontal and vertical role substitution in health care are more likely when there are staff shortages. A review of the utilisation of assistant staff (support workers) also points to staffing as an important facilitator, across all nursing and allied health professional

groups (Moran et al. 2011). Dubois and Singh (2009) also found that staff shortages led to role substitution.

For Cheryl, the dietitian in the North, increasing demands on their services was causing them to push the boundaries even further: “We’ve got a waiting list through the door...” (326). More recently, the SLTs in Billington were also looking to shift the line, by placing a greater emphasis on training others. For them, this shift was occurring as the result of patient complaints and clinical incidents.

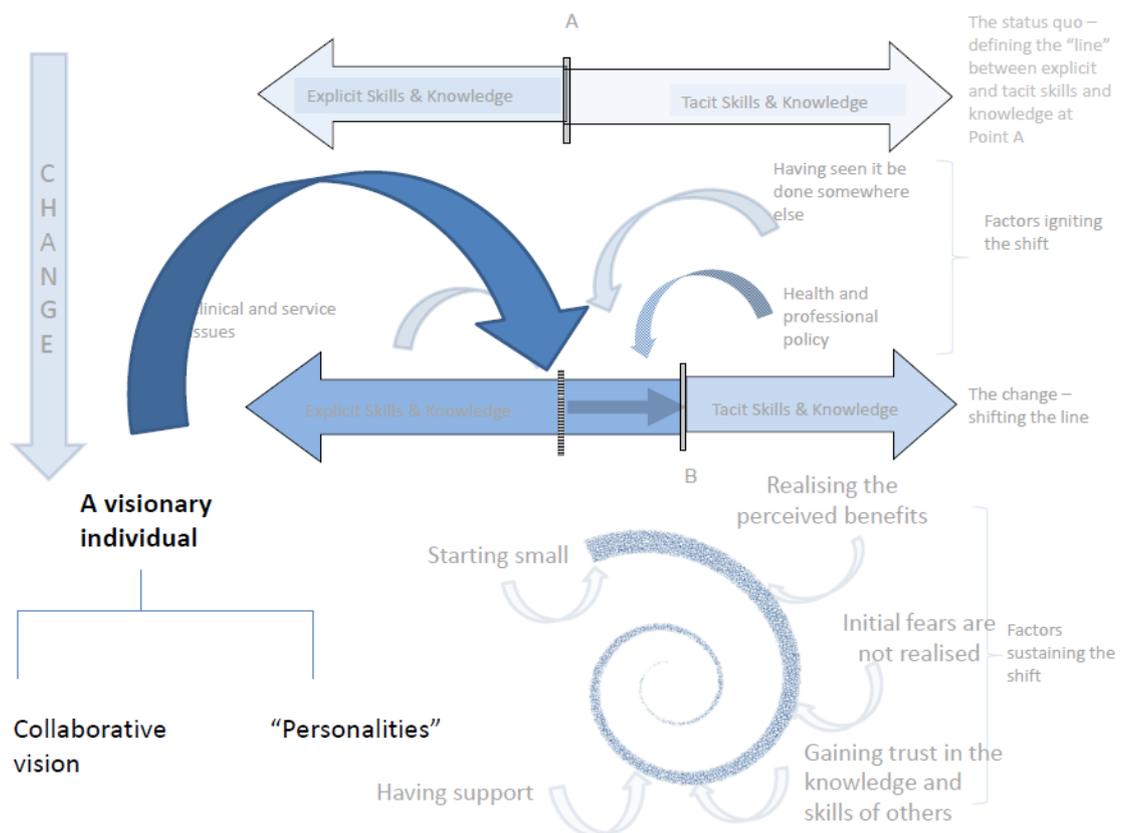
“...we were getting quite a lot of complaints about how long it was taking for people to get assessed for intervention for dysphagia in the community. And the director who was managing our sort of branch for the service at the time was very keen that complaints should be enabled to go away, so put some money into the service and what she wanted was to buy a speech and language therapist – a speech and language therapist – for the whole county who would make dysphagia complaints go away. What we managed to do...was to create a post that would be responsible for putting together our clinical approach to sharing our dysphagia skills at that very sort of ground floor level...” (73 – 87) (Olivia, an SLT manager, Billington)

Mavis, the stroke co-ordinator in Haslem, could see the process of shifting explicit skills and knowledge in many professions, including SLT and dietetic colleagues. She questioned the degree to which this shift was actively instigated by the professional groups in the situation, or whether this process happened as a reflex to the changing situation and workload:

“So the other thing is that if your staffing levels are perceived to be low by your staff, they quickly get to the point where they either share their knowledge or they go under and they walk. And actually if you, and I don’t know whether this is overt or covert, I don’t know whether it’s overt in that your staff understand that reality in terms of speech therapy, dietetic staff understand that reality and work with it and therefore share their knowledge openly or whether it’s more of a covert, you know ‘how can we work leaner?’ given that we’re not going to get any more speech therapy staff and given that you are absolutely pushed to the hilt and we can see that you’re working under stress, how do we extend the people that have got some of your knowledge?” (37 – 45)

#### **7.4 An individual with a clear vision for the service**

Not unsurprisingly, a visionary individual was needed to spark the change in the way that SLTs and dietitians worked (Van Wijk et al. 2008; Van de Ven et al. 2008; Dubois and Singh 2009; Kotter 2012), as depicted in the diagram below:



**Figure 18:** An individual with a clear vision for the service

Gail, one of the SLTs in Haslem, refers to these individuals as “trailblazers” (484). Michelle, the hospital SLT manager in Haslem, describes it like this:

“And I think there’s somebody who drives it, there’s somebody who’s got that motivation and interest... (101) I think we were very lucky in the early days, the person that, ‘cause XY was the one... (489). She was the one who actually instigated it...” (494)

Mavis, a stroke co-ordinator who had been working in Haslem for many years, corroborated Michelle’s view:

“...it is that vision and XY was particularly strong on vision, very much so, and very, very clear thinking.” (474 – 475)

Other colleagues of XY’s too, were able to point to the essential influence that she had had on the process starting in the first place:

“Again, I think there was only me and XY really that sort of did the training initially, it was just almost like a pilot in the hospital. (383 – 384) ... I don’t know why we felt initially, I think it was XY that took that decision, why we felt the best way forward was to encourage management of dysphagia as well as the

assessment. I don't know what made her go for that approach." (636 – 638)  
(Linda, an SLT, Haslem)

"Oh it was set up many years ago by XY... (437) (Karen, an SLT, Haslem)

If the person that I was interviewing was the visionary individual, then she (all such participants were female) had a clear vision for the service, where she saw it going and how this new way of working played a part in that vision. In Carla's first interview in Phase 1, she described her vision and three-pronged approach to how she was going to get there.

"Um, we'd thought sort of at three levels...first of all we need to support the hospital staff so that we can pull out a bit more but we don't tell the hospital staff that we're pulling out more, (interviewer laughs) um, and then it would be, well we've got sort of three, as part of this strategy, three stages if you like; one would be dealing with, um, and this is across community settings so nursing homes as well as people in their own homes, um, who are malnourished and addressing that so it's, it's getting people out there to be able to identify it, and then setting up the treatment programme. Um, so that would be one level then looking at long term chronic conditions, um, and then basically you know, getting in a bit earlier, um, to prevent the malnutrition in the first place so perhaps looking at the younger older person if you see what I mean?" (459 – 467)

In Phase 2, when I explored this with her again, she elaborated on the need to keep a focus on vision.

"... if you're starting in a new project you need a plan, you need to have something to work to...you had to have a plan that you could try and have an impact on it. So I think working, yeah I think it's the way we should be working, not just drifting along 'cause half the time all we're doing is putting sticking plasters on things, so you need to move things forward I think." (253 – 255)

Service commissioners could also see the impact that an individual could have on initiating new ways of working.

"Cause a lot is down to individuals, I hate to say, and but on both if you like sides of the fence, both on the side of the sort of, if you've got speech and language therapists and dietitians who have got the vision and the drive and the interest and the willingness, that's got to be key." (163 – 166) (Jenny, a commissioner, Haslem)

The visionary individual was also present in the Midlands and the North. Cheryl, the dietitian in the North, describes her own enthusiasm and vision in shaping the new way of working.

“...So my dream for many years has been how do we get a collaboration... (22 – 23) ...now my vision is how do we pull that together and we have a full wide, county wide collaborative to really get to people in their own home, raising public awareness and that’s my dream and that’s really in the next few years where we need to be looking at as a service and moving into....” (28 – 31)

Despite her successes (this scheme has won many national awards), she continues to use that vision to identify new areas to develop their way of working.

“And starting very soon to start working with our dom carers and ‘cause how do you get to that 93% of people that aren’t under health and social care; it’s your dom carers, it’s public awareness and that’s the area that we need to be moving as a service ‘cause that’s my dream – it’s how do we get to that 93%?” (14 – 17)

Senge (2006) suggests that “People with a high level of personal mastery live in a continual learning mode. They never ‘arrive’.” (p. 132). This was evident in how both Cheryl and Carla continuously pushed their services forward. Carla focussed her service and the dietetic assistants on a new “project” every year.

“It’s to do something different, to keep us as a team because if we’re just doing the same things – going to the local hospitals once a fortnight, going to the nursing homes, we need to have that push of an ongoing project that you’ve got a fired up interest about as well as the routine stuff. (261 – 264) ...so the next project that we’ve got is looking at the nursing homes...” (268)

In recent years, the organisational literature has shifted its focus from the idea of a central leader to one of “distributed leadership” (von Krogh et al. 2012), which focuses on the interplay between individuals as they work towards a shared vision. Vision may play a role in creating shared goals, and thus influencing the subjective norm and attitudes towards knowledge sharing, an important factor in facilitating the sharing of individually held knowledge (Chow and Chan 2008). Despite this, von Krogh et al. (2012) suggest that, in the domain of knowledge creation, leadership appears somewhere between the two extremes. They suggest that, “even in autonomous and non-hierarchical knowledge creation” (p. 259), leaders and leadership are required to guide and direct knowledge creation and sharing. Certainly in these data, the change process was initiated in large part by one visionary and passionate individual and leader.

“Both Carla and I, Carla being that dietitian, have this vision that we would love to be able to do the preventative let’s work at maintaining our older population well for as long as possible before they knock into [...] when it’s reactionary dietetics which is where we’re still at. We’re desperately trying to move into that proactive mode.” (245 – 248) (Sharon, community dietitian manager, Haslem)

Von Krogh et al. (2012) suggest that organisational vision, as indicated by managers and leaders higher up in the hierarchy, are instrumental in setting the direction and organisational goals, which then allows managers, leaders and workers to create knowledge that is in line with this vision. This was not necessarily the case in Haslem and the North. The initiatives started without encouragement from senior management, although there is now an organisational vision supporting the use of assistant staff.

“...certainly every time we have a vacancy now, every time anybody leaves we are asked to look at that job and say do you need like for like? Or do you need something different?” (306 – 307) (Phoebe, dietitian manager, Haslem)

## **7.5 Collaborative vision**

Although this visionary individual was an essential catalyst to the transformation process, she also acknowledged the important role of those that she worked with.

“I think it is just because I am very passionate about what I do and once you’ve worked with me for a bit a lot of the people that I work with then have that passion... (708 – 709) But I couldn’t have done that by myself... (711) I’ve got the best team in the world – I have got six people that are within my team and they’re not as passionate as me, I think that’s hard, but they’re bloomin’ passionate and they believe in the service and they fight for that service in those areas that they work in.” (952 – 954) (Cheryl, dietitian, the North)

“If you’ve got a group of therapists who have been working for quite some time who are very experienced and who aren’t you know kind of too entrenched in ‘this is the only way it can be done’” (79 – 81) (Michelle, SLT manager, Haslem)

This observation echoes von Krogh et al.’s (2012) review of the literature regarding leadership in knowledge creation. They state that:

“Two or more individuals ... from across different organizational levels and functions recognize a task at hand and intuitively believe it to be important for their work or interests.” (p. 254).

They go on to suggest also that these practitioners exercise leadership by deciding “whom to collaborate with and why” (p. 254). Cheryl, the dietitian in the North, demonstrates this point:

“We managed to get an SHA bid as an organisation, and I did my normal thing – went to the right people and said ‘Here I’ve had a great idea, what do you think to this?’” (979 – 981)

Lorenzi and Riley (2000) identified “No clear vision for the change” as one of the major factors influencing failure to change IT systems in healthcare organisations. Powell et

al. (2014) suggest that the public sector generally falls behind the private sector in providing clarity of direction for workers. The ability to create a future vision is described as transformational leadership (Jackson et al. 2013) when that future visioning results in transformational change in an organisation. The transformational leadership behaviours of the group leader play a significant role in group members' attitudes towards change (Oreg and Berson 2011). Leaders who are able to communicate a future vision instil a sense of control over the change in their staff, as well as their belief in their ability to manage stress associated with a change (Martin et al. 2005). Feelings of powerlessness can attenuate negative attitudes towards change in some clinical areas (Laker et al. 2014). As we will see later in this chapter, control over a new way of working coming from within the professional group itself, positively influenced the shift in Haslem. Transformational leaders can motivate employees by creating a compelling vision of the future, while attending to individual employee's needs. Michelle, the SLT hospital manager in Haslem, demonstrates this when talking about how she managed a dissenter.

“And one person in particular, who on the surface you'd think has got very definite ideas about what is OK for a speech therapist to do and what is not OK for a nurse to do, for example, but at the same time was also able to see that there was some shared ground and didn't feel like she needed to protect the speech and language therapy role. I think she could see that there was enough within the speech and language therapy role that other people couldn't possibly do, so it didn't mean that we were going to lose it just because we were sharing some skills with another professional group.” (133 – 139)

## **7.6 “Personalities”**

“Personalities” and personal traits could either facilitate new ways of working, or work to maintain the status quo. Alexis, a dietitian in Billington, and Susan, an SLT colleague, both demonstrate how personality can act as a barrier to shifting the line between explicit and tacit skills and knowledge:

“Well I suppose again we've all got different perceptions haven't we? So you know, um, I suppose it depends on how possessive you are, I mean we're all different individuals, we're all different personalities...” (1192 – 1194) (Alexis)

“I think it probably comes from different places, um, there's the sort of human nature... (1093 – 1094) I think some of its ego but perhaps some of my colleagues would run me out of town for that one.” (1098 – 1099) (Susan)

A need to be needed existed for some of the participants, which could also act as a barrier to shifting the line.

“If somebody started doing things that I would do, ‘well you don’t really need me then!’” (769 – 770) (Harriet, a dietitian, Billington)

In the first phase of the research, “length of service” seemed to emerge as a condition enabling the sharing of skills and knowledge. As the research progressed into the second phase however, this concept seemed to be more about experience, linked to confidence. Participants became both more confident with sharing their skills and knowledge as experience showed them that their initial fears were not realised. This finding is consistent with O’Brien et al. (2013), who found that SLTs who had previous experience of working with assistant staff were more likely to be positively predisposed to working with assistant staff than SLTs who had not had such experience. SLTs who had experienced working with assistant staff were also more willing to suggest a wider range of clinical tasks that could be provided by assistant staff. This confirms how the process of defining the line between explicit and tacit skills and knowledge grows and develops as professionals gain experience of the process and come to realise the perceived benefits. This is consistent with theories on role growth, with mastery and confidence growing, enabling the person to take up ever more challenging tasks (Vough and Parker 2008).

Previous research into the effect of “personal characteristics” (Wejnert 2002, p. 298) and the adoption of innovations has suggested that self-confidence is an influencing factor. The “prevailing model” (Berwick 2003, p. 1971) of characterizing personalities in the context of adoption of innovations stems from Rogers (1995) work on the adoption of hybrid corn seed. According to this model, innovators are divided into 5 groups which are presented on a bell curve, each section determined by the number of standard deviations from the mean adoption time. Thus, the first 2.5% of users of the innovation will be “Innovators”, the next 13.5% “Early Adopters”, the following 34% the “Early Majority”, the next 34% the “Late Majority” and the last 16% the “Laggards”. Despite widespread use of Rogers’ model, Greenhalgh et al. (2004) are critical of its use, claiming that there is little empirical support for the categories, and that they are “stereotypical and value-laden terms” (p. 598).

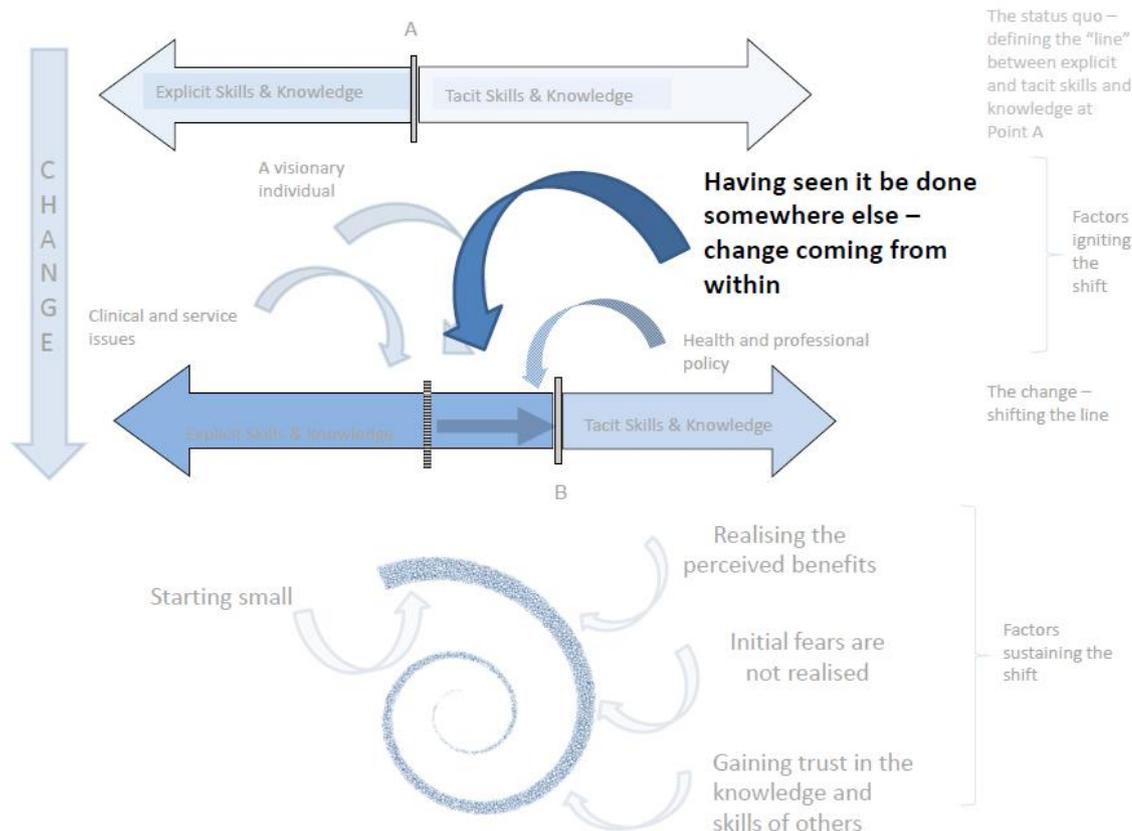
Despite this, recent research does demonstrate that personalities effect an individual’s predisposition to sharing knowledge (Matzler et al. 2008; Matzler et al. 2011; Perez et al. 2014). Specifically, personality traits such as agreeableness, conscientiousness (Matzler et al. 2008; Matzler et al. 2011), openness (Matzler et al. 2008) and affective commitment (Matzler et al. 2011) are all positively related to sharing knowledge with others (Matzler et al. 2008). Siemsen et al. (2009) suggest that the trust to share your knowledge may be more down to baseline, personal characteristics than team

dynamics. A proactive personality has previously been found to translate into both role-breadth self-efficacy and proactive work behaviour (Parker et al. 2006). Raja and Johns (2010) demonstrated that role breadth moderated the relationship between worker personality traits and organisational citizenship behaviours.

The role of personality and knowledge sharing can also be viewed in terms of information or knowledge sharing self-efficacy (Cabrera and Cabrera 2002; Chen et al. 2012), or the belief that one's knowledge may be useful to others. Role orientation, perceived job breadth (Parker 2007) and role-breadth self-efficacy (Axtell and Parker 2003) can all influence an individual's perceptions of, and attitudes towards, the breadth of their roles. Confidence in one's knowledge, which increases with the codifiability of that knowledge, can influence psychological safety, or the confidence to share knowledge that may be wrong (Siemsen et al. 2009). O'Brien (2013) demonstrated that SLTs ability to see the benefits to the professional of sharing skills and knowledge with SLT assistant staff depended in part on the individual's disposition and perception towards such sharing.

### **7.7 Having seen it be done somewhere else**

"Having seen it be done somewhere else" was the third necessary condition, igniting the shift in the line that had been drawn between explicit and tacit skills and knowledge, depicted below. In every department that was working in a new way, somebody had witnessed or heard about a similar way of working in another organisation. Although the shift was caused, in part, by having seen it be done elsewhere, change had to nevertheless come from within the service itself, rather than be imposed on the professionals.



**Figure 19:** The influence of “having seen it be done somewhere else”

In both the dietetic and SLT departments in Haslem, the visionary had taken ideas from elsewhere – either through word-of-mouth or at a conference. Indeed, this is how I identified the participants from the Midlands and the North for Phase 2 of the research. Carla, the dietitian in Haslem, had heard about, and then visited, Cheryl, the dietitian in the North.

“We’d like to be where, um, Cheryl is now, you know... (496) They’ve run up a, a wonderful service for the elderly which she started 13 years ago, well I’d like to be where she is, now... (505 – 506) ...where she is now is where we’re aiming to get...” (511 – 512)

Wejnert (2002) states that the rate of adoption of an innovation is proportional to the novelty of the innovation – the more familiar it is, the greater the rate of adoption. Greenhalgh et al. (2004) list “observability” (p. 7) as a factor in the spread of health care innovations. Argote and Miron-Spektor (2011) suggest that, in terms of organizational learning, direct and indirect experience of knowledge may be complementary and/ or substitutable for each other. XY, the visionary SLT who had started the new way of working in Haslem, had come across this whilst on a course.

“I think XY had been on a course, I think it was in W because the team therapist in W had produced a published pack called something like Dysphagia Working with other Professionals and XY had been on some training and they were trying to set up training for nurses in W and based on that when XY came back from that she sort of opened it up for discussion and said ‘I really think this is something we could look at here’... (156 – 160) ...and you know here was a kind of an opportunity to do something different that was taking off in another area. (163 – 164) (Linda, an SLT, Haslem)

Wejnert (2002) states that actors are influenced more by close peers in social and organizational networks than by objective sources. Greenhalgh et al. (2004) also point to the importance of social networks in the spread of innovations, many of these informal. Networks and individuals (Greenhalgh et al. 2004) that span the boundaries of different organisations are of particular relevance, where new innovations can be spread or learned about by an organisation’s own workers. These observations could help explain why the different way of working starts small, in a small area, and then grows exponentially as the benefits are realised: the innovation is now less novel for a department or professional group when it has already been used elsewhere. More recently, Hu and Randel (2014) demonstrated that relational social capital, the quality of relationships and contacts, was strongly related to explicit knowledge sharing, whereas cognitive social capital, or a shared perspective and understanding, was related to tacit knowledge sharing. Chow and Chan (2005) demonstrated that shared goals are positively related to the subjective norm towards knowledge sharing, positing that social networks may influence subjective norms with relation to knowledge sharing, influencing both attitudes towards knowledge sharing and intention to share knowledge.

Van Wijk et al. (2008) points to the need for establishing strong, trusting relations between organisational units, both to facilitate knowledge transfer, but also to create relationships that can broker and mutually understand tacit and situation-specific knowledge. Affiliation is an important driver in knowledge sharing intention (Chen et al. 2012). Alexis, a dietitian in Billington, works closely with an SLT colleague and this has facilitated both mutual trust and an understanding of the knowledge that is shared between the two professionals. She describes witnessing a patient drinking in an unsafe way, and flagging this up to her SLT colleague:

“I flagged it up to the speech therapist so then I, ‘cause they’re only 3 doors down (laughing) which is really handy, so when I popped back to the office I said ‘oh by the way, just seen so and so, you may just want to check’ (laughing) ‘cause I said I’ve spoken to this particular person and this is what they’re doing...” (512 – 515)

This is particularly relevant for younger participants in this study, as they were influenced by the more experienced staff that they worked with. Julie, one of the newly qualified SLTs in Billington, says:

“...I’m quite new into the profession, into my career, it probably is kind of what maybe what’s gone before and what’s already established. So it’s kind of things that are you know the way things are and learning from my colleagues who have been working longer. That very much drives what I suppose my feeling about how things should be.” (327 – 330)

Hornsey and Hogg (2000) point to the important role that group leaders play in forming attitudes towards both members of the social group and those outside the group. This can be explained by the role that subjective norms play in influencing both the individual’s and the work group’s attitude towards, and thus knowledge sharing behaviour (Bock et al. 2005; Chow and Chan 2008). Grace, one of the professional body representatives, felt that shifting the way of thinking amongst professionals already practising was one of the key factors, as she recognised that these influenced newly qualified staff.

“Yeah we talk about this with the HI’s, the problem of course we face is that somebody goes out on a placement and they’re in an environment that’s totally counter to what you’re trying to shift them to, they’re back at square one. So I think you’ve got to shift; you’ve got to do both cultural shift and change management within current services, but then also change the mindsets of people coming out. If you just do one without the other you’re not, you’re going to fail basically, or we will fail.” (319 – 324)

## **7.8 Change coming from within**

One of the key features was the need for the shift in defining the line between explicit and tacit skills to be driven by the professional groups themselves. Susan and Olivia admit the need to feel professionally in control of any such changes:

“...that’s why I took money out of the general pot and put a little bit into the training. (491 – 492) (Susan). And that was a professional decision...” (494) (Olivia)

Olivia goes on to say:

“I’ve got a lot more time for it now than I did because I’ve seen it so badly didn’t work when we had, it was ‘thou shalt do it’ and it didn’t work and it caused more problems.” (654 – 655)

Evetts (2011) uses McClelland’s (1990) terminology of “from within” and “from above” (p. 407), to describe two different ways in which change can happen within professional

groups. Discourse originating “from within” can be beneficial to the occupational group, as it helps the group to construct its occupational identity. Change “from above” refers to discourse around the professional role being imposed by the organisation and management. Employees fatigued by change initiatives, particularly where these reduce the resources available to employees, including autonomy through standardisation, seek to conserve their remaining resources by resisting further change efforts (Dubois et al. 2014). Where change is imposed on professions, resistant and defensive practices are more likely (Evetts 2011).

Clinical guidelines which codify clinical expertise can be perceived by professional groups as an attack on the profession – both the privileged, monopolistic position of the professionals themselves, but also the professional values of acting in the best interests of the clients that they are serving (Adler and Kwon 2013). Adler and Kwon (2013) suggest that innovations are more likely to spread within a profession when the innovation can be seen as in the interests of the professional group itself. Other researchers have noted the need to maintain a balance between control and flexibility in the use of protocol-driven work design (Parker 2014). An organisation may want control, to reduce the cost and errors associated with flexibility, but flexibility is important for job satisfaction and employee well-being. This study demonstrates that flexibility and control are not necessarily opposing, irreconcilable forces. Standardisation and codification of dysphagia and nutritional assessment and management were borne out of perceived benefit to the professional groups, rather than imposed on them “from above”. Loss of status has been shown to play a major role in identity threat (Hornsey and Hogg 2000), identity threat is a barrier to change (van Dijk and van Dick 2009) and role threat a barrier to role expansion (Read et al. 2001). The danger in trying to control shifting the line in skills and knowledge, rather than incentivising a wilful shift, is that the professional may hold back certain contextual aspects of their skills and knowledge (Gray 2001). For Phoebe, the hospital dietetic manager in Haslem, organisational support of a way of working that the dietitians themselves had initiated was thus not perceived as instruction, but rather as supportive.

“We weren’t told by senior management ‘Oh you’ve got a vacant post, it’s a band six, you will have...’ We made a conscious decision ourselves because we’ve seen the benefits of what dietetic assistants can do in the department.” (329 – 331) (Phoebe, hospital dietitian manager, Haslem)

Given the importance of “having seen it be done somewhere else” to ignite the shift, it is somewhat surprising that knowledge and information about these new ways of

working are not more widely known amongst the SLT and dietetic professions. This phenomenon was also noted by Lord Willis (Royal College of Nursing 2012) in his review of the education and training of nurses and health care assistants: good practice in extending roles was not being shared widely enough, leading to variable practice. As Carla, the community dietitian in Haslem, says:

“But they’re not shouting from the rooftops probably are they?” (292)

She goes on to explain why this might be:

“...but who’s got the energy, the time to go and dig it all out and put it in a report I suppose [...]. I am going to step out of the hamster wheel (laughing). Yeah it’s true isn’t it, you know it’s sharing then if you found something that works it’s always good to share. (330 – 332) ...when I first started in this post, I mean I went up to the North ‘cause they’ve got a wonderful set up there...and I went to LB and PB to see how things worked there. And both centres that I went to were absolutely full of the way that they were working and delighted to share ... but you had to go knocking on the door almost.” (333 – 339)

During feedback events (used for member checking, which I described in the Methods chapter), some participants in Billington were very keen to learn more about, and even copy, how their SLT colleagues in Haslem were working. Participants in Haslem claimed that they were not “keeping it any great secret” (Carla, dietitian, Haslem). The dietitian in the North was proactively sharing their experiences, and she felt that this was having some impact.

“And that’s what’s happened with us – we’ve spoken at conferences, we’ve done different events and people have picked up on it – ‘Oh why don’t we try that here?’ That’s one way.” (511 – 513) (Cheryl, dietitian, the North)

Gail, one of the SLTs in Haslem, suggests that innovative ways of working are spread throughout a profession in this way.

“That’s the way things usually change isn’t it? You get a few people sort of forging ahead and start writing it up and then somebody else in another trust catches hold of it and does it as well.” (487 – 489)

Participants identified that much more could be done to spread these innovations:

“So I think it’s, in terms of what would influence, I think yes people’s experience and positive experiences being shared across the profession, so you write that up in bulletin, you know, you go to a study day and hear somebody say it worked really well and you have the person that you shared it with stood beside you going yes I think it worked really well as well – those sorts of things. (593 –

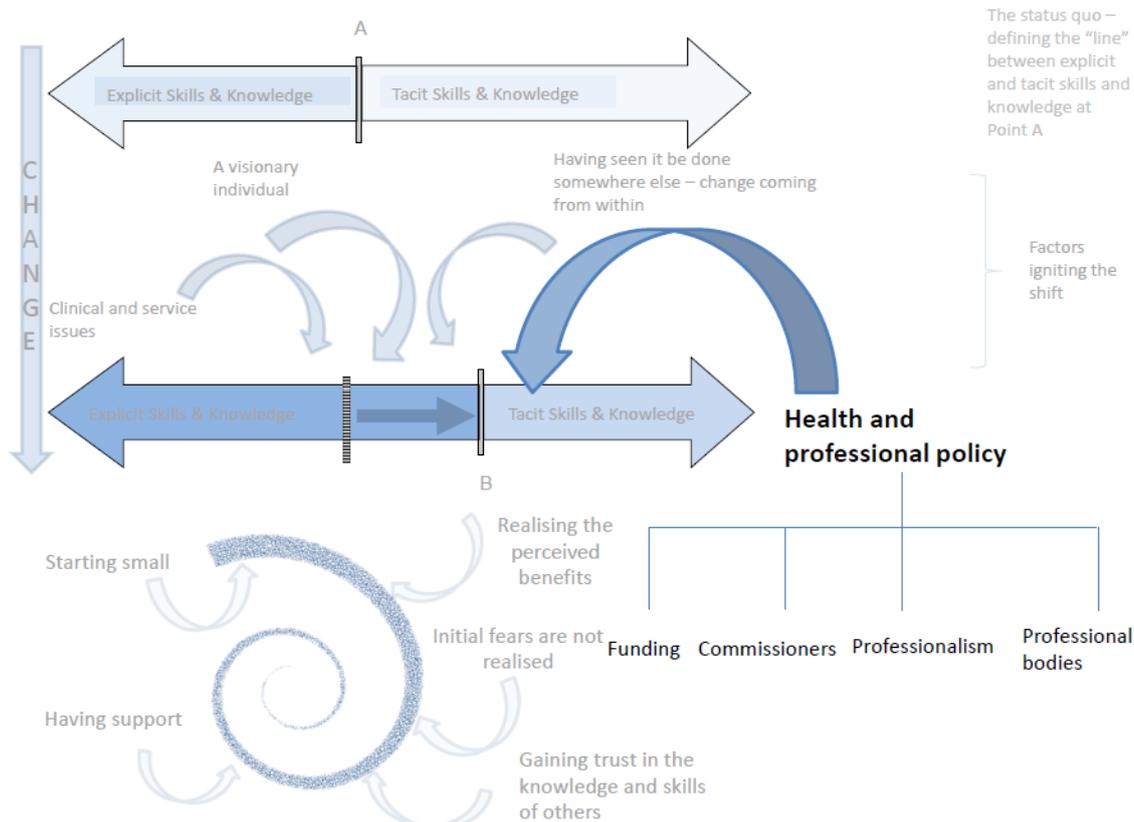
597) ...why can't we get a national picture?" (Olivia, SLT manager, Billington)  
(636 – 634)

If "hearing about it from somewhere else" is a necessary causal condition, but the message is not getting out to other departments, then this would seem to be an issue that must be addressed. Wejnert (2002) suggests that the closeness of network members, the frequency of contact and the openness within the network, are the greatest factors predicting adoption. It therefore seems imperative that these networks are encouraged to openly share different and unconventional ways of working and are perhaps actively used to allay any fears of adoption by those who have already experienced the shift.

### **7.9 Health and professional policy**

Health and professional policy played only a facilitative role in causing the shift in the line between explicit and tacit skills and knowledge. This influence was exerted by the following factors, depicted in the diagram below:

- Funding,
- Commissioners,
- Professionalism itself, and
- The professional bodies.



**Figure 20:** The facilitative role of health and professional policy

Although policy directives (such as dysphagia screening within 24 hours) had influenced the shift, every initiative had been borne out before these policy directives came into force. Michelle, the SLT hospital manager in Haslem, had been there since the beginning of the initiative.

“Certainly within stroke we know now that if the nurses didn’t start off, if the DTNs didn’t do that initial screen we wouldn’t meet the standards that we’re expected to meet, so that’s a really big incentive to make sure that we make it work. Where we don’t have that sort of incentive it does make it easier to let it fall by the wayside, so I guess, maybe that’s what I’m saying – you need some kind of incentive there for it to almost be viable.” (465 – 469)

In this study, shifting the line beyond the necessary, such as basic dysphagia and MUST screening, had to come from within the services themselves. This is in keeping with previous research on knowledge sharing in organisations (Connelly et al. 2012), which demonstrates that enforced knowledge sharing by outside agencies is rarely successful, particularly when professional expertise is highly valued but sharing knowledge is not. Enforced knowledge sharing meets particular resistance when the individual potentially stands to lose by sharing his or her knowledge and skills (Bock et al. 2005).

In Haslem, the North and the Midlands, the shift in their way of working was driven by the services themselves (i.e. dietitian and SLT departments), rather than commissioners. The limited effects that NHS organisations have on influencing different ways of working, and the strong role of the profession(al)s themselves, has been noted by other researchers (McBride and Mustchin 2013). Currie and Suhomlinova (2006) go so far as to suggest that health policy intended to overcome traditional professional divides can exacerbate professional power struggles. UK government attempts to create more flexibility in the NHS workforce has had limited success where initiatives have run counter to professional autonomy and closure (Hyde et al. 2005). Currie and White (2012) suggest that professional jurisdiction over a body of knowledge may thwart any health policy attempts to influence the division of labour in health care settings, instead merely reproducing “existing structures of professional control” (p. 1355). “Tension” (Currie and Suhomlinova 2006, p. 22) in recent years between performance-related health policy directives, such as waiting time targets, and health policy intending to shift professional boundaries may run counter-productive. Susan, the SLT manager in Billington, made this observation:

“And I would challenge, politely, you said about commissioners, you were hopeful that commissioners were more informed now about dysphagia and what it needed in order to be sort of managed successfully and I don’t think they are. I think they want to meet the targets that they’ve been set...” (395 – 397)

Although Greenhalgh et al. (2004) suggest that a policy push at the early stage of an innovation can increase its chance of success, mainly by making funding available and incentivising its implementation, it does not fundamentally affect the organisation’s ability to adopt it and may actually divert efforts away from innovating itself.

In the model presented here, political directives did have some influence in igniting new ways of working. This can be seen in meeting the target of swallow screening within 24 hours. This was first mandated through the RCP (2008) stroke guidelines and later stipulated through NICE (2008) guidelines, which were then included in commissioning intentions. In this situation, the risks versus the costs of new ways of working change for professionals (Greenhalgh et al. 2004). In order to comply with this target, staff have to either work beyond the existing pattern of Monday to Friday 9 – 5, or they have to find another way of meeting this target. It is from this policy that swallow screening first developed, as Susan, the SLT manager in Billington, describes:

“...it started in 2008, that was when it had to be invented. (225) ...the question is, are we supporting the patients to be swallow screened according to RCP guidelines and commissioner requirements...” (789 – 790)

Policy directives facilitated a shift in the line between explicit and tacit skills and knowledge only where the directive shifted the balance of incentives for the professional group. An example of this is in tube feeding for the dietitians. Dietitians wished to maintain control over this clinical area:

“Um, I would say if the person is being provided with supplements, um, or, or tube fed then I would say that needs to be left to (coughs) the dietitian so that if it, the dietitian would sort of make the, um, assessment as to whether feeding could be stopped and food could be introduced or supplements needed increasing or decreasing or whatever.” (Phoebe, dietetic manager, Haslem)

Directives enforcing the initiation of tube feeding within 24 - 48 hours if a patient was to remain NBM meant that dietitians would either have to work 7 days per week or put an alternative solution in place to meet the directive. The solution was the “emergency feeding regimen”, a set of instructions on a small amount of feed that could be administered without a dietitian prescription if this were to be started outside normal working hours. Aspects of the dietitian’s role in this area had been captured as a flowchart with instructions on which blood results to monitor before starting the feeding regimen.

“...so as much as possible, we’ve got things on the Intranet so that they are covered, like the out of hours NG [nasogastric] feed regime, so that somebody doesn’t have to wait until we come back in on a Monday morning and that they are aware that they do need to check the magnesium phosphate and you know it’s a set regime that they follow...” (1138 – 1141) (Ali, a dietitian, Billington)

### **7.10 The influence of funding**

A disincentive to shifting the line had come from increases in NHS funding, certainly in the years leading up to Phase 1 of this research. This has resulted in greater staffing numbers and less “tension for change” (Greenhalgh et al. 2004, p. 12). National surveillance data demonstrate an increase in the number of registered SLTs and dietitians in the UK from 2000 to 2004 (Dorning and Bardsley 2014), exceeding the aims of the 2000 Department of Health strategy document *Meeting the Challenge: A Strategy for the Allied Health Professions* (DH 2000a).

“Over the years, uh, we have now developed; we’re now a 9.6 whole time equivalent...” (49 – 50) (Susan, SLT manager, Billington)

“We had a very, very scant service at that time. I think just one whole time equivalent on each hospital site. It’s very different now.” (82 – 83) (Linda, SLT, Haslem)

During the first phase of data collection, conducted in 2011, Agenda for Change pay awards may have had the effect of incentivising professionals to create their roles as complex to ensure a higher pay band, and thus, earnings:

“Um, and this is purely my observation, this, next statement is, it, cos I do wonder if Agenda for Change hasn’t helped (laughs) because in order for people to kind of get their Band 7 for example, they had to say, you know I’m highly specialist in...stroke or whatever.” (835 – 837) (Jenny, a commissioner, Haslem, interviewed in August 2011)

Evaluations of some of the Changing Workforce Programme initiatives (Hyde et al. 2005) noted that some staff would not take on additional tasks without remuneration. McBride and Mustchin (2013) found that opportunities for role redesign brought about by health policy initiatives, such as the ‘Skills Escalator’, introduced in *The NHS Plan* (DH 2000) and *The HR in the NHS Plan* (2002) got caught up and conflated with Agenda for Change and the associated Knowledge and Skills Framework (DH 2004). This meant that opportunities for skill mixing were missed. Dubois and Singh (2009) have suggested that this shortcoming is due to a focus on staff types rather than skills and the effective use of those skills. Nancarrow and Borthwick (2005) suggested that although increasing specialisation leads to increased pay awards for doctors, there are few instances where this has been the case in other health disciplines (although this pre-dates Agenda for Change). More recent research in other health disciplines conducted during 2009/10 (Nancarrow et al. 2010) noted that, in intermediate care services, Agenda for Change had introduced a disincentive for more generic roles with only narrow, profession-specific roles being rewarded under Agenda for Change. This is despite the initial intention of the scheme to break down traditional barriers and incentivising new ways of working (National Audit Office 2009). Although attempts to increase pay through creating roles as specialist may have been an initial driver in this study, this driver had disappeared in the second phase of the study, as NHS funding had by then reduced (2009).

“I think there has been something of a reality check as to when it first came in there seemed to be a lot of everyone wanted to be a band seven and above, and I get the sense that we’ve had a bit of a kind of most organisations I’ve come across are, I don’t know how to put this politically correct, basically down-banding...” (417 – 420) (Jenny, a commissioner, interviewed again in February 2014)

Nevertheless, if role distinction and associated role status was previously brought about through the Agenda for Change pay award scheme, health policy makers, organisations and the professional bodies may have to consider ways to improve the

status of those pioneering cross-boundary working as a new social identity, rather than professional specialisation alone.

### **7.11 Clinical risk and funding**

A further disincentive to shifting the line between explicit and tacit skills and knowledge came from maintaining clear role boundaries as a method for obtaining additional staff, as discussed in the previous chapter. Incident forms were completed to identify perceived staffing shortages. Only by being dependent on particular tasks being carried out by a specific staff group was funding made available for additional staff in that staffing group. This method had been used over the years preceding Phase 1 to obtain more staff. This coincided, of course, with increases in funding to the NHS in the period directly before and during the first phase of the research (Tooke 2008; Appleby et al. 2009). This particular aspect demonstrates the ongoing tension between professionals and health policy makers – whereas governments have sought to manage AHPs and provide title protection in exchange for conformity to the managerialist agenda under the guise of risk reduction (Larkin 2002), the professional groups are then able to counter the risk argument to gain control over the clinical area and increase their numbers, thus enhancing their status. Although the RCSLT may be increasingly open to using assistant practitioners and/ or training nursing staff, the 2014 version of their Dysphagia Competency Guidelines nevertheless recommends that:

“The SLT’s role in dysphagia is central. In an increasingly competitive health market it is important that we continue to clarify this role and our skills in dysphagia.” (p. 5)

The use of clinical legitimacy to safeguard funding has been noted by other researchers (Currie and White 2012). Heather, one of the SLTs in Billington, alludes to her desire for greater recognition of her professional skills:

“...it [modifying food and fluids] isn’t all that we do and sometimes I think, you know, because maybe they haven’t had the training... (450 – 451) ...sometimes they don’t look at the advice and follow recommendations but maybe, it’s because they don’t really understand why and what we’re doing. (458 – 459) ...people aren’t following advice and reading our signs, our safe swallow plans...” (476)

### **7.12 The role of commissioners**

Jenny was vaguely aware that they commissioned both SLT and dietetic services.

“CCGs now we’re in, do commission as far as I’m aware most speech and language and dietetic services either as part of acute contracts or as community contracts.” (219 – 221)

Despite this, even she did not fully understand their role in service delivery.

“...we commission the service and the kind of, what that actually means I don't know.” (233 – 234) (Jenny)

A lack of understanding of workforce issues and workforce planning to facilitate service change was noted by Skills for Care (2011) in the New Types of Worker initiative. Similar disparities between service needs and redesign and workforce planning to meet these changing needs have also been noted in NHS organisations (McBride and Mustchin 2013). One of the key barriers to a greater focus by commissioners on how services were provided was their own lack of knowledge of the subject area.

“... the challenge with that is that it's dependent on the awareness and knowledge of that group of commissioners of this way of working.” (222 – 223) (Jenny, commissioner, Haslem)

The way in which services are currently set up as stand-alone departments does not facilitate shifting the line between explicit and tacit skills and knowledge. As Mavis, the stroke co-ordinator in Haslem, put it:

“Yes and then it comes through the East Midlands and then the East Midlands put pressure on local commissioning and local commissioning say ‘Well actually if we don't have to tick that box because we have so little money, if we don't have to tick that box we won't tick that box’...” (122 – 124)

Linda, one of the SLTs, could see a move away from valuing the wider benefits of sharing skills and knowledge with other types of workers:

“It's not bums on seats is it? That's what counts in the current climate unfortunately, quantity. (370 – 371) ... it's short sighted to look at numbers or just numbers rather than quality and the effects of having dysphagia trained nurses mean that people have a better service and there is less risk to them in the nursing home if they've got dysphagia than if there weren't trained nurses in that nursing home. So you know there are benefits but it's like anything, I think people just don't, they don't count.” (375 – 379)

Current one-to-one contact, service specific, commissioning arrangements have created a disincentive to pursue this process, an issue recognised by the professional body representatives also.

“...they're not yet commissioning on outcomes, they're still commissioning on inputs, which is patient contacts. Well they shouldn't be doing that, they've got to move.” (241 – 243) (Grace, professional body representative)

Commissioning for outcomes, and the new Multispecialty Community Providers and Primary and Acute Care Systems proposed by *The NHS Five Year Forward View* (NHS England 2014), may add yet another dimension to greater sharing of skills and knowledge. If both dietetic and SLT departments were to focus on providing services based on outcomes, it is feasible that this would raise confidence in the value of their professional groups and their distinct role, thus facilitating greater openness (Hornsey and Hogg 2000).

Commissioner participants were hopeful that future integrated commissioning and the need for providers to be cost-effective might incentivise further shifts in knowledge sharing in the future.

“... there’s a lot of discussion about sort of...people become much more aware that in a sense we’re spending, as commissioners, public money. (549 – 551) ...there’s the whole integration agenda which is the big, hot topic of the world. And in actual fact there’s an increase of expectation for us to work more jointly, more collaboratively. As I said, we’re doing lots of work looking at a whole community model and to say where can we make services much more joint, if you like, so that we are not sending out three professionals when would be able to do it... (529 – 533) That actually they have got to look at their own sort of cost effectiveness really...” (567) (Jenny, commissioner, Haslem)

Despite this, Nelly, the commissioner in Billington, perceived that the onus very much remained on individual SLT and dietetic departments to adopt new ways of working themselves:

“It’s very difficult, well it’s in the service specification, so in the service specification you can’t be specific about grades of stuff...” (119 – 120) (Nelly, commissioner, Billington)

She saw the challenge mainly as being in the hands of service providers themselves.

“Yeah I think so because they [SLTs] will probably come to us asking for more funding, but even though we will say our stroke service delivery group and every contracting commissioning meeting that actually there’s no funding, this is where our funding is going for the next year, so then it’s about looking at different ways of working.” (451 – 454)

Despite a lack of health policy incentives driving a significant change in the way of working in Billington, in Haslem, the Midlands and the North, the visionary individuals had nonetheless initiated their own change efforts. They seemed able to see beyond the present and were planning for a more challenging future. Both Cheryl, the dietitian in the North, and Carla, the dietitian in Haslem, were actively preparing for this eventuality.

“And if dietitians don’t do it, somebody else will do soon... (444 – 445) ...if we keep on doing the traditional model for what we always do, we ain’t going to be here, we ain’t going to be here in ten-twenty years’ time, we’re going to be a dying breed and we’ve got to adapt our role to the time.” (587 – 589) (Cheryl)

“...you’ve got to start somewhere and three or four people can’t do it. If we’re going to have an impact it’s sharing those skills.” (171 – 172) (Carla)

Cheryl was planning to go further still, expanding the training to domiciliary care providers and the local hospital. She also saw the opportunities that technology could afford. When I interviewed her, an online version of her program was being provided to other NHS Trusts for a fee. She was also setting up a telephone and electronic reminder system and had won innovation funding to start this work. There was talk of this being provided to other areas for a fee too, once established. Clinical guidelines and protocols, such as those used in Haslem and the North, can facilitate the transfer of tasks from one type of worker to another while maintaining quality amongst Allied Health Professions (Sibbald et al. 2011). As Poppy, the SLT in the Midlands, states: “I think they can screen because they’re following an algorithm.”

### **7.13 Professionalism and knowledge sharing**

Health policy objectives of greater role expansion sit uncomfortably with professional imperatives of restrictive entry (McBride et al. 2005) and the competitive nature of professionalism to “defend and expand their boundaries” (Nancarrow and Borthwick 2005, p. 902). There was certainly a sense amongst the dietitians and SLTs in Haslem that they had been battling professional colleagues when codifying their skills and knowledge.

“Nobody was outright ‘Oh do you think you’re doing the right thing?’ but you knew that ‘Hmmm not happy about having to lose dietetic time’ to skill mix. It was the protectionist of the profession. (164 – 166) ...we battled to get the dietetic assistant role...” (553) (Sharon, community dietetic manager, Haslem)

This may have been compounded by increasing professional regulation.

“...in 2009, because of I think of the advent of HPC and that really it was difficult to continue to be a speech therapist in a role that was so, not so traditionally based.” (51 – 52) (Betty, SLT, Haslem)

The professional body representatives were aware that this insight had to come from their members. In considering the potential of assistant staff, Nina says:

“I do think managers will have to and will be forced to because of you know the current climate... (130 – 131) ...having looked at the roles and the responsibilities, that there is plenty that support workers could do and add value to, to leave our experts to do what they do. (165 – 166) ...I don't see why a dietitian has to have a degree and have this expertise to put a supplement carton on the end of a bed and see if someone ate their meal. That is quite adequately done by somebody else.” (167 – 169)

It has been argued that the autonomy of the professions in managing how they operate has been in decline in recent years, with the rise of managerial and organisational control of professional workers (Evetts 2003; Evetts 2011; Adler and Kwon 2013, Huby et al. 2014), or the “managerialist agenda” (Nancarrow and Borthwick 2005, p. 903; Currie and White 2012). A 1996 review into the allied health professions commissioned by the then Ministry of Health criticized AHPs for using:

“...statutory mechanisms of registration and regulation to pursue their own particular agendas, rather than to secure public benefits in health care.” (Larkin 2002, p. 128)

This report sparked a change for AHPs in the UK, and it was deemed that protection of title was only justified where it served to protect service users. Dubois and Singh (2009) have even proposed that role extension may serve managerial interests, rather than professional ones. Despite this, HR departments have had little influence over role redesign in NHS organisations (McBride and Mustchin 2013). Evetts et al. (2006) suggest that professions continue to gain monopoly over a field by reference to the skills needed to perform their role:

“Professionalization in this strong sense means that a group of experts claims jurisdiction over the skills needed to be duly qualified to practice in the respective field. In cooperation with state authorities, they aim to transform their claims into a legal restriction of access to the respective field of activity for people who have undergone a certain vocational training, accounted for by formal credentials.” (p. 118)

Professional groups continue to control tasks and domains (Evetts 2003; Evetts 2011), as can be seen from the research presented here. Specifically, in dietetics, other researchers have identified other aspects of nutritional care as “ripe for adoption and incorporation by dietitians” (Stanley and Borthwick 2012, p. 302), by reference to the lack of a specific professional group claiming jurisdiction over a new clinical area. The authors actively promote that dietitians lay claim to professional jurisdiction over tube feeding care, without regard to user nor organisational needs, demonstrating the professional “self-interest” referred to by critics of professionalization (Cameron 2011).

## 7.14 The role of the professional bodies

Despite widespread “policing of occupational boundaries by professional associations” (Currie, Finn and Martin 2010, p. 944), participants generally felt that their respective professional bodies were supportive of codifying skills and knowledge, whether to assistant staff or to nurses. As Cheryl, a dietitian, says:

“BDA [British Dietetic Association] does support what we do, really supportive and whenever we can join any initiative with them to promote the service and help them promote the services of dietitians we do do.” (599 – 601)

Nevertheless, influential individuals within both professions were keen to maintain the boundaries, and participants were aware of this influence. In referring to a recent campaign highlighting the role of dietitians in tackling malnutrition, Cheryl felt:

“... well that was obviously a farce (laughing), I didn’t say that. (618 – 619) ... dietitians are absolutely pivotal but there’s not enough dietitians to solve the problem of malnutrition.” (622 – 623) (Cheryl, dietitian, the North)

This feeling was not confined to dietitians, as Michelle, the hospital SLT manager in Haslem, had also felt these “vibes” (170) (Sharon, community dietetic manager, Haslem):

“Whether there is a slight reluctance and this is a purely personal opinion – whether there’s a slight reluctance that if they are too positive about it, actually might that end up having a negative impact on us as a profession and could some people begin to lose their status because we are trying to encourage other professions to take this on board. I don’t know. And there may be one or two very strong, vociferous people who don’t like it, who would influence that thinking, I don’t know.” (588 – 593)

Although professional bodies more broadly may have been opposed to the use of assistant staff in the past (Moran et al. 2011), both the British Dietetic Association (BDA) and the Royal College of Speech & Language Therapists (RCSLT) have compiled competency frameworks for assistant staff (RCSLT 2003; RCSLT 2014; BDA 2014). For SLTs, training nurses was accepted practice, as Michelle states:

“They know that it goes on and they’re not anti it at all... (586) It’s a recognised way that we work.” (588) (Michelle, SLT manager, Haslem)

Nina, one of the professional body representatives, stated that their professional body was actively influencing their members’ position on assistant staff by publishing a profession-wide competency framework. This framework includes non-registered staff, allows non-registered staff to become members of the professional body and includes

assistant staff on the governing board. Grace, the second professional body representative, reported that one of their planned actions is to identify members according to their professional areas of interest. This would mean that members could be selectively e-mailed information that is relevant to them.

Despite the transfer of skills and knowledge being adopted in many areas, this has not been the case in others. Nina, one of the professional body representatives, was able to see this picture at a national level.

“And you know what is probably even more unfortunate is the fact that there is definitely regional variations as well you’ll find, you know, [some] departments are very much more proactive... Then you’ve got departments ... who haven’t changed in years... So it does vary... there are pockets where it’s just not happening...” (357 – 365)

Some participants looked to the professional bodies to facilitate the process.

“I’m not sure why they’ve not sort of taken it up as a particular issue for them in the past. They know that it goes on and they’re not anti it at all ... whether there’s a slight reluctance that if they are too positive about it, actually might that end up having a negative impact on us as a profession and could some people begin to lose their status because we are trying to encourage other professions to take this on board.” (585 – 591) (Michelle, SLT manager, Haslem)

Phoebe, the hospital dietetic manager in Haslem, recognised that this was a joint responsibility:

“Um, I mean I suppose the only thing is using the various networks through the professional organisation sort of flagging up that these things are happening and if people want more information to get in touch with the various people who are running these schemes. But it does require the individuals to let the BDA know what they’re doing (laughing). So it’s a bit of a catch 22! But I think part of the problem is we’re just not very good at shouting about what we do...” (416 – 420) (Phoebe, dietetic manager, Haslem)

The professional body representatives felt that members themselves had a greater role to play in communicating the message.

“...they are College you know. ...they need to tell us and we have a route in, a communication route. ...there is something about responsibility and taking responsibility. ...you are College so what are you going to do to tell us about your work and to share it with your peers?” (365 – 371) (Grace, professional body representative)

They were relying to a large extent on “critical mass” to drive a wider use of assistant staff, as Nina demonstrated:

“Well first of all I think there’ll be a critical mass, I think generally the more you see it the more managers say to the next ‘you haven’t got a support worker doing that.’ The more you see that, there’ll be an element of hang on I think I need to look at this.” (119 – 121)

Wejnert (2002) suggests that as more peers adopt an innovation, pressure upon other peers to adopt the innovation increases, while the perceived risks diminish. In this case, the new way of working is ultimately more likely to become successfully adopted for each new department that starts to work in this way. This is because social pressure and subjective norms play an important role in knowledge sharing behaviour (Chow and Chan 2005; Adler and Kwon 2013).

Having explored the conditions that caused the shift in the line between tacit and explicit skills and knowledge to happen, in the next chapter I will explore how the shift happened and how the change was sustained. This will be concluded with a discussion of the implications of the findings of this research in Chapter 9.

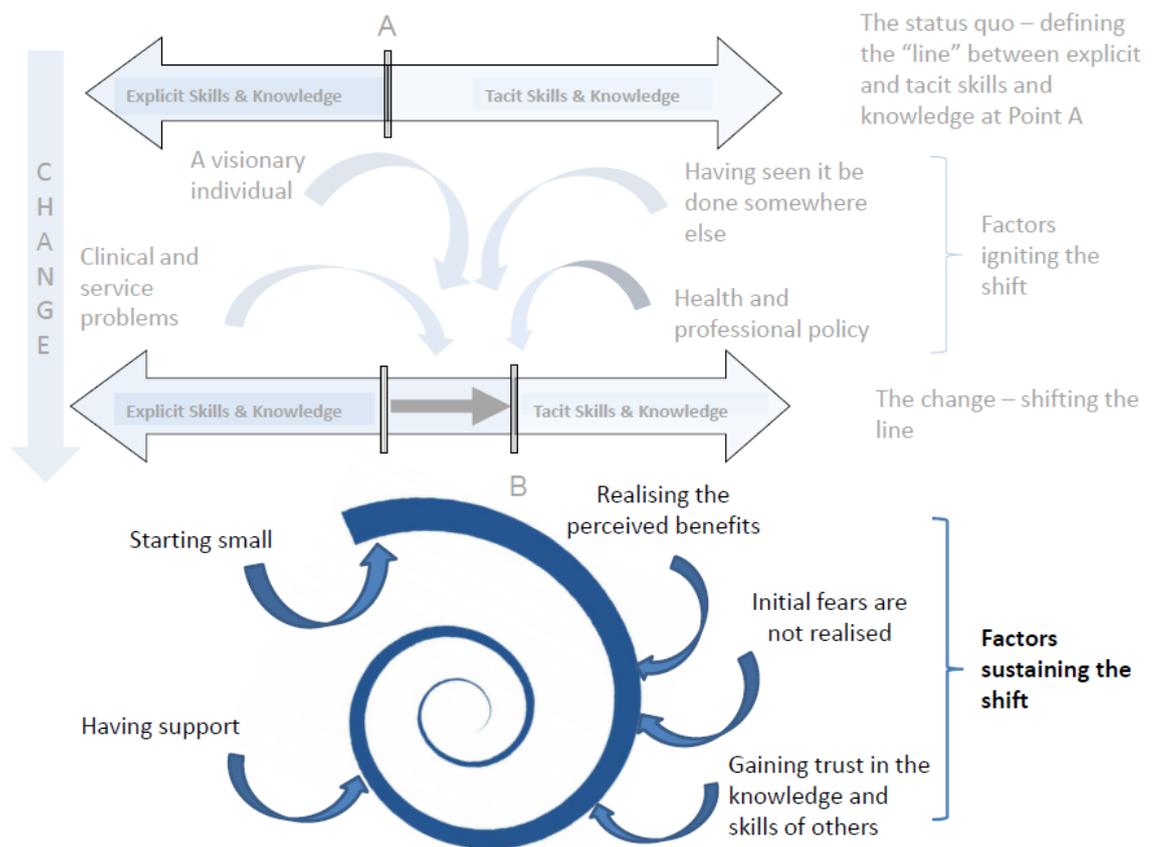
## CHAPTER 8 FINDINGS

### SUSTAINING AND MAINTAINING THE SHIFT

#### 8.1 Introduction

Having explored the factors maintaining the status quo in Billington in Chapter 5, and the conditions that caused the shift in the line that had been drawn between explicit and tacit skills and knowledge in Haslem, the Midlands and the North in Chapter 6, I will now turn towards exploring the factors that sustained and maintained the shift.

Once the process of shifting the line that had been drawn between explicit and tacit skills and knowledge had started, the change was sustained through a number of conditions, depicted below:



**Figure 21:** Sustaining and maintaining the shift

These conditions caused the process to continue to develop and evolve into new areas – the dietitians started to use assistant staff for an ever greater range of clinical tasks and the SLTs grew their dysphagia trained nursing programme into other clinical areas

in the hospital and in the community. I will explore each one of these conditions in turn, but in summary they were:

- Starting small
- Realising the perceived benefits
- Initial fears are not realised
- Gaining confidence in the skills and knowledge of other types of worker
- Having support.

Starting small was the first of these conditions to sustain and grow the process.

Realising the perceived benefits, that initial fears were not realised, gaining confidence in the skills and knowledge of other types of worker and having support were all concurrent factors, which furthered the growth of the process of shifting the line.

Participants initially start with smaller initiatives (such as dysphagia screening for stroke ward nurses and nutritional review by dietetic assistants). Once the shift had been ignited, participants realised the perceived benefits of working in a new way, and this sustained a further shift in the line between definitions of tacit and explicit skills and knowledge. Examples include training of nursing home nurses in dysphagia screening, and then management, and training of nursing homes in nutritional management, first by dietitians, and later by dietetic assistants. As participants' initial fears are not realised, and as they also gain confidence in the skills and knowledge of those to whom they are transferring their previously tacitly held skills, the spiral grows further, as they transfer an ever greater proportion of their skills and knowledge to these workers. The ever-growing spiral nature of this change is re-enforced by having support; management support for those transferring skills and knowledge, and increasing confidence and support for those to whom skills and knowledge are being transferred.

## **8.2 Starting small**

Both the dietitians and the SLTs in Haslem, the North and the Midlands had been working in this way for several years. They described their respective projects as starting small:

“We have now subsequently moved on – we’ve got two, we haven’t quite got two full time, we’ve got 1.9 full time dietetic assistants.” (158 – 159) (Sharon, community dietetic manager, Haslem)

Both the dietitians and the SLTs had built on these projects as they gained confidence in assistant staff and the other types of workers that had been trained. As Lauren, the community SLT manager in Haslem, describes:

“Yeah I think people seeing the benefits and seeing that it was doable ...”  
(1217) (Lauren, community SLT manager, Haslem)

Sharon, the community dietetic manager, joked:

“If I threatened to convert that time into dietetic time I think everybody would walk out on me now. It’s been complete role reversal... (159 – 160) They’ve proved an asset and I say they’re worth their weight in gold and everybody appreciates that within the service.” (162 – 163)

For the SLTs in Haslem, the process of making the shift started small with the dysphagia trained nurse programme on the stroke ward. Following the perceived success of this, the programme was further developed and extended.

“So like I say, the original form was this flow chart and actually the original form stopped at teaspoons of custard, it didn’t let you go on to sips of custard. So that was alright in acute where you can get your speech therapist within a day or two at the most, but for your nursing home you’re not going to leave people dehydrated on teaspoons of custard when they’ve got potential to manage more. ...we train them to do more than assess, we train them to review (334 – 335).”

This then grew and developed to include other wards in the hospital, such as the Intensive Care Unit (ICU).

“...we have got DTNs in ICU. So she does additional training because the majority of “people in ICU are on a ventilator or they’ve got... So they have additional skills the DTNs that work over there to everybody else who works in community or on the general wards.” (Linda, SLT, Haslem) (117 – 120)

In more recent years, the programme has been extended into the community, such as community hospitals and nursing homes. Linda, one of the SLTs, recalls how the programme developed:

“...it was originally open to nurses that worked on the general medical wards I think as a kind of a pilot – let’s see how this goes. And then obviously that over the years has included everybody within the acute trust and then it’s spread out to KW which was in the mental health trust... (191 – 194) And then it was spread out to primary, so all the nursing homes, the residential homes, district nurses, community hospitals.” (201 – 202)

As the professionals gained trust in the skills and knowledge of those to whom they were transferring their own skills and knowledge, the process grew into other clinical areas as the perceived benefits continued to be realised and their initial fears did not come to bear. These initial fears included “being done out of a job” and other types of workers “overstepping the mark”.

This process of starting small and growing as the perceived benefits are realised can be explained from a social-psychological point of view. For example, Bock et al. (2005) found that employees who had shared their knowledge and received feedback in some way about the benefits of sharing to the organisation or work group were then better disposed towards sharing their knowledge again. This led to even greater knowledge sharing behaviour, which was also present at the group level, expressed through social norms. Positive experiences of knowledge sharing led to a greater subjective norm to share knowledge, which in turn led the individual to have a more positive attitude towards sharing knowledge. Cabrera and Cabrera (2002) reported that employees are more likely to share information and knowledge if they receive feedback that their contribution has made a difference and has been useful to somebody else.

### **8.3 Areas where the shift had not grown**

The SLTs in Haslem had attempted to develop their programme across all the wards in the hospital in the early days. This had not been successful in many areas, and they had withdrawn the scheme from most of the wards, with the exception of the stroke ward and ICU.

“Now, that has, it used to be across the whole of the hospital, it has now gone down to just being on specific wards...” (66 – 67) (Phoebe, hospital dietetic manager, Haslem)

It was important to get “buy-in” from both staff receiving training and their managers for the training to be successful.

“...we did two managers’ specials as I called them, managers’ training and three blocks of these three units and in that time we only managed to get four new nursing homes to come. So in all that training time, the rest were made up of people that had already done the training, so we only managed to capture four new. So that’s a big thing, is to try and get on board those nursing homes that don’t send anybody.” (94 – 98) (Lesley, dietetic assistant, Haslem)

For the SLTs, it was important that they kept up communication with ward and nurse managers, particularly when there were staff changes. Michelle, the hospital SLT manager in Haslem, feels this may have contributed to the programme not being

successful throughout the hospital.

“...if somebody new came in and didn’t understand the scheme terribly well and we might not have made enough effort to make sure that they, that it was advertised to them, it perhaps wasn’t embedded enough at that point for them to get on board with it. And then other managers above them came in who perhaps didn’t fully understand the setup and I think that made it easier for things to start to fall away...” (236 – 240) (Michelle, hospital SLT manager, Haslem)

She goes on to describe why it continued to work on the ICU, but not in other areas:

“In the end what we had to, we had to decide and where we are now is that the DTN, we had to recognise that the DTN scheme only really works when you have a very contained clinical group. So it works really well in stroke because it’s just stroke, so they’re not having to think with lots of different hats on about the sorts of person that they’re dealing with. (251 - 254) It works in critical care, in ITU, because we’ve done that enhanced training, that one to one contact or one to two contact with the nurse, the fact that they can focus on the patient, it’s easier for them too. And it works within our community hospital settings because generally the people moving into community hospitals they’re less acutely ill, they’re more stable, they’re probably going to be if they’ve come out from the acute hospital and gone into the community hospital and they’ve started on something then they’re in a position to then look at how they can progress that. But unfortunately we’ve tried really hard to make that work everywhere. I mean we were really, really keen to introduce it on to medical assessment unit because that would be ideal if you’ve got people coming in... (261 - 278) ...but the turnover down there is so rapid, not just from a staff point of view but obviously from a patient point of view. (281 – 283) ...we had to abandon the scheme within the respiratory service... (188 – 189) But we’ve made it work in ITU, for example, very successfully.” (190 – 191)

Another issue was maintaining the competency of the dysphagia trained nurses, particularly on wards with few patients requiring dysphagia screening.

“The nurses were finding it difficult to maintain their skills and to maintain their competency at it because they weren’t doing it as often for various reasons.” (58 – 59) (Rebecca, ward nurse manager, Haslem)

She echoed Michelle’s thoughts - the programme had worked for them in defined areas, but not in others.

“I think in some areas it’s probably very appropriate and it would depend on what sort of areas they had within that trust. I think, like I say, stroke rehab – yeah. One of my areas is also in neuro rehab and they’ve got some dysphagia trained nurses and I think, yeah, I think it works for some places and not in others and I think that the nursing staff that you train you have to be confident that they are going to be able to maintain their competencies and they are able to put it to use because if they’re not going to put it to use what’s the point in training them? And I think in some areas it will work really well and in other areas actually it’s not going to be...You’re either going to have patients so few

and far between that need assessing or they're going to be that acute that it's not appropriate for the nurses to assess them..." (89 – 97)

Susan, the SLT manager in Billington, recollects the same issues around maintaining competency and throughput when she ran her extended nurse dysphagia management programme a few years ago:

"I did the stroke unit because we didn't have enough people to push people through consistencies and they were on puree for weeks on end, so I did it everywhere and then contracted it back to where, elder care and stroke, because that's where it worked and we had shared care high level of experience, high level of exposure, confident nurses, nurses skilled in other things, high level of exposure to dietitians and that sort of thing which helped to support. And went back out and then we went into water swallow screening and then they wanted that in A&E and then they took it back out of A&E because it really didn't work." (820 – 826)

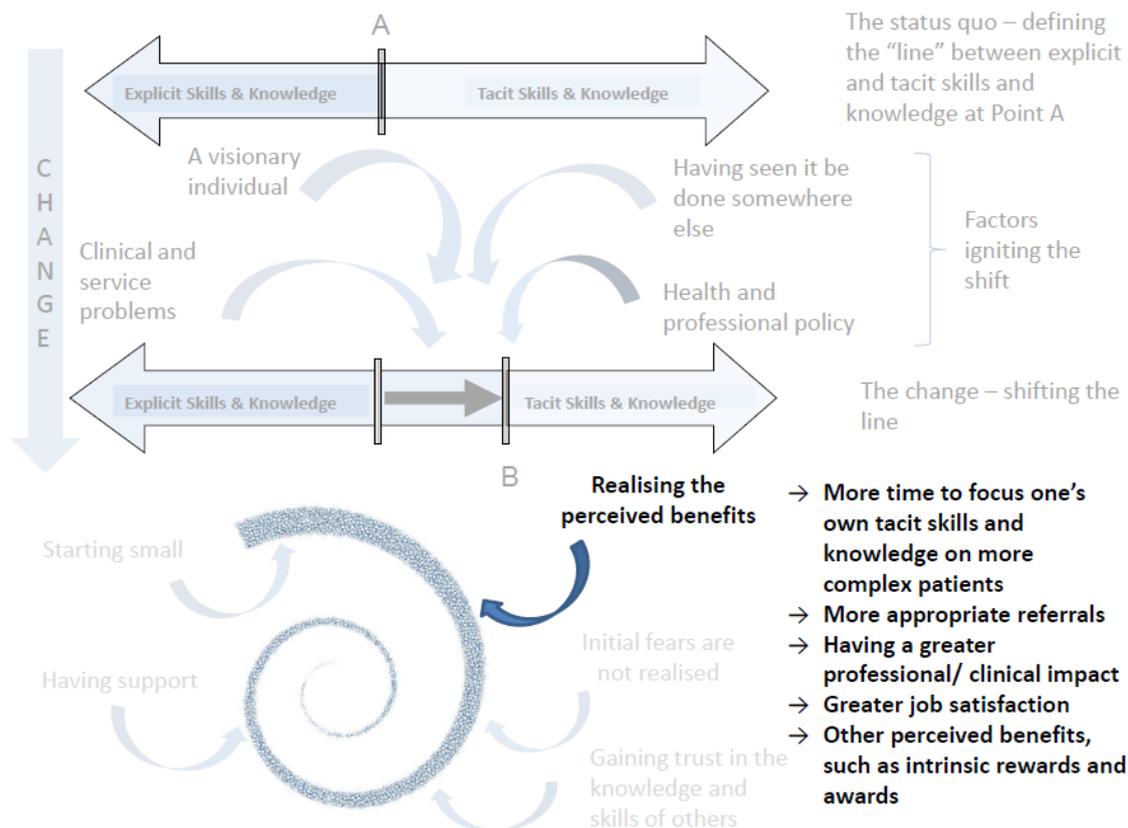
Olivia, her community counterpart, notes the importance of throughput and manager support for their basic dysphagia awareness programme in the community:

"And the same with community, which is what we're finding, that even the nursing homes that have got a high level of dysphagic patients, they really, plus all the other variables of good manager and la de da de da, they've really taken dysphagia awareness and we've really grown." (835 – 838)

#### **8.4 Realising the perceived benefits**

There was an overwhelming sense from participants in Haslem, the North and the Midlands that training others, and codifying and sharing their skills and knowledge in other ways, brought benefits to the professionals in the arena. These benefits sustained the shift in the line that had been drawn between tacit and explicit skills and knowledge, as depicted below. In summary, the perceived benefits of codifying explicit skills and knowledge in Haslem, the North and the Midlands included:

- More time to focus one's own tacit skills and knowledge on the more complex patients
- More appropriate referrals
- Having a greater professional/ clinical impact by reaching a greater number of patients and improving the overall skills and knowledge in the clinical area
- Greater job satisfaction
- Other perceived benefits, such as awards



**Figure 22:** The perceived benefits sustaining the change

In the North and the Midlands, these perceived benefits had continued the change process, further pushing the line. Participants in Haslem, the Midlands and the North could no longer conceive of working in any other way. Linda, an SLT in Haslem, says: “I don’t know how we’d manage without them really...” She goes on to say:

“Well I can’t imagine for a second that anyone would think, even the sceptics initially, I can’t imagine that they would want to return to that. I don’t know how we’d manage without our nurses in community. (286 – 288) So I can’t think why on earth we’d ever want to return.” (290 - 291)

They were no longer talking a language of where things had gone wrong or other workers had overstepped the line, but rather one where they expected other types of worker to be able to take on parts of their role.

“I mean I don’t know whether it will get to this, but I would imagine we’ll get to a stage where we won’t take on patients onto the caseload in a nursing home if there isn’t a dysphagia trained nurse there, because there’s too much routine stuff that we get called to do that is not difficult for a nurse to do.” (171 – 174) (Gail, SLT, Haslem)

The perceived benefits included those to patients, in that patients could be seen more quickly, seen more often and would only need to be assessed by one person. Participants also described benefits to their service and to themselves as professionals. Cheryl, the dietitian in the North, said: "...to me it's the future of dietetics." (1125) Michelle, the hospital SLT manager in Haslem, says: "...most people think it's a brilliant idea (laughing)" (385). As Wejnert (2002) suggests:

"...whether an innovation is considered for adoption by an individual actor is strongly determined by compatibility between the characteristics of an innovation and the needs of an actor." (p. 303).

### **8.5 More time to focus one's own tacit skills and knowledge on the more complex patients**

In Billington, participants referred to time as a barrier to not codifying aspects of their skills and knowledge and transferring these to other types of worker in the form of training. For example, both Heather and Alexis suggested that they would not have time to add clinical tasks to their current roles:

"... you'd have to have more time if you were going to be doing, keeping the five people who are nil by mouth, getting to them, plus doing an extended role." (691 – 693) (Heather, an SLT, Billington)

"I think it [...] the time constraints, I mean I can barely (laughing) you know... but it's purely the time, it's the fact that say I've got enough to do even at the moment within my own role and developing that, um..." (509 – 521) (Alexis, dietitian, Billington)

This finding is in tune with O'Brien et al.'s (2013) interview research exploring barriers to using more assistant staff amongst SLTs in Australia. His participants were concerned that they seemed to be spending a greater proportion of their time training as they started to use assistant staff. Wood et al. (2011) also reported concerns over the time required for qualified professionals to train community assistant staff. Lack of time is a frequent finding as a barrier to new ways of working in health care (Read et al. 2001; Oelke et al. 2008).

It was also assumed by some participants that "receivers" of extended skills and knowledge would not have time, a point also noted in previous research (Dubois and Singh 2009):

"... you know it is extra time when they are so short staffed anyway..." (271) (Heather, an SLT, Billington)

“Felt that it’s all very well us doing your job but who’s going to do our job, so nurses are already running around like headless chickens doing everything that they can possibly do, they didn’t have the time to then spend 20 minutes doing an assessment and the documentation and the management planning and talking to the carer.” (1057 – 1060) (Susan, an SLT, Billington)

Despite these assumptions, those receiving skills and knowledge felt that taking on additional tasks gave them more time, in that they could get on and manage patients. For example, Margaret, one of the stroke ward nurses who carried out the basic dysphagia screening, did not feel that the time that it took to carry out a dysphagia screen impacted upon her. This sentiment was echoed by Sarah and Amber, both stroke ward nurses in Billington carrying out dysphagia screening.

“I don’t feel like that is putting some pressure on my workload at all.” (130 – 131) (Sarah)

“I think it’s just one of those things that we’ve incorporated into our workload. It doesn’t take long to do a swallow screen, I mean probably ten minutes maximum...” (1146 – 1147) (Margaret)

Even if the time to perform extended role clinical tasks was not necessarily an issue, there were other potentially adverse effects for those receiving extended skills and knowledge, particularly nursing staff. Susan, the SLT manager in Billington, refers to this as “headspace” (1130).

The sense that extended roles may erode the core nursing role has been reported by other researchers (Currie et al. 2010). Although the nurses in this research did not feel that the roles that they were performing currently in dysphagia and nutrition were too time consuming, the nurses in Billington did acknowledge that taking on any more than the basic dysphagia screening would not be possible due to time constraints. As Amber, one of the stroke nurses in Billington states:

“That goes back to the time consuming part, if we took on more of their role and learned a fuller assessment then obviously that would take up more of our time to do less nursing care and it goes back to the time issue.” (448 – 450)

The impact of increasing task demands in recent years on nurses’ ability to work to their full scope of practice has been reported by other researchers (Oelke et al. 2008).

Although participants in Billington identified the time it takes to train other types of worker as a barrier to shifting the line, there was also a feeling that this would be “time well spent” (Alexis, dietitian, Billington). Heather, one of the SLTs in Billington,

suggested that perhaps more time should be dedicated to providing training and that providing time for training should perhaps be a bigger priority for SLTs.

“I think it is becoming more and more of a priority and that we just need to take the time, and there is never going to be enough time...” (464 – 465)

It seemed that time was being created as a barrier, as “not having time” to impart the skills and knowledge means that one retains these. Nonaka and von Krogh (2009) suggest that where an organisational unit is committed to knowledge creation and conversion, practitioners remove barriers, such as lack of time and resources, to enable the innovation to happen. Lack of time has been demonstrated to be a barrier to sharing knowledge (Hu and Randel 2014), although “not having time” here was instead created as a barrier.

Participants in both Haslem and the North felt that training others enabled them to concentrate on the more complex aspects of their roles. Qualified healthcare staff can spend a large proportion of their time performing tasks that they do not have to do (Mackey and Nancarrow 2005; Dubois and Singh 2009) and the use of assistant staff can free them up to perform more complex tasks (Moran et al. 2011). Participants in Haslem and the North did not identify the time taken to provide training as a barrier, reflecting a shift to more of a training role. As Carla, the community dietitian in Haslem, says:

“So you’ve got to be – ‘Well what can I do more effectively and is there something that if I stop doing and put that time to something else I could achieve a lot more?’ ‘No I haven’t got time to do this, well is it important that I do this and is there something else that I could do that might be a lot more effective than this?’ Or ‘Why am I doing this, is it just ‘cause I’ve always done this and people have said this is the way you do it?’ (460 – 465) ...it’s up to the service or whoever to think right ‘Well which is the best avenue that I can put all my effort in?’ And to me, getting people who can help in a similar role to yourself by sharing and passing on those skills has got to be time saving.” (469 – 471)

Cheryl, the dietitian in the North, was even more vocal about the benefits of working in this way:

“We’ve got a waiting list through the door, you know, yes dietitians are protective but you’ve got to look at your role as a dietitian and if you can empower other people to take on that real basic stuff you’re a more efficient service and the patients you are seeing are the most appropriate that you should be seeing... (326 – 329) Well actually, you doing that is going to help your work level when you get those patients in they’re more what you need to do.” (481 – 482)

She could not understand why dietitians would continue to work in a more traditional way, having experienced the benefits of working in this new way.

“But it does my flippin’ head in when I see on it moderate was referred to a dietitian, high risk was referred to a dietitian and then it’s ‘oh we’re rushed off our feet, we can’t cope with nutritional screening’. Well no wonder because you’ve put in place refer to a dietitian but actually why can’t you facilitate staff to put in place that first line?” (461 – 464)

Participants in Haslem viewed their way of working as giving them more time. As Carla, the community dietitian, says:

“I think you’ve got to be realistic about what you can achieve because everybody, not just dietitians, not just NHS, everybody’s overworked aren’t they and they’ve got too much to do.” (458 – 460)

This sentiment was shared by her manager, Sharon, who had started using assistant staff many years ago:

“I think it was me recognising that, that I was the manager who was haring round like a maniac that in actual fact if I skill mixed, trained the person and clinically supervised them we could manage this process a lot more effectively and a lot more efficiently.” (152 – 155)

Gail, one of the SLTs in Haslem, felt that their time was better used focussing on the more complex patients, and that assessing and reviewing the less complex cases was not a good use of their specialist skills:

“But we’re definitely moving towards that ‘cause there’s so much routine stuff like that. I mean the minutiae of whether somebody can go from puree to forked mash or they’re struggling with forked mash and they need to go to puree. It doesn’t, you know, nurses have that skill, it doesn’t take... You know that’s why they’ve put people on stuff already. It’s definitely going to that and we’re going to be doing the more complex stuff, definitely.” (181 – 186) (Gail, SLT, Haslem)

In Haslem, the SLTs had realised the benefits of investing time in their Dysphagia Trained Nurse (DTN) project, in order to release time for more complex work. Both Linda and Michelle, SLTs in Haslem, viewed the way that they were now working as saving time for SLTs, thus allowing them to focus their tacit skills and knowledge on the more complex patients.

“...this is a good way of managing our patients, we have the skills to be able to do this and for these patients we can provide that skill and where the therapists who have a different and enhanced skill, you know, we can actually get them to

focus on those patients that we know we can't manage." (218 – 221) (Michelle, hospital SLT manager, Haslem)

The initiative also released time previously spent reviewing the more routine patients.

"...the first thing that they do ... they ring the nursing home, see if they've got a dysphagia trained nurse and see if that dysphagia trained nurse can manage the case and if they can that referral doesn't come to us. If the dysphagia trained nurse feels that she can't for whatever reason, whether they're complex or multiple comorbidities then the referral comes to us. And so we'll go out and see them and then if we can pass it over to the dysphagia trained nurse after that, we will." (217 – 223) (Linda, SLT, Haslem)

Michelle, the hospital SLT manager, saw the time spent in training nurses as a good investment of their time:

"And there is this competition between having the foresight to see if we invest the time in this now that's going to have a longer term impact on how we do things when particularly the more front end things become as far as acute hospitals are concerned and the greater the pressure to see people, to get them out of hospital, get them discharged ... (442 – 445) I think it's the right thing to do..." (460 – 461)

The dietitians in Haslem had experienced similar benefits from investing in training assistant staff:

"We would only deal with the ones that were high risk, priority patients. (180) And we have another one who, another dietetic assistant, who assists with the oncology team, so she will go down and monitor one or two of the patients who may be coming back to chemotherapy or radiotherapy who have been started on supplements by the dietitian. So she will go down and follow them up. And that's the sort of thing that we've sort of tried, 'cause again it means that the dietitians can deal with the new people that are coming through the system and the ones that may be a little bit more time consuming and difficult to deal with. And that again is using their skills where they're most needed." (233 – 239) (Phoebe, hospital dietetic manager, Haslem)

## **8.6 More appropriate referrals**

Participants in Haslem felt that transferring skills and knowledge to other types of workers also resulted in more appropriate referrals, as they were now able to manage the less complex patients.

"So, you know, it's been from our point of view it's saved on some, not necessarily inappropriate referrals but referrals that could be managed by somebody else." (176 – 177) (Linda, SLT, Haslem)

Increasing the skills and knowledge of other types of worker meant that those workers now had a greater understanding of which conditions and situations were complex, and which less so, and were able to manage some cases until SLT review.

“So in some cases it means that you don’t have to go in immediately or that you’re going in at a more appropriate time...” (214 – 215) (Emma, SLT, Haslem)

The SLTs were also able to provide a rapid response service, through releasing SLT time from dealing with less complex patients.

“...one of the aims of it was to look at whether it was possible to, by up-skilling dysphagia trained nurses in nursing homes, it would release speech and language therapy time to be able to respond more rapidly to urgent, um, referrals in the community cos we don’t have a rapid response service at the moment...” (525 – 528) (Lauren, community SLT manager, Haslem)

Even Susan and Olivia, SLT managers in Billington, could see that time was being released from the small beginnings of nurse training that they had only recently started.

“That we’re looking at numbers, we’re saying it hasn’t reduced referrals. Has it reduced inappropriate referrals? Possibly. For BH, it has. Yes and MC, definitely yes.” (722 – 730)

The dietitians in Haslem also felt that this way of working had improved the appropriateness of their referrals.

“But we’ve certainly noticed I think that the, um, the number of referrals from the nursing homes in the city, where they’ve put more training in, um, the referrals have been a lot more appropriate, certainly... (968 – 970) So that we’re only brought in at the high risk...” (1333) (Carla, a dietitian, Haslem)

Jenny, the commissioner in Haslem, could see these same benefits in the way that the DTN programme ran in Haslem:

“In Haslem you’re covering big geographical areas so even the sheer practicality of going out and visiting takes time etc etc, where if you’ve got more people sort of on the ground in the locality in that care home they can do some of that first level stuff, so you actually know that when you get a referral it’s, if you like, a good and appropriate referral and you’re not going to journey all the way to AH or somewhere to find actually all they needed was...” 326 – 330) (Jenny, commissioner, Haslem)

Previous research with twenty intermediate care teams (Nancarrow et al. 2010) demonstrated that the use of support workers enabled qualified staff to spend a greater proportion of their time attending to patients with higher care needs.

Carla also felt that working in this way had reduced their referral rates:

“Um, and if they can do then, then that could perhaps reduce our referrals by about 50 per cent... (1328 – 1329) (Carla, a dietitian, Haslem)

Other participants, however, did not report a reduction in referrals from transferring skills and knowledge to other types of worker. If anything, there may have been a sense that it increased demand through raising awareness. A significant increase in attitude towards the importance of dysphagia following a dysphagia training programme in nurses has been demonstrated by other researchers (Ilott et al. 2013). Other participants in Haslem, and also the dietitian in the North, were categorical that other departments should not adopt this way of working in order to reduce referrals:

“So it does release some, but you know, in terms of doing you out of a job, you know referrals are just massive and we’ve got a 27% increase in referrals so it hasn’t stopped the numbers coming in.” (223 – 225) (Linda, SLT, Haslem)

“Well let’s just say we still have referrals through the roof in our department despite the fact of having these in place. So it hasn’t negatively impacted our service and if anything the more proactive people are by screening, the more you’re going to pick up malnutrition, the more you’re going to use supplements, the more you need dietitians to review people, you know what I mean?” (410 – 414) (Cheryl, a dietitian, the North)

Whereas this can be perceived as a benefit, in that you are not “being done out of a job”, it does raise issues of demand management through raised awareness that should be considered.

### **8.7 Greater professional/ clinical impact by reaching a greater number of patients**

Another perceived benefit of shifting the line between explicit and tacit skills and knowledge for participants in Haslem, was being able to reach more patients. By codifying a greater proportion of their skills and knowledge, they were able to “have a greater clinical impact”. For example, Carla, the community dietitian in Haslem, spoke of being able to reach more people by working in this way:

“Yeah because it just makes logical sense if you think there’s three of us and there’s only two dietetic assistants. (166 – 167) ...three or four people can’t do it. If we’re going to have an impact it’s sharing those skills.” (171 – 172)

By starting to use more assistant staff, the dietitian in the North was also able to spread her service much wider throughout the county:

“So I had a DA working with me three days a week that over the years ...their role evolved gradually over time until actually why are we doing this, why can't they do this? You know, let's release dietitian time. And as a result of that we were in the south of the county and then we went county wide...” (195 – 198) (Cheryl)

She describes gaining satisfaction from the wider impact that the programme has had, by enabling her to stretch the resources to reach a greater number of people.

“I get nurses that come up to me saying ‘Cheryl I can tell the moment I pretty much walk in a door whether it's been a Focus trained home or whether it's not.’ ‘What do you mean?’ ‘You're walking in the door and probably within five minutes of being in that home I can tell whether it's a trained home, it's a huge difference in the home straight away, you can tell it.’” (929 – 932) (Cheryl, dietitian, the North)

This quote also demonstrates the positive feedback on this way of working that Cheryl is receiving. Parker (2014) describes feedback on the impact of changes to those a job effects as influencing “prosocial” (p. 699) behaviour, i.e. the desire to benefit others. The SLTs, too, spoke about improving dysphagia care more broadly in the nursing homes with dysphagia trained nurses:

“Yeah they're [dysphagia trained nurses] brilliant for the patients and their whole knowledge and awareness of dysphagia within that nursing home if they've got a dysphagia trained nurse is so much better and therefore that can only be good can't it for the patient.” (288 – 290) (Linda, SLT, Haslem)

Karen, one of the SLTs in Haslem, was working there before the scheme started, and remembers the work pressures and the waiting times for patients.

“Um, well what would, what used to happen in the good old days (interviewer laughs) when I first started, um, patients were nil by mouth for perhaps ten, twelve days waiting for us, um, because you couldn't cope with that number, of volume.” (697 – 699)

## **8.8 Greater job satisfaction**

The result of being able to focus one's expert skill on complex patients, and having a greater clinical impact, was greater job satisfaction. As Carla, the community dietitian in Haslem, states:

“Because you spend a lot of time at work and if you're not enjoying it a) you don't do as good a job and you don't get the benefits and the rewards so, keeping the spark going, you know thinking that you're doing something.” (280 – 282)

Gail, one of the SLTs in Haslem, thought that referrals for non-complex dysphagia patients wasted her time.

“... it just irritates me and I just think my time with the skill set I have could be spent far better seeing people who have complex swallowing difficulties that need a lot of skill.” (196 – 198)

On the other hand, Linda, one of the SLTs in Haslem, suggested that this shift to a more complex caseload may not be entirely beneficial:

“Yeah, I think we do feel that we’ve probably got more complex cases. We don’t get as many classic, easy wins if you like. Sometimes it’s lovely when you’ve got such a busy complex caseload to actually go to a nursing home where it’s a straightforward person with dementia that you can deal with quite easily, but those are getting less.” (252 – 255)

Dubois and Singh (2009) refer to the effect of increasing complexity specifically for doctors as tasks are increasingly shifted to nurses – doctors are often deprived of the breaks provided from the less complex patients (Brown et al. 2011). The need to intersperse complex tasks with less demanding ones has been highlighted by organisational researchers, particularly as work becomes increasingly complex and mentally demanding (Parker 2014). Raja and Johns (2010) demonstrated reduced worker performance with higher scope jobs in those who already scored highly in neuroticism as measured using the Big Five personality traits model.

In this study, results on the effects of sharing skills and knowledge with other types of worker on job satisfaction were conflicting. In the first phase of the study, some participants perceived that sharing skills and knowledge, and thereby perhaps losing one’s specialism, might result in less job satisfaction. For example, on discussing broadening her own role, Rachael, a dietitian in Billington, had this to say:

“...that’s your skill area that you learn to do and I suppose that’s what makes your job worthwhile, so if you can’t then do something then maybe you wouldn’t get as much fulfilment from your job...” (364 – 366)

This conflicted with participants in Haslem, who viewed having a greater impact and focussing on the more complex patients as giving them greater job satisfaction. For example, Philippa, an SLT in Haslem, did not feel that nurses performing more of the less complex dysphagia work had impacted upon her own job satisfaction.

“I don’t think as a, sort of a broad thing you’d miss out on but say you know, for example, in...I suppose in stroke, you know, building up specialist skills in terms

of evidence base around aphasia and dysphagia and all those things. (1194 – 1196) I love, yeah, I'd love to know everything about everything but it's just not possible and you know, I wanted to be a speech therapist because the communication and the swallowing side of things really interests me." (1202 – 1204)

Phoebe, the hospital dietitian manager in Haslem, echoed these thoughts by saying:

"And I would say there's a fourth one there, as in staff satisfaction because if staff are doing stuff that they feel that they are getting benefit from doing it and enjoy doing it, rather than having to do constant following up of patients and that sort of thing, whereas they can concentrate on their areas of speciality that they should be doing and you get better staff satisfaction as well because they can do the job that they set out to do rather than spending half the time doing something that really they don't want to be doing." (281 – 286)

Carla, the community dietitian in Haslem, felt that job satisfaction came from moving things forward and making a difference, which codifying and transferring skills and knowledge had afforded her. Developing and expanding a service was found to be a motivating factor by Read et al. (2001) and Collins et al. (2000). Carla says:

"It's to do something different, to keep us as a team because if we're just doing the same things – going to the local hospitals once a fortnight, going to the nursing homes, we need to have that push of an ongoing project that you've got a fired up interest about as well as the routine stuff. And I was doing that 'cause the two dietetic assistants that I've got are brilliant, well you've met them, they're first class and I want them to carry on enjoying the job, not to get bored and you know '(sighs) I've done so many calls today', it's not the job satisfaction that you want. So we always try to have a new project ongoing..." (261 – 268)

Cheryl, the dietitian pushing the line in the North, also thought that job satisfaction came from making a difference:

"And you get your practice nurses saying when we've done like nutritional championing, they'll be 'You know what, I've spoken to the care home and they do exactly the same things that we do and they're doing the same things and I speak to the community nurse and she's doing the same the GP's doing the same' and I'm like yeah that's what it's supposed to be like, that's what joined up, seamless working is like. And then you think that's because of Food First, that's what we've achieved as a team, we've done that." (932 – 938)

In contrast, Rachael, a dietitian in Billington, felt that fulfilment came from being highly skilled.

"I suppose you go into a job for a reason don't you and that's your skill area that you learn to do and I suppose that's what makes your job worthwhile..." (364 – 365)

Although Heather, an SLT in Billington, enjoyed dysphagia work, she was frustrated at providing an “assessment and advice” service only. The demands on her time for dysphagia assessment and management planning meant that she did not have time to provide communication nor dysphagia therapy: “The therapeutic side is quite minimal...” (31)

One explanation for this dichotomous view in Haslem and Billington may have been the sense of control over changes to one’s job (Parker et al. 2006; Vough and Parker 2008), referred to in Chapter 5, as “change having to come from within”. Self Determination Theory (STD) (Parker 2014) tells us that a sense of choice over changes, as when initiating the shift in the line that has been drawn between explicit and tacit skills and knowledge in this research, can motivate employees. If the change is foisted on a professional group, they may feel a loss of control of the initiative, and thus less job satisfaction.

Dubois and Singh (2009) note that role enhancement, or increasing the breadth or a worker’s tasks, can lead to greater job satisfaction in the healthcare setting, as this increases the worker’s control and responsibility and thus, motivation. Humphrey et al. (2007) found that task significance is positively related to job satisfaction in their meta-analytical review of motivational, social and contextual work design features. They also found some evidence for a relationship between job complexity, information processing and job satisfaction, suggesting that more complex jobs may provide greater job satisfaction.

The process of change that had occurred in Haslem, led by the professional groups themselves, may therefore improve job satisfaction. This then impacts upon the perceived benefits of the change, facilitating further growth and development of the process.

## **8.9 Job satisfaction and professionalism**

The normative nature of “professional and occupational socialization” (Evetts 2003, p. 401), whereby “uniprofessional” training (Evetts 2013) continues to foster a sense of belonging to a professional group and a professional identity, may also have influenced these findings. A sense of belonging is a known facilitator of job satisfaction (Parker 2014), although interprofessional education (Nancarrow and Borthwick 2005) can help to foster a client rather than a profession-specific blurring of professional boundaries (Khalili et al. 2014). Alternatively, the results found in this study may simply reflect the multifaceted nature of job satisfaction (Spagnoli et al. 2012). Despite this complexity,

understanding the components of job satisfaction is important in healthcare settings, as these can impact directly upon attitudes towards change (Laker et al. 2014).

If feelings of internal control over a job enrichment can help facilitate a “promotion versus prevention regulatory focus” (Higgins et al. 1997) and a sense of professional belonging provides normative structure to one’s perception of job role, then this highlights further that changes have to come from within the profession(al)s. Adler and Kwon (2013) suggest that the professional bodies can influence the universities and thus, those receiving their initial training. Although the universities do play a part, it has been demonstrated here that the fundamental shift must come from the professions. As Grace, one of the professional body representatives, says:

“Yeah we talk about this with the HI’s, the problem of course we face is that somebody goes out on a placement and they’re in an environment that’s totally counter to what you’re trying to shift them to, they’re back at square one. So I think you’ve got to shift; you’ve got to do both cultural shift and change management within current services, but then also change the mindsets of people coming out. If you just do one without the other you’re not, you’re going to fail basically, or we will fail. (319 – 324) ... we need both, you know the post-reg and the pre-reg training to be in harmony really if we’re going to shift the way of working.” (325 – 327)

The positive effect of starting to use assistant staff, certainly in the dietetic services in Haslem, may also be explained by “in-group” and “out-group” team dynamics. Phoebe, the hospital dietitian manager in Haslem, was more comfortable with the concept of sharing skills and knowledge with other types of worker, when these workers fell under the auspices of the dietetic department, or the dietetic “in-group”.

Written in 2006, the *BDA Guidance Document on Extended Scope Practice* suggests that “role extension and new ways of working” (p. 3) are needed in order to provide patient centred care. The authors acknowledge that, although some of their members “may see extended practice as an erosion of the profession” (p. 8), for others, role extension is an opportunity for the profession to continue to evolve. Despite these positive statements, the *Professional Leadership Policy Statement* (2012) still sees dietetic services being managed uni-professionally, e.g. by a dietetic professional lead employed within the organisation, although it does specifically mention that dietetic assistants are likely to be employed within a dietetic department. This suggests that the profession sees this development as par for the course, but also that the profession may be more comfortable if extended roles are managed within the profession itself. Phoebe, the hospital dietetic manager in Haslem, had pushed the boundaries of the tasks that their dietetic assistants were performing considerably. Despite this, when

discussing whether an SLT or a nurse could take a greater role in nutritional management, she had this to say:

“I think it is around, um, having the correct knowledge and skills to do it and, um, maintaining those competencies, um, ‘cause in a sense I suppose what I’m thinking is it, it takes us four years to train as a dietitian, um, to get all the information that we need to be able to do things. You’re not going to be able to give that same degree of, of knowledge and skills to somebody, um, in a short period of time to take, take on some of that role.” (587 – 591)

Although Nancarrow and Borthwick (2005) refer to this as “discarding” the “dirty work” (p. 899), the professional group does retain control over how the work is carried out (Evetts 2003; Evetts 2011). Ultimately, by maintaining supervisory control over the area, the professional group reinforces their professional dominance in the clinical area (Currie and White 2012). Phoebe, the hospital dietitian manager in Haslem, put it like this:

“So we I suppose in a sense have used our dietetic assistants and I think a lot of people are perhaps happier doing that than handing it over to a member of the nursing staff.” (215 – 217)

Some researchers have found that the boundaries between professional groups can be manipulated so as to include more diverse professions within the “in-group” of trust (Eckel and Grossman 2005), so that they are no longer perceived as a threat to professional identity (Currie et al. 2010; Mitchell et al. 2011) nor social identity (Steele et al. 2002). Huby et al. (2014) demonstrated the changing nature of in- and out-groups in professional boundary disputes specifically in the UK health care setting. Their study explores professional boundaries between hospital and community managers, specialist nurses, GPs, consultants and GPs with a Special Interest (GPwSI's) in respiratory care in five different geographical arenas. The different groups would at times sit on either side of the in- or the out-group, and the group member's position could change over the course of time, as each project developed. On the other hand, others have suggested that group dynamics are more complex than simply in-group and out-group dynamics (Hornsey and Hogg 2000), and that individuals may locate themselves within different groups simultaneously. In this sense, assistant staff may be located within one's in-group or may be located within the group of the dietetic department (and hence therefore trusted to be one of us), without necessarily being included within the group of dietitians *per se*.

Hornsey and Hogg (2000) suggest it is important to maintain subgroup identity to prevent defensive reactions to subgroup identity threat. Maintaining group identity may

help to dissipate social identity threat, a response that people are “highly attuned to” (p. 153):

“...rather than trying to eliminate status differences, each group’s areas of expertise should be recognized but equal value accorded to dimensions favouring each group.”

Loss of group cohesion can be seen as a loss of resources that contributes to resistance to change (van Dijk and van Dick 2009; Dubois et al. 2014). For nurses and occupational therapists in extended roles, job satisfaction in the new role is significantly related to feeling part of your own, original professional group (Collins et al. 2000). Preventing subgroup identity threat and loss of group cohesion may thus be part of the solution – extending professional identity to a wider group of workers, such as assistant staff and nurses trained under one’s own professional auspices – rather than aspects of a role being relinquished to another type of worker altogether. Rachael, one of the dietitians in Billington, refers to this when she suggests that it would be less of a threat if “...they weren’t not doing it, you weren’t taking over the role just assisting...” (366 – 367).

#### **8.10 Other perceived benefits, intrinsic rewards and awards**

There were other perceived benefits that continued the shift in the line between tacit and explicit skills and knowledge. These included benefits to patients other than having a greater clinical impact, discussed earlier in this chapter. For example, Linda, one of the SLTs in Haslem says:

“At the end of the day it’s all about delivering what’s best for the patient isn’t it? That’s what we’re all here for and I think if you could skill up your DTNs so that they can offer something that you can’t earlier than you can and, then great.” (428 – 431)

When pressed further on the line that had been drawn by colleagues in Billington, she went on to say:

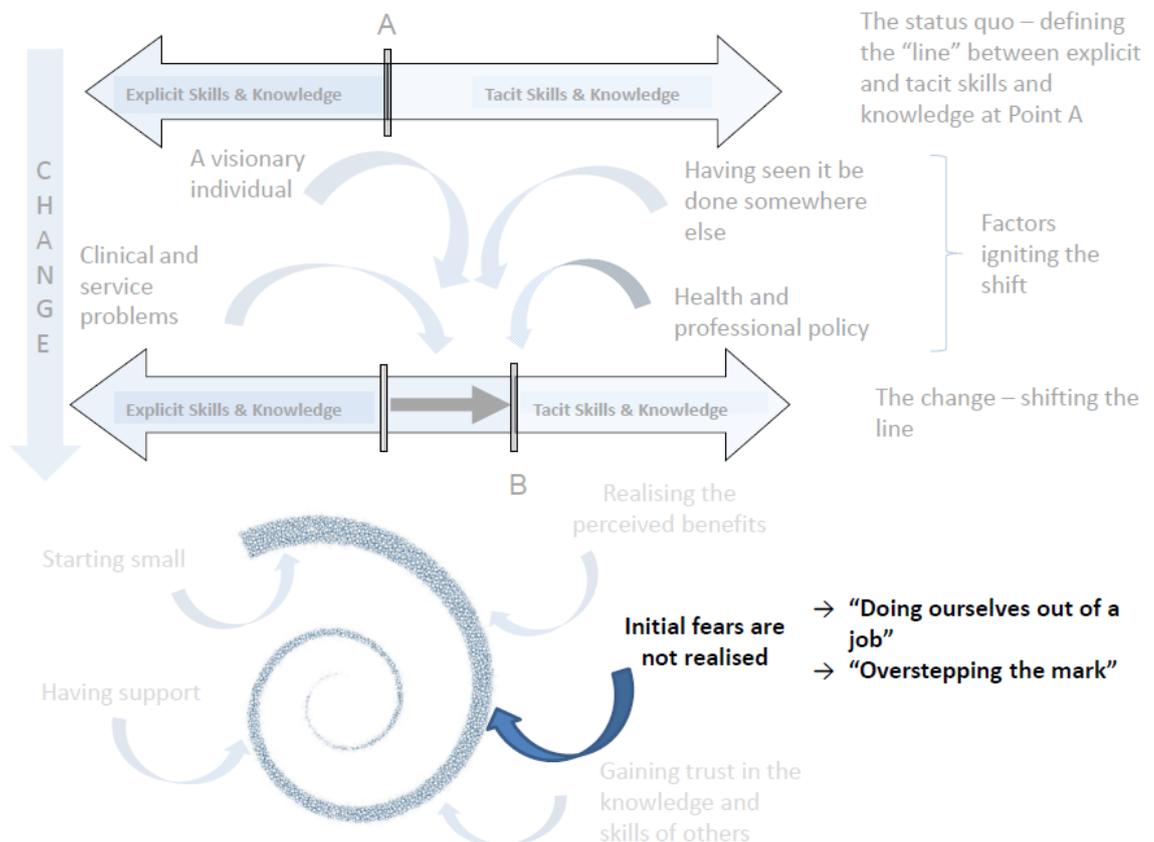
“It’s for patients’ benefit and that’s the bottom line.” (625)

The effect of intrinsic motivation and rewards, particularly on creativity and sharing of tacit knowledge, are well documented in the literature (Osterloh and Frey 2000). Receiving external recognition and awards was also a factor in sustaining the shift. For example, the SLTs in Haslem had won a prestigious national award. Cheryl too, had won many awards for their project. In the sphere of knowledge creation, some researchers have identified the lack of extrinsic rewards as a barrier to knowledge

sharing (Perez et al. 2014) and extrinsic incentives can facilitate knowledge sharing between team members (Hu and Randel 2014), whereas others (Politis 2001, 2002; Bryant 2003) demonstrated that the satisfaction of higher goals may be more effective in knowledge processes. Extrinsic rewards may even be detrimental to knowledge sharing (Bock et al. 2005). Higher goals and intrinsic rewards in the context of this research are the concepts “having more time to focus one’s skills and knowledge on the more complex patients”, “more appropriate referrals” and “having a greater professional/ clinical impact”. Such higher order goals may motivate people more than extrinsic rewards (von Krogh et al. 2012).

### 8.11 Initial fears are not realised

The third factor sustaining the shift in the line that had been drawn between explicit and tacit skills and knowledge, was that initial fears associated with codifying and transferring skills and knowledge were not realised. These initial fears included “doing ourselves out of a job” and staff to whom skills and knowledge are transferred “overstepping the mark”. These factors are depicted in the diagram below:



**Figure 23:** The initial fears of codifying explicit skills and knowledge are not realised

### 8.12 “Doing yourself out of a job”

The concept “doing ourselves out of a job” featured as a significant concern and a barrier to greater codification of skills and knowledge amongst SLTs and dietitians in Billington. In discussing passing on some of the dietetic assessment to SLTs, Rachael, one of the dietitians, expressed concern at the potential loss of her job role.

“And I guess does it eradicate your role from the team if somebody else can do your role?” (388 – 389)

Linda, one of the SLTs in Haslem, also expressed this concern amongst her colleagues.

“So I think some of us would perhaps feel that more knowledge and skills can be passed onto nurses and other therapists probably feel that that is very much the role of speech and language therapy and shouldn’t necessarily be, part of that role shouldn’t necessarily be given over to other professionals when in a sense it kind of does you out of a job, you know what I mean? (45 – 49)

Although Michelle, the hospital SLT manager in Haslem, did not subscribe to this view herself, she too could see that some SLTs did.

“And also there’s a sense of status associated with it that ‘I’ll lose my status if I allow...’ ‘What does it say about my role if a nurse can do it as opposed to me?’ (369 – 370) ...because that’s got the medical, clinical implications and consequences associated with it, that if we don’t keep good control over that then they won’t have us in hospitals anymore and lots of people will lose their jobs. Now that’s a fairly extreme way of thinking and you know I would hope there’s not many people around who really believe that’s going to happen, but I think there’s still an element of that...” (364 – 368)

Even for Phoebe, the dietetic hospital manger in Haslem, who had been using dietetic assistants in an expanded role for many years, had reservations about extending the role of the SLTs into the realms of nutritional assessment and management. These reservations were also based on fear of job losses.

“I think, uh, my main concern would be if you (pauses slightly) started extending roles and people got wind of it, they would then think oh well, we don’t need that profession anymore, therefore we can do without them, does that make sense?” (836 – 838)

Although she admitted that this had not been borne out in reality for her: “It didn’t happen, but I think there was that fear.” (116) Nancarrow and Mackey (2005) found that occupational therapists were concerned over job loss and whether those in management positions would assume that professionally qualified staff could be replaced with assistants. Despite this, there are no examples of where professions have disappeared through the redefining of role boundaries or tasks (Nancarrow and

Borthwick 2005). Sibbald et al. (2011) suggest that it is not possible for the original type of worker to be substituted – substitution can only ever be partial, for some tasks, and there will always be a need for the original worker. This view was supported in the New Types of Worker initiative (Skills for Care 2011), where an increased use of support workers only worked where it was felt that they were being supervised “back at base” (p. 13) by technically trained and qualified specialist staff, such as nurses, physiotherapists and occupational therapists.

Personal loss of some sort is a common reason for people resisting change (Lorenzi and Riley 2000), including fear of job security. Gray (2001) argues that the use of tacit knowledge repositories may disempower employees by reducing their bargaining position based on their discreet knowledge within an organisation. Employees may be disadvantaged if they lose control over distinctive areas of specialised knowledge (Currie et al. 2010). This was certainly a feature in this study. Sharon, the community dietitian manager in Haslem, remembers when she first introduced dietetic assistants:

“Nobody was outright ‘Oh do you think you’re doing the right thing?’ but you knew that ‘Hmmm not happy about having to lose dietetic time’ to skill mix. It was the protectionist of the profession. (164 – 166) ... Yes, fellow dietitians who weren’t having the work, doing the work that the dietetic assistants were doing, felt protective professionally that this was weakening the profession.” (177 – 178)

Cheryl, the dietitian in the North, had felt this fear from professional colleagues and that she was “doing dietitians out of a job”:

“Oh I’ve been accused of that loads of times, yeah.” (425)

Nina, one of the professional body representatives, was able to point to specific recent examples where departments and individuals were being put under the threat of job losses. She felt that this had mainly come about from not changing their ways of working, suggesting that departments that did change might avoid this fate.

“But until that challenge comes along unfortunately that’s what we’re seeing from the trade union part of our organisation when departments say ‘Oh we’ve had the letter saying we’re going to have to rationalise, we’re going to lose two posts, what are we going to do?’ And now the trade union are busy trying to save the jobs, absolutely, but if they thought about it when they did, when they had that person that left and they didn’t think strategically about they might move forward as a department, that’s why it’s happening.” (344 – 349) (Nina, professional body representative)

Despite these initial concerns, participants in Haslem, the North and the Midlands emphatically stated that this had not been their experience – codifying greater aspects of their skills and knowledge had not led to job losses. If anything, shifting the line and codifying more of their skills and knowledge had increased the demand for their services. They felt that demand was increased precisely because sharing some of their skills and knowledge raised awareness of their unique skill set and the importance and interest in dysphagia and nutrition. Michelle, the hospital SLT manager, could see that this demand would only continue to increase:

“No (laughing), if anything it’s the opposite, it’s always been like we need more” (400) (Michelle)

Michelle identified changing population demographics as an area for further development.

“Obviously with dementia increasing, with the elderly increasing, that’s a very well recognised issue as far as swallowing is concerned.” (407 – 408)

Demand for dysphagia services in other clinical areas notwithstanding, Karen was witnessing a dramatic increase in demand in stroke alone:

“We would not cope, particularly in stroke; the stroke service is expanding, expanding, expanding in the hospital in fact, um, I’m not sure how many beds they’ve got now in acute stroke unit but there wasn’t enough so they’ve now taken half the ward next door, as from next Monday.” (660 – 667)

Commentators have predicted an increasing demand for swallowing assessment and management services as the population ages (Kertscher et al. 2014). The cost of managing, as well as the cost of not managing, dysphagia is likely to produce an increasing economic burden to health care services (Miller and Patterson 2014). Whereas participants in Billington were worried about potential job and/ or role loss from transferring more of their skills and knowledge to other types of workers, participants in Haslem felt that working in this way had raised awareness of their respective fields.

The power invested in possessing specific skills and knowledge, and the unwillingness to share such skills and knowledge, has been demonstrated in the literature (see for example Hu and Randel 2014). It is not surprising that these fears exist in the UK health care system. Skill mix has been used in the past as a method of substituting more expensive, trained staff, for staff that are not professionally registered, and therefore less costly (McBride et al. 2005; Dubois and Singh 2009). “Demystification of

aspects of professional knowledge and expertise” (Evetts 2011, p. 415) is one factor linked to a shift away from professional autonomy and discretion towards organisational management.

Previous research also supports the notion that individuals are less likely to “give away” knowledge in a work situation if they are set to lose “one’s unique value” (Renzl 2008, p. 210). Researchers have also demonstrated a reluctance to share knowledge when there is a threat to professional status through the erosion of professional boundaries (“Professional identity threat”, Mitchell et al. 2011). Specifically, for SLTs, O’Brien et al. (2013) showed that fears over job security were a major concern for SLTs delegating clinical tasks to assistants. The fear of losing one’s unique value and professional identity threat can both be hypothesized to be very closely linked to the concept of “doing yourself out of a job” that developed in this research.

Despite these initial fears, participants who had codified and transferred some of their skills and knowledge did not experience a loss of their unique value nor a threat to their professional identities. For example, Linda, one of the SLTs providing dysphagia nurse training in Haslem, described the difference between the role of the SLT and that of the dysphagia trained nurse as follows:

“But I don’t think they haven’t got the appropriate skills to do it. The skills they’ve got involve them doing a basic assessment/screening and basic management and the same thing with like dysphagia therapy, you know we’ve got practitioners and we’ve got assistants who have short training courses but they’re always supervised by a clinician, they can’t make the judgements that you make, they haven’t got the theoretical background and they haven’t got the knowledge base that you’ve got after 3 years of training. So they do something differently, but they’re supported by you, so no we’re not suggesting that nurses are speech therapists... (676 – 682)

The literature also indicates a clear distinction between the role of the SLT and the facilitative role of the nurse in the area of dysphagia (see for example Hines et al. 2011). In many respects, although aspects of a role, or specific tasks within that role, can be codified and transferred to other types of worker, the complex nature of health care will always require deep expertise in an area and the ability to create new knowledge based upon that deep understanding, as well as the ability to link concepts from other fields of knowledge (Fraser and Greenhalgh 2001). It is therefore inconceivable that roles can be eradicated, although the nature and content of roles may be subject to change.

### 8.13 “Overstepping the mark”

The second initial fear expressed by participants in Billington was other types of worker “overstepping the mark”, e.g. going beyond the boundaries of their competence for the tasks and skills which they had been transferred. They could recollect accounts of when this had happened:

“... there was too much emphasis on chucking water down people. (609) ...Oh dear they're choking and blue!” (621) (Susan, an SLT, Billington)

Despite these fears, those to whom skills and knowledge were being shared were very clear on the boundaries of their competence. If anything, they appeared to be very cautious, a finding that is concurrent with the literature on role expansion. One of the disadvantages of transferring medical skills and knowledge to nurses and other types of worker has been an over-ordering of e.g. investigative tests (Sibbald et al. 2004; Laurant et al. 2005). As Margaret, one of the ward nurses who performs the basic dysphagia screening in Billington, says:

“And we would never upgrade someone ourselves. (1177) ... You know, I'm probably, um, over cautious (1031) ...well I don't know if I'm over cautious or if I'm as cautious as I need to be but if I had any doubts at all I wouldn't give them anything, I have to be completely confident, I wouldn't be happy if they started, you know, if we were asked to sort of do them on people that were, sometimes you sort of, you get a doctor come along and they will say to you, well can't you swallow screen this patient and we will say, well no we can't because, um, they've got a chest infection so we're not allowed to, and the doctor will sort of say, oh come on I, you know, I really want them swallow screened. And there have been times when we've actually said, well no we're not doing it, that's up to you; if you want to do then you do it, and you document in the notes that you did it but the nurses won't do it.” (1031 – 1083)

Alexis, one of the dietitians in Billington, had worked closely with the SLT on the stroke rehabilitation ward for a number of years. She had picked up a fair understanding of the recommendations, advice and assessment of the SLT. She admitted to making a few recommendations informally, such as recommending a chin tuck for a gentleman that she had witnessed “putting his head back” (497) and also making recommendations regarding “some of the utensils, um the nosey cups and things like that” (500 – 501). Despite this, she was very clear on where the boundaries of her skills and knowledge lay:

“I wouldn't dare do anything that I really shouldn't do because I've not been, um, assessed as being competent and all the rest of it (both laughing)... (518) ...if I was really unsure I wouldn't even go there at all, do you know what I mean, and I would straight away say you know 'Are you still under the speech and language therapist?' and if they are and yes they know the name and they

know the contact number then obviously I would suggest either they contact the speech and language therapist or would they like me to do it. ...” (533 – 537)

Betty worked with the community stroke rehabilitation team, a team that had been actively using generic assistant staff for some time, with a fair amount of role overlap. She too describes being aware of the boundaries of her own competence in nutrition:

“But if I feel they’re not sort of... If they’re not eating a range of foods or perhaps they’re not eating the things that may be best for them, I would pass it on to the dietitian for a more in depth and proper assessment and advice. I’d rather they were under the care of the dietitians than struggling, but it doesn’t come up too often, I mean generally just the conversation with people and making sure the carer’s aware so that the right things are being bought and the right things are being provided and there’s a range.” (501 – 509)

Susan, the SLT manager in Billington, had created and delivered a programme of training stroke rehabilitation ward nurses in the past. This programme enabled nurses to move patients through the consistencies, rather than wait for review by an SLT:

“...back in 1998 I, when we had hardly any speech therapists, I developed a project which was about dysphagia trained nurses, DTN’s and I did train nurses on the stroke rehab unit to move patients through consistencies so basically to pre-assess and move people with consistencies and that worked really well.” (1021 – 1024)

By her own admission, “when it worked well it worked really well” (112 – 113). Despite this previous positive experience, she still held fears that other types of worker might “overstep the mark”. Nancarrow and Mackey (2005) found that occupational therapists were reluctant to let go of clinical tasks until they “trusted” the assistant practitioner (p. 336). Issues around scope of practice have been reported in other assistant roles, including SLT and dietetic assistants (Wood et al. 2011). Rebecca, a dysphagia trained ward nurse manager in Haslem, and Lesley, one of the dietetic assistants in Haslem, were both very clear about the boundaries of their competence and where this “mark” lay.

“Yeah or you’d go perhaps for the safer option and then wait for SALT to come and review before you changed anything else.” (127 – 128) (Rebecca)

“But I would, if I was unsure, I would seek Carla’ advice... but I suppose I am always wary that I over-tread that mark, but I would never compromise a patient’s safety. If anything I’d probably go too safe so that I don’t seem to be stepping out of my remit as it were.” (539 – 540) (Lesley)

Participants codifying and transferring their skills and knowledge were also very clear on where those boundaries lay: “We have to make it quite clear, the boundaries of what they’re doing” (509 – 510) (Emma, SLT). Linda, one of her colleagues, goes on to say:

“I mean they have clear guidelines in their training as to who exactly they should and shouldn’t be managing and who they should pass onto speech and language therapy for assessment and why, you know, very clear criteria to make sure they don’t overstep the mark and do things that are not within their remit.” (77 – 80)

In relation to transferring tasks to assistant staff, the RCSLT (2003) sets a requirement that duties are only delegated that are within the competence of the assistant. The BDA (2012) also recommends that, when taking on additional tasks:

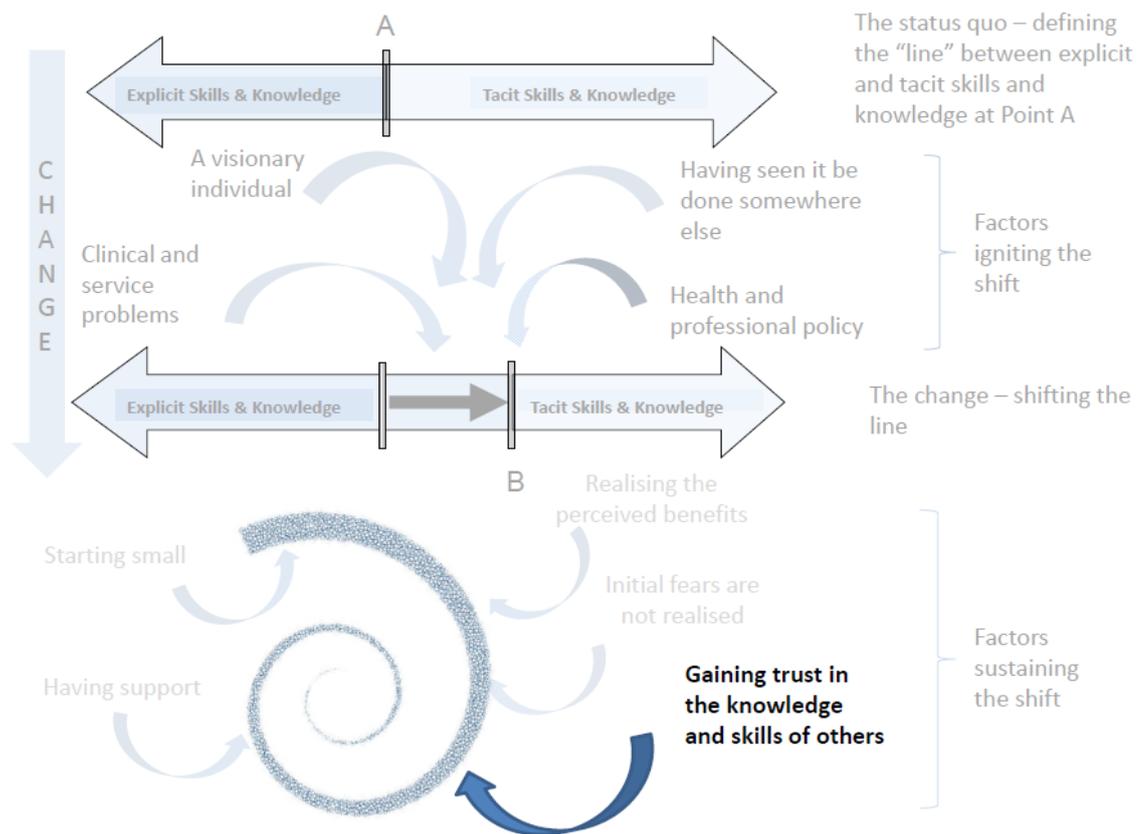
“It is important that the team/practitioner identifies clear boundaries which limit where extended practice will end and when further referral is needed. These boundaries should be clearly indicated in the supporting protocol.” (p. 6).

Both the SLTs and the dietitians in Haslem had incorporated clear boundaries into both the training and the associated paperwork, as part of the process of codification and transferring skills and knowledge. Linda, one of the SLTs in Haslem, demonstrates this point below:

“So they had quite a nice flow chart that they followed and obviously there were warnings and you know if the person was this, this and this then you refer these to speech therapy, these you managed in this way and so on. (128 – 130) I think they’re aware of their competencies and when to refer on and the form tells them when to refer on so we’re not expecting them to be able to manage everything, we’re expecting them to sort of screen your simple dysphagias and offer some early management.” (447 – 450) (Linda)

#### **8.14 Gaining “trust in the skills and knowledge of others”**

The process of shifting the line that had been drawn between explicit and tacit skills and knowledge was sustained in part through gaining “trust in the skills and knowledge of others”, e.g. other types of worker, as depicted in the diagram below:



**Figure 24:** Gaining trust in the knowledge and skills of others

Not having trust in the skills and knowledge of others created a barrier between professional groups, or a reason to not share skills and knowledge:

“That’s where this kind of mutual you know, I would ask a physio for advice, or they would ask me and we’ve got this kind of understanding that’s what your role is...” (754 – 755) (Harriet, dietitian, Billington)

Trust has been shown to be an important factor in both knowledge transfer and knowledge creation (Nonaka and von Krogh 2009), as well diffusion of innovation and innovative practices (Adler and Kwon 2013). An organisational climate of trust also plays an important role in employee intention to share knowledge (Bock et al. 2005; Chen et al. 2012). Both Hansen (2002) and Renzl (2008) demonstrated that trust in management facilitated the documentation of knowledge. Trust in the competency of assistant staff is an important factor in the types of tasks qualified staff will delegate (Moran et al. 2011). Currie, Finn and Martin (2010) found that the gradual gaining of trust in the skills of genetics nurses enabled the consultants to relinquish ever more control to the post holders.

Trust in others specifically in the sphere of knowledge transfer has been described as having two aspects (Chowdhury 2005): 1) affect-base trust, and 2) cognition-based trust. Affect-based trust refers to the degree to which one has trust in the intentions of the person to whom one is entrusting knowledge. Affect-based distrust has certainly been linked to “knowledge hiding” (Connelly et al. 2012, p. 64). In this study, affect-based trust could refer to trusting that the person to whom you are transferring your skills and knowledge will not misuse that knowledge, to undermine your position or “do you out of a job”.

Cognition-based trust refers to the trust that one has in the skills and abilities of another. The public places their trust in the knowledge and skills of professionals in this way (Evetts 2003; Evetts 2011; Khalili 2014). As Steven, a service user who had just started to eat and drink, says:

“I’m in their hands, I’ve gotta trust the name... (964) ...you’ve gotta trust them, you’re here, that’s what hospital is, you’re here for their expertise.” (973 – 974)

Chowdhury (2005) demonstrated that both affect- and cognition- based trust impact positively with knowledge sharing between individuals and within a work group. Van Wijk et al. (2008) corroborated the importance of trust in knowledge sharing between work units in a more recent review, while Parker et al. (2006) reported that co-worker trust mediated proactive work behaviour. Siemsen et al. (2009) found that “psychological safety” facilitated knowledge sharing between receiver and recipient. In the study presented here, trust in the skills and knowledge to whom one was transferring those skills and knowledge was important. It seemed that participants in Haslem who were “giving away” skills and knowledge had a greater level of trust in the skills and knowledge of others. Lauren, the community SLT manager in Haslem, puts it like this:

“Because you trust that DTN, you’ve got that working relationship, you’ve seen how they’ve worked, you know that they’re competent and you tell from the conversation that, you know, they know what they’re talking about. There are others you ring and you think, oh my God she doesn’t know what’s she doing (emphasis in voice) and I need to go and see that person...” (897 – 900)

A similar level of trust existed between the community dietitian, Carla, who was “giving away” skills and knowledge in Haslem to assistant staff. This trust was related to the dietetic assistants not overstepping the boundaries, explored in the previous section:

“Because they both know where their boundaries are and they would never step over them and I trust that. So that’s as much due to them as in personalities

because I can see other people in the team who would clearly step over boundaries. No, they know exactly what their roles are and that gives me the confidence.” (370 – 373)

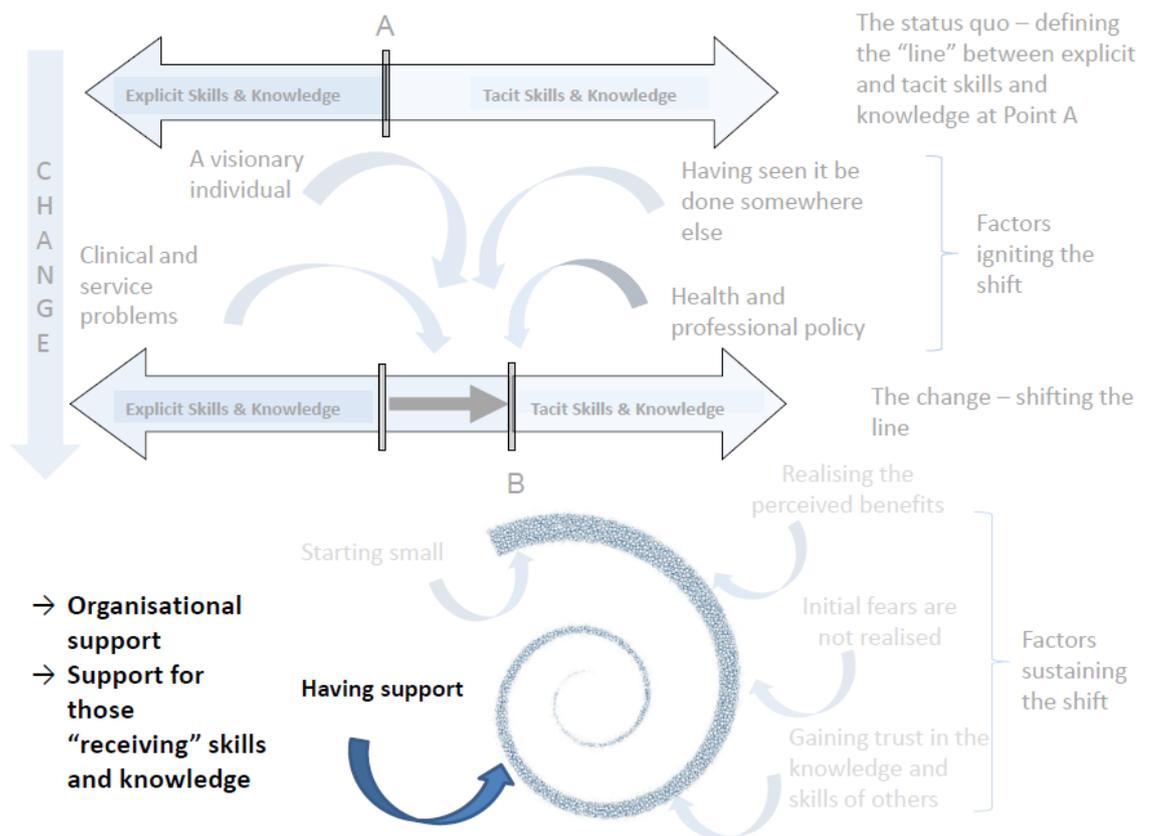
Participants in Haslem may have started off with a greater base level of trust in the skills and knowledge of other types of worker. Siemsen et al. (2009) found that 67% of “psychological safety” was due to individual, e.g. personal, differences, explored in the section “Personalities”. Alternatively, they may have gained this through their experience of transferring skills and knowledge. Contrast the starting position of Susan, the SLT manager in Billington, with that of Poppy, an SLT in the Midlands, who was extending the skills and knowledge of nurses in dysphagia management:

“When they came in with the headset that fundamentally it was all a bit of a fuss and they’d been feeding patients for years and you know, if they cough, thicken the fluids. (1330 – 1331) You don’t feed them the wrong food, stood over them with their head tipped back as you shovel it down while you’re talking to your colleague. Now that all sounds like common sense but actually it’s not common sense, it’s not... (1363 – 1369) I think the basic problem is that you don’t know what you don’t know. So somebody can watch me go out to a nursing home, ten people have been referred that are coughing when they drink and they will watch me put some of them on thickened fluids. So there is now this if somebody coughs give them thickened fluids.” (217 – 220) (Susan, SLT manager, Billington)

“...they...are experienced nurses, so they’re often ward sisters or senior staff nurses who have a lot of experience in the area they work in. So if you take stroke for that, the nurses that have been trained are stroke nurse specialists. So they come at it, they’ve been around dysphagia for a long time. (328 – 330) ...So they come at it that way where we’re coming at it that way and there’s no reason why we can’t meet at this point for the classic, straightforward non-complex cases.” (333 – 334) (Poppy, SLT, the Midlands)

### **8.15 Having support**

The departments that had shifted the line between tacit and explicit skills were emphatic in stating the importance of support in facilitating the shift in the line between explicit and tacit skills and knowledge. The concept of “Having support” took two different meanings in this research, as shown in the diagram below. The first was to mean support to pursue different ways of working, referring primarily to organisational support. The second meaning was support for those “receiving” the skills and knowledge from SLTs or dietitians, such as assistant staff and nurses. I shall examine each one in turn.



**Figure 25:** "Having support"

### 8.16 Organisational support

Having the support of at least one individual from more senior management was an important condition sustaining the shift in Haslem. Although the community dietetic manager initiated dietetic assistants without explicit support from senior management, both the hospital dietetic manager and the SLT manager referred to this support. Organisational support was an important condition for the dietitian in the North too. In her own words:

"You've got to use the champions... (712) ...who are those champions...? (713) I couldn't have done it without my champions to open up them doors." (717 – 718) (Cheryl, dietitian, the North)

Senge (2006) suggests that "...sometimes they [e.g. visions] emanate from personal visions of individuals who are not in positions of authority" connecting "...with the personal visions of people throughout the organization." (p. 200). Michelle, the SLT manager, refers to this as "find who your advocate's going to be" (538).

Kotter (2012) suggests that although it is possible for "a brave and competent soul" (p. 49) somewhere further down the hierarchy to lead a change in practice, they will

always require the support of at least one individual further up the hierarchy. Von Krogh et al. (2011) suggest that this support is necessary to provide access to resources that the frontline individuals creating knowledge cannot access themselves. More recently, Hammami et al. (2013) found that organisational support plays a significant role in “knowledge transfer activities”.

In Haslem, this “advocate” was necessary in both facilitating the SLTs to change their way of working, but also in allowing other, interdependent (Currie et al. 2010; Kotter 2012) parts to get involved, such as allowing the ward nurses to perform the extended dysphagia management and supporting them with time to train.

“It has to be signed up to by all the relevant people and the nurses clearly have to be on board with that. ... the matron is very much on board with it, she absolutely agrees that this has to happen, so that’s really helpful. And the managers above her, because of the standards that are set, they realise that that needs to be in place for that to work. ... We’re too small as a profession to make these things, you know, there are organisational issues inevitably in how this works and for the logistics to be put in place somebody beyond us has to say ‘Yes, that’s OK, we’ll make that happen.’” (575 – 583) (Michelle, SLT manager, Haslem)

Where this had not been the case, the initiative would fall down.

“... if their managers weren’t on board with it then they didn’t get the support to be able to carry on and sometimes the scheme fell down because they weren’t allowed the time to do it or to come to the updates that we were setting up or they didn’t feel that their manager was really interested enough to let them keep going...” (225 – 228) (Michelle, SLT manager, Haslem)

“Organisational support” could come in the form of support towards a department initiating a change of working, or could come as more indirect support through confirmation of the choices made.

“From the management point of view, when they’re looking at your department’s profile, if they see lots of members of staff who are at the higher grades they then start to think that it’s a very expensive service, whereas if you’ve got people of a much lower grade then it’s looked at slightly differently, so it helps from a financial point of view.” (255 – 258) (Phoebe, hospital dietitian manager, Haslem)

Support could also come in the form of more direct organisational encouragement, as in encouraging a department to make skill mix changes.

“Certainly every time we have a vacancy now, every time anybody leaves we are asked to look at that job and say do you need like for like? Or do you need something different?” (306 – 307) (Phoebe, hospital dietitian manager, Haslem)

This encouragement was perceived as support, rather than instruction:

“We weren’t told by senior management ‘Oh you’ve got a vacant post, it’s a band six, you will have...’ We made a conscious decision ourselves because we’ve seen the benefits of what dietetic assistants can do in the department.” (329 – 331) (Phoebe, hospital dietitian manager, Haslem)

Organisational support and approval from more senior managers was beneficial to those who had shifted the line, reflecting back on the services themselves.

Organisational recognition can certainly increase job satisfaction for those taking on extended roles (Collins et al. 2000). Despite the need for organisational support, it was also clear from participants in this study that the visionary individual knew how to make the best use of this support:

“I did my normal thing – went to the right people and said ‘Here I’ve had a great idea, what do you think to this?’” (980 – 981) (Cheryl, dietitian, the North)

Having organisational support seemed to be important in facilitating a shift to the new way of working, once the spark to do so had ignited. In this respect, participants referred to two main concepts: “pick your areas wisely” and “find your champions”. “Picking your areas wisely” refers to picking areas to start the shift where other managers are committed to the process.

“Finding your champions” refers to finding the person or people within the organisation who are in a position of more influence or authority to help you make the shift. This concept links to the concept of the visionary starting the process – the visionary found out **who** this or these champions were going to be and proactively went to them.

Michelle, the hospital SLT manager in Haslem, refers to how XY, the visionary, sought out the right people in the beginning:

“I’m pretty sure she had a conversation with somebody called GC who at the time was working within this hospital who was a therapy lead and she was always, she was very kind of open person, very keen to look at new ways of doing things – working smarter, being more efficient, not precious about ‘Oh you can’t do that because only those sorts of people can do that.’ ... And because she was quite high up within the management structure she helped to drive it.” (494 – 500)

In the North, Cheryl knew the importance of getting the right people on board:

“And things and chief dietary nursing was there and I managed to take our nurse who chairs our nutrition steering group and she came with me.” (541 – 542)

### **8.17 Support for those “receiving” skills and knowledge**

A crucial aspect to facilitating the process was that those who were “receiving” skills and knowledge felt supported. This applied to both support to dietetic assistants by dietitians and to nursing staff by SLTs, and was recognised as crucial for those codifying their skills and knowledge.

“I think staff want to feel supported don’t they? ... (180) ...both those areas get a lot of support from speech and language...” (262) (Rebecca, a dysphagia trained stroke ward nurse manager, Haslem)

“So I think it’s important to have some structure in place for the support role and I think they were new nine years ago, they were fairly new you know and fortunately Susan, our manager at the time, she was really into skill mixing and introducing them into our department, thankfully, and she was a brilliant mentor, brilliant...” (212 – 215) (Eve, dietetic assistant, Haslem)

Susan, the hospital SLT manager in Billington, who had run an advanced dysphagia screening programme for nurses in the past, felt the main variable in the success or not was in the amount of SLT support available:

“Whereas the other wards where I tried to hand over some responsibility, they either took too much or not enough and it didn’t work. And I do think that although it’s the same teaching and the same hospital, and actually broadly the same sort of patient group I think the difference was our presence.” (291 – 294)

The *RCSLT Standards for Working with Speech and Language Therapy Support Practitioners* (2003) specify the need for support to assistant staff under section 1.6.

This states that there must be in place:

“...a system for SLT support practitioners to access supervision and clinical advice from a speech and language therapist” (p. 6).

Lack of appropriate training programmes and support for workers taking on skills and tasks through role substitution or delegation has been identified as an issue (Dubois and Singh 2009; Nancarrow et al. 2010). Adequate training and support plays an important role in the satisfaction nurses and occupational therapists derive from extended roles (Collins et al. 2000) and the ability of support workers to take on extended roles (Skills for Care 2011). Despite these concerns, both the nurses taking on skills and tasks from the SLTs in Haslem, and the dietetic assistants delegated tasks from the dietitians, felt that they were adequately supported. Both community

dietetic assistants felt that they had the support that they needed and were clear on when they were allowed to make treatment decisions.

“But I would, if I was unsure, I would seek Carla’s advice...” (539) (Lesley, dietetic assistant, Haslem)

Lesley describes an example of having this support:

“I mean with this lady... (579) So I didn’t go straight running to Carla because I knew before she made any decisions she would want to see the food chart, she would want a double checking of the weight to make sure it wasn’t an error and she would want to know that they’re actually fortifying the food, which they assured me they are. So I know that she wouldn’t, if I went to her, which I did today but not yesterday. I went to her today and said I’ve done all that are you OK with that? (581 - 586) ...I just said ‘Oh by the way...’ and she said ‘No, that’s fine.’” (588 - 589)

Eve, the second dietetic assistant, describes both the formal and informal arrangements in place for clinical support:

“Before we used to do clinical supervision with Carla mainly, but saying that if Carla was on annual leave or there was an issue that couldn’t wait until Carla returned, I’d always just speak to a dietitian who was in the office at the time, and that’s what we’re doing at the moment. I think I’m having clinical supervision with most of the dietitians in the team. And I know they’re available, if we’re out and about and I’ve got a query I’ll just ring in or catch a dietitian.” (262 – 266)

Most of the training that assistant staff received in the early days was provided in-house:

“But I started you know quite new and then it was sort of in house training when I first started, I had loads of in house training and clinical supervision.” (12 – 13) (Eve, dietetic assistant, Haslem)

Eve, the longest serving dietetic assistant in Haslem, identified a lack of formal training opportunities as problematic when she first took up post:

“...last year I did the diploma, the level 3 diploma in Allied Health Professional Support and it was set for me for dietetics. Now I’ve waited eight years for that...” (153 – 154)

This is in keeping with Nancarrow et al. (2010), who found a lack of formal and/ or accredited training opportunities to be an issue for the increasing number of support staff in intermediate care services. This landscape is changing following the recommendations of both the Willis Report (2012) on nursing and the Cavendish

Review (2013b). Although focussing specifically on support staff in nursing, both reports highlighted the need for adequate training of support staff, but also recognition of the important, and increasing, role that they play in healthcare delivery. We can certainly see changes in this research, as Eve now reports greater access to more formal qualifications, much of which is now provided through the BDA.

Time and effort that has to be invested when starting to use more assistant staff (Nancarrow et al. 2010), particularly if much of this training is provided in-house by qualified staff. This may be reflected in the benefits perceived by participants in Haslem and the North and explain in part the growing nature of making the shift. They have made the investment in training over time, in incremental, small steps and have realised the benefits of this investment along the way. The initial investment happened some time ago in Haslem, the Midlands and the North, as their dysphagia trained nurses and assistants have now been with them for some time. This has given them the opportunity to make use of the skills that their assistants and the nurses have learnt:

“But they’ve been with my team for five years my DAs, I had one with me for ten years...” (874) (Cheryl, dietitian, the North)

The necessary time investment in training may present more of an issue for services just starting to shift the line between explicit and tacit skills and knowledge – they will have to make the initial investment in time and effort, perhaps over several months, before they start to see the rewards.

### **8.18 Conclusion to research findings - Chapters 5, 6 and 7**

The barriers and enablers to new and different ways of working in dysphagia care in this research centred on how participants had defined explicit and tacit skills and knowledge. In Haslem, the North and the Midlands, many clinical tasks performed by SLTs or dietitians in Billington, were here performed by nursing or assistant staff. Whereas participants in Billington identified these same tasks as clinically complex, requiring tacit skills and knowledge (expertise), participants in Haslem, the North and the Midlands had codified these same areas of skills and knowledge. These skills and knowledge had been codified as either protocols or through training, thus delegating these clinical tasks to the other types of workers (nursing and assistant staff).

In Haslem, the programme was developing further more recently. Firstly, the increasing clinical complexity of the patients that were being treated on the stroke ward, as well as

a risk-averse culture surrounding the threat of litigation, was stifling further development of the programme:

“I think it got to the point where nursing staff thought actually I don’t know if I dare do a dysphagia assessment on this person if they’re confused, you know. (270 – 272) ...Personally, I can’t see it becoming something that’s widespread across all the wards again unless things change very dramatically and I don’t think, you know, who knows ten years ago, I think it’s changed very dramatically since then so.” (289 – 291) (Rebecca, ward nurse manager, Haslem)

This meant that there were no longer the opportunities for the role to develop further. Increased patient acuity for nurses working to full scope of practice has been reported by other researchers (Oelke et al. 2008).

The second development was the growth of the programme into the community, as the demands on dysphagia services were seen to be growing there:

“Obviously with dementia increasing, with the elderly increasing, that’s a very well recognised issue as far as swallowing is concerned.” (407 – 408) (Michelle, hospital SLT manager, Haslem)

It is possible, probable even, that demands on NHS dysphagia services will increase, “as the NHS takes greater responsibility for frail, older residents in care homes...” (NHS England 2014, p. 24).

For the delegation of work tasks from one type of worker to another to be more cost-effective, the less complex tasks must be transferred from the more senior, and therefore expensive, worker to the less senior and expensive type of worker (Sibbald et al. 2011), as was happening in Haslem, the North and the Midlands. Here, there was a growing assumption that an increasing proportion of previously expert tasks should be performed by other types of worker:

“...that isn’t our role. Our role is to see people once they’re dysphagic in the same way we say all the people who come in with falls to the hospital, you don’t send them all off to an x-ray, you only send the ones off who you suspect have got a broken bone to x-ray so that you use x-rays properly. Speech therapy is the same, you only refer them to us if you think they’ve got dysphagia.” (509 – 513) (Poppy, SLT, the Midlands)

Brookfield (2008) suggests that challenging paradigmatic assumptions creates the greatest amount of resistance, perhaps because:

“...practitioners sense the potentially traumatic implications of questioning paradigmatic assumptions that they are so reluctant to do so.” (p. 67)

We often do not view these as assumptions, but rather as “objectively valid renderings of reality” (Brookfield 2008, p. 67). This way of thinking about how dietitians and SLTs provide their services requires a fundamental shift in the way their unique skills and knowledge are perceived, and how they put those skills and knowledge into action. Are they ready for this? I have explored the findings constructed during this research project and in the final chapter, will discuss the limitations of these findings, their implications for practice and direction for future research.

## Chapter 9 DISCUSSION

### 9.1 Introduction

At the beginning of this research, I set out to develop a theory regarding:

1. The barriers to extended scope practice in dysphagia management in routine clinical practice, and
2. Any enabling factors in adopting extended scope practice in dysphagia management.

In this final chapter I will review the research findings and theory and discuss the findings in relation to current knowledge in the field. After reviewing the quality of the research, I will then conclude with the key messages and recommendations drawn from the theory constructed, as well as areas for future research.

Although the findings presented in the previous three chapters are specific to the area of dysphagia care in specific services, because I have described the context and research methods in detail, the reader will be able to judge the transferability of these findings to other dysphagia service settings.

I started the research with an assumption that role expansion in dysphagia care would most naturally occur between SLTs and dietitians. In the time that has passed since then, attitudes in the health community have moved on from enthusiasm about interprofessional working and role extension across professional boundaries, to integrated working and downwards delegation of clinical tasks (Christensen 2009). This has meant a shift away from a focus on more qualified staff performing a greater range of tasks, to delegation of clinical tasks to assistant staff (Nancarrow et al. 2010).

### 9.2 The central process and theory

The findings of this research present a theory and model to better understand how the process of enabling or resisting role expansion in an area of professional practice is played out. This, in turn, points to how the two professional groups can be supported to accelerate role extension in the area.

As presented in Chapter 5, the central process enabling or preventing role extension in the area of dysphagia care is the way in which the professionals group “draw the line” between tasks and skills that can be codified and transferred to other types of workers, and those which cannot. Skills and knowledge are presented on a continuum, with tacit

skills and knowledge at one end of this continuum, and explicit skills and knowledge at the opposing end. This model is in keeping with Nonaka and von Krogh's (2009) and Nonaka et al.'s (2014) proposition that tacit and explicit knowledge lies on a continuum. The fluid nature of this continuum was articulated by participants during data collection. The model also maintains the focus on knowledge itself, rather than on human abilities, as recommended by Collins (2010).

This research identifies the different way in which professional groups can, and do, conceive of the transition point along such a continuum for the same skill set and area of knowledge and clinical practice in different ways. Professionals from different departments working with the same client groups, draw this conceptual line between explicit, and thus transferrable, skills and knowledge at very different points along this continuum. By defining a greater proportion of their skills and knowledge as tacit, they were therefore neither codifiable nor transferrable. The definition of these skills and knowledge as tacit, and thus the status quo, was maintained by reference to the expertise required to perform certain clinical tasks and lack of the right training, skills and experience in other types of workers. In contrast, the same clinical tasks had been defined differently in Haslem, the Midlands and the North. This line could feasibly be drawn at Point B in the model, as had been done in Haslem, the Midlands and the North. By maintaining the line at Point A, the dietitians and SLTs in Billington retained a greater range of skills and knowledge, and thus clinical tasks, within the boundaries of their respective professional group.

### **9.3 Key constructs presented in the model**

The theory that was developed during this research presents a number of constructs involved in this process, which I have summarised into three main groupings. In the first group are the concepts that are at play in maintaining the status quo in the first research setting. In the second are the conditions that were necessary to spark a shift in the line that had been drawn in the second setting. In the third are the factors that sustained the shift in the second setting and enabled the line to be pushed even further, to encompass an ever greater proportion of tacit skills as explicit.

### **9.4 Maintaining the status quo**

This research supports the importance of having "the right skills, training and experience" to increase role breadth self-efficacy, as referred to by Axtell and Parker (2003). This research also demonstrates how professional groups can and do utilise skills and knowledge to retain closure over a clinical area. Nancarrow and Mackey (2005) found a similar trend when conducting focus group research with occupational

therapists just starting to work with assistant staff. Accountability was created as a barrier to maintain “power” (p. 336) over the professional domain, which Nancarrow and Borthwick (2005) refer to as “the creation and maintenance (p. 901) of exclusive rights” (p. 902).

Currie and White (2012) have claimed that areas of specialist expertise may confer a defence to a clinical territory and Adler and Kwon (2013) have referred to the importance of expertise and perceived complexity in the power that professional groups can exert over the codification of their expertise. The theory presented here supports these findings and advances a conceptual model of how the professional groups studied maintain that professional dominance. The professionals maintain exclusive rights over the domain by reference to whether or not the skills and knowledge required to perform clinical tasks are tacit – skills and knowledge that colleagues in other areas have defined as explicit, and thus both codifiable and transferrable.

There have been many attempts to codify aspects of the SLT dysphagia assessment for use by other types of workers, mainly nurses. Recently, Illot et al. (2013) were able to: “draw out ... the tacit knowledge embedded in clinical experience and work-based practices...” (p. 1355) of dysphagia trained nurses and SLTs and present these as an e-learning programme for nurses and HCAs. This demonstrates the willingness of some SLTs to codify aspects of their dysphagia knowledge and skills. The theory presented here demonstrates further examples of how complexity has, and can, be defined, and how aspects of tacit skills and knowledge can be codified. For example, the SLTs in Haslem have, similar to Illot et al. (2013) codified their assessment and management planning and are transferring this to nurses. The dietitian in the North is codifying aspects of the dietitians’ assessment and management planning into flowcharts with accompanying literature, which is being transferred to nurses and assistant staff.

Although previous research has shown that lack of time is frequently a barrier to new ways of working in health care (Read et al. 2001; Oelke et al. 2008) and knowledge sharing (Hu and Randel 2014), this research demonstrates how lack of time can be created as a barrier and how perceptions about the benefits in terms of time (e.g. “more time to focus one’s own tacit skills and knowledge on the more complex patients”) can be an enabler. Previous research (e.g. Nancarrow et al. 2010) has demonstrated that by using assistant staff, professionally registered staff are able to spend a greater proportion of their time attending to patients with higher care needs. The professionals in Billington had not experienced this phenomenon, pointing to the

pivotal role of, and gap in, communication in the spread of this innovation. I will later propose that this is a role that the professional bodies must fill.

Commissioning and health policy had surprisingly little influence in shifting the line between explicit and tacit skills and knowledge in this research. Although health policy think-tanks, most notably the King's Fund, have identified professional silos as a significant problem in managing finite health care resources in the UK, and government policy has aimed to bridge this gap through various publications and initiatives, workforce silos remain (DH 2014).

The Dalton review (DH 2014) notes weak incentives in bringing about organisational form change and the Cavendish Review (DH 2013b) suggests "align[ing] incentives" (p. 11) to bring about new and different ways of working. Earlier researchers and commentators noted the incentive for professional groups to close off occupational areas of practice and assert professional dominance and jurisdiction over these areas (i.e. Larson 1978, Freidson 1986 and Abbott 1988). Larson termed this "the professional project". Although some recent researchers have suggested that such occupational closure has been replaced by managerialism, others have noted that this has had limited impact in the NHS, where professional resistance is a barrier to role extension (Laurant et al. 2010). It could be said that whereas think tanks continue to comment on the problem of professional silos, and government policies and initiatives seek to break these silos down, the incentives in the system and the professionals themselves continue to maintain professional silos.

This research demonstrates that professionals retain significant control over clinical domains, despite government efforts to change. Both SLTs and dietitians used clinical risk and perceived lack of the "right skills and knowledge" in other types of workers to maintain control over their areas of expertise. The research also demonstrates how the perception of role threat can be minimised when the change comes from within the professions themselves, continuing to grow as the professionals perceive benefits to the new way of working.

## **9.5 Making the shift**

The findings presented in this study support the concept that a threat to the current system is a condition sparking change. This is in keeping with previous research (Watzlawick et al. 1974; Van de Ven 2008). The theory in this thesis also supports previous research suggesting that this threat came in part from staff shortages (Nancarrow and Borthwick 2005; Dubois and Singh 2009; Moran et al. 2011).

This research suggests, however, that such a staffing threat is not in itself enough to spark a shift in the line that is drawn between explicit and tacit skills and knowledge. A further two factors were also necessary conditions. The second necessary condition was a visionary individual (or “trailblazer”); the third was the need to have “seen it be done somewhere else”.

Previous research has found the need for such a visionary (e.g. Van Wijk et al. 2008; Van de Ven et al. 2008; Dubois and Singh 2009; Kotter 2012). Research has also demonstrated that vision may play a role in creating shared goals, and thus influence the subjective norm and attitudes towards knowledge sharing, an important factor in facilitating the sharing of individually held knowledge (Chow and Chan 2008). Leaders who are able to communicate a future vision instil a sense of control over the change in their staff (Martin et al. 2005). This was an important factor in this research, as change had to come from within the professions.

Although Von Krogh et al. (2012) suggest that organisational vision, as indicated by managers and leaders higher up in the hierarchy, is instrumental in setting the direction and organisational goals, this was not necessarily the case in this research. The shift had started several years prior, without encouragement from senior management. Even though leadership theory may be shifting from a focus on a central leader to one of “distributed leadership” (von Krogh et al. 2012), this research demonstrates the need for an individual with vision, even though that individual calls on others to realise his or her vision.

Given the need to have “seen it be done somewhere else”, it is perplexing that knowledge of the way in which dietitians and SLTs work in Haslem, the Midlands and the North is not more widespread. Some participants in Billington were keen to learn about, and even adopt, the way in which Haslem was working. This echoes O’Brien et al.’s (2013) findings that SLTs who had previous experience of working with assistant staff were more likely to be positively predisposed to working with assistant staff than SLTs who had not had such experience. SLTs who had experienced working with assistant staff were also more willing to suggest a wider range of clinical tasks that could be provided by assistant staff.

Although the professional bodies were generally supportive of these new ways of working, they did not demonstrate the leadership needed to accelerate change. Participants in Haslem and the North who had started to make the shift a number of years ago described how, until recently, there had been professional resistance to these changes, and a sense that they were eroding the professions. They looked to their professional bodies for definitive guidance. The professional bodies, in turn,

looked to the members to keep them abreast of innovations. Both professional bodies have issued guidance (RCSLT 2003; BDA 2006; BDA 2010; BDA 2014; RCSLT 2014) recently on role extension and the delegation of clinical tasks. For example, the BDA (2014) has specified the specific tasks that assistant practitioners can undertake. As such, they are indicating their permission for the codification and transfer of skills and knowledge to other types of worker. Despite this, the professionals themselves seemed to be looking for more direction from their professional bodies.

## **9.6 Sustaining the shift**

Despite fears by participants who had not shifted the line between explicit and tacit skills and knowledge that other types of worker might “overstep the mark”, this was not experienced by participants in Haslem, the North and the Midlands. This supports previous research (Nancarrow and Mackey 2005; Wood et al. 2011) indicating that, contrary to initial fears, those to whom skills and knowledge are being transferred do not “overstep the mark” nor work outside of their scope of practice (e.g. Sibbald et al. 2004; Laurant et al. 2005).

As the codification and transfer of skills and knowledge in this research was led by the relevant professional groups, they were able to define the boundaries of practice and to what extent the line between explicit and tacit skills and knowledge was to be pushed. This was facilitated by the fact that those to whom skills and knowledge were being transferred were in most cases under the direct supervision of the professional group (e.g. assistant staff) or received at least a modicum of supervision (e.g. dysphagia trained nurses). Decisions about which aspects of skills and knowledge were to be codified and transferred were therefore in the hands of the professional group.

Participants became both more confident with sharing their skills and knowledge as experience showed them that their initial fears were not realised. This finding is consistent with O’Brien et al. (2013), who found that SLTs who had previous experience of working with assistant staff were more likely to be positively predisposed to working with assistant staff than SLTs who had not had such experience. This confirms how the process of defining the line between explicit and tacit skills and knowledge grows and develops as professionals gain experience of the process and come to realise the perceived benefits. This is consistent with theories on role growth, with mastery and confidence growing, enabling the person to take up ever more challenging tasks (Vough and Parker 2008).

Skill mix has been used in the UK health care system as a method of substituting more expensive, trained staff, for staff that are less costly (McBride et al. 2005; Dubois and

Singh 2009). Despite these fears, it is also true that there are no examples of where professions have disappeared through the redefining of role boundaries (Nancarrow and Borthwick 2005). It is not possible to completely substitute a new type of worker for the original worker (Sibbald et al. 2011). The findings of this research should allay fears amongst the professional groups that codifying skills and knowledge will lead to a loss of their job role. Workers “receiving” their skills and knowledge need their support to be able to do so, which has also been demonstrated by other researchers (Dubois and Singh 2009; Nancarrow et al. 2010; Skills for Care 2011).

### **9.7 The contribution of this theory to existing knowledge**

Several researchers have identified persistent gaps in our understanding of knowledge translation (Estabrooks et al. 2006; Riehl 2006), the processes, barriers and enablers to tacit knowledge sharing (McAdam et al. 2007) and the diffusion of innovation and new ways of working in health care (Greenhalgh et al. 2004). As recently as 2012, Ovretveit et al. (2012) reported that:

“...knowledge about how organisational and management innovations are formed, developed and spread in healthcare is relatively undeveloped...” (p. 238).

The Royal College of Nursing (2012) points to the need to stimulate debate around areas of role extension with less evidence. Greenhalgh et al. (2004) recommend further research in understanding how health care organisations capture outside knowledge and internalise this. Greenhalgh et al. (2004) also recommended more research into how knowledge of innovations can be transferred between organisations, and what role the professional bodies and the interprofessional networks could have in this.

If the willingness to train other types of worker in one’s unique professional skills and knowledge is directly related to the willingness to hand over that part of one’s role (Hyde et al. 2005), then a greater understanding of how such willingness is facilitated is needed. Whereas we have some understandings of employee and workforce drivers and motivation from the organisational literature, one cannot assume that findings from other sectors are directly applicable to either health care settings or the NHS (Powell et al. 2014). Cameron (2011) suggests that we need to move beyond a focus on training, education and regulation in relation to professional boundaries, and instead focus on the human and social aspects. Currie and White (2012) suggest that, although national policy may support new and different ways of working, little attention is given to the professional and social aspects of policy initiatives and relatively little is still known about the social influences to knowledge sharing in health care settings.

Given these gaps, the theory presented in this thesis suggests ways in which two professional groups define the boundaries between explicit and tacit skills and knowledge in their area of practice. The theory also describes the conditions that were necessary to facilitate a shift in the line that had been drawn between tacit and explicit skills and knowledge, thus enabling other types of workers to take on selected tasks. This theory also demonstrates the role of the professional bodies in leading on innovation and knowledge transfer in this arena, and communication about such developments. Communication should not be focussed on the possibility of professional identity threat posed by shifting the line between tacit and explicit skills and knowledge, but rather towards the benefits experienced by those services and areas that have already made the shift. Although specific to the settings described, and SLTs and dietitians, this theory may have applicability for other professional groups negotiating the boundaries of their scopes of practice and delegating their own unique skills and knowledge to other types of workers.

This research also supports consistent findings by other researchers suggesting that knowledge complexity is used to retain professional control of an area (see for example Renzl 2008; Oelke et al. 2008; Connelly et al. 2012; Khalili 2014; Perez et al. 2014), particularly where scopes of practice overlap. Although some researchers have argued that the autonomy of the professions in managing how they operate has been in decline in recent years (Evetts 2003; Evetts 2011; Adler and Kwon 2013, Hubby et al. 2014), this research demonstrates that professionals still retain a significant amount of control over who can perform certain tasks within their domain. Control is retained by reference to knowledge and skills, clinical complexity and clinical risk. This is in keeping with other research in the area (i.e. McBride and Mustchin 2013) and commentary by other authors (i.e. Evetts 2003; Evetts et al. 2006; Evetts 2011). What is particularly striking in this research, is how “professional identity threat” (Mitchell et al. 2011) or, to use the terminology of the participants in this research, fear of “doing ourselves out of a job”, can have such a profound effect on how tasks within a clinical area are carried out, and by whom, leading to such differing practices in Billington, Haslem, the Midlands and the North.

Evetts (2011) suggests that, where change is imposed on professions, resistant and defensive practices are more likely. She suggests that discourse originating “from within” (2011) can be beneficial to the occupational group, as it helps the group to construct its occupational identity. Adler and Kwon (2013) suggest that innovations are more likely to spread within a profession when the innovation can be seen as in the

interests of the professional group itself. In Haslem, the Midlands and the North, codification of dysphagia and nutritional assessment and management were borne out of perceived benefit to the professional groups, rather than imposed on them. If role threat is a barrier to role expansion (Read et al. 2001), the danger in forcing a shift, rather than incentivising a wilful shift, is that the professionals may hold back aspects of their skills and knowledge (Gray 2001). They may also continue to use clinical complexity to maintain the status quo, in keeping with previous research on knowledge sharing in organisations (Connelly et al. 2012). The strong role of the profession(al)s, and the limited effects of NHS organisations, on influencing different ways of working has been noted by others (i.e. McBride and Mustchin 2013). This research goes further still, by suggesting ways in which to influence the professional groups to voluntarily relinquish power and control by allowing such change to come from within the professional groups themselves. By allowing the professional groups to retain power and control over the area, but nevertheless transfer skills and knowledge to other types of worker, e.g. by using assistant staff under their direct supervision, this allows the professionals themselves to define the boundaries of practice and expertise, or to “draw the line”. They therefore maintain supervisory control over the area (Currie and White 2012), while perceptions of “in- and out-groups” are manipulated (Eckel and Grossman 2005).

Although the professional bodies acknowledge the challenges ahead, and are in principle supportive of new and different ways of working, this is not enough. They must lead on an honest appreciation of where the line between tacit and explicit skills and knowledge should be drawn in their respective professions. They must send out clear messages regarding this “line” and take a lead in shifting the line for their members. The primary source of such leadership should come from benefits communication.

As participants in this research have indicated, many would embrace shifting the line, given direction from their professional body. The experience of those departments that have shifted the line is not getting out to other departments. This experience includes the process of making the shift, the benefits of such a shift, and allaying fears of making the shift, such as “doing ourselves out of a job” and staff to whom skills and knowledge are transferred “overstepping the mark”. Given the importance of “having seen it be done somewhere else” in igniting the shift in these data, the importance of peers in social networks in spreading innovation (Wejnert 2002; Greenhalgh et al. 2004) and the influence of subjective norms in attitude towards and knowledge sharing

behaviour (Bock et al. 2005; Chow and Chan 2008), the professional bodies must do more to facilitate this change.

These issues are going to become more pressing, as demand for dysphagia services increases (Kertscher et al. 2014; Miller and Patterson 2014). Although this research has explored the issue in the area of dysphagia management in stroke, dysphagia care in dementia presents a significant area of growth for dysphagia and associated nutritional services. The prevalence of dysphagia is between 13% and 57% in individuals diagnosed with dementia (Alagiakrishnan et al. 2013). This will necessitate the professional groups at the centre of dysphagia care to look towards creative solutions to meet the population needs in an ever-shrinking funding envelope. Codifying and transferring their explicit skills and knowledge, thus “having more time to focus one’s own tacit skills and knowledge on the more complex patients”, may be a significant part of the solution.

### **9.8 Quality of this study**

Having concluded the research, presented the findings and theory that was developed, and demonstrated how these have furthered our understanding of role extension and knowledge sharing in the area of dysphagia care in stroke, I will now turn to examine the strengths and weaknesses of this study.

### **9.9 Strengths of this study**

The main strength of this study is the frontline perspectives on the barriers and enablers to role extension in dysphagia care, which were brought about by the chosen methodology, grounded theory.

The study explored the research questions from the perspective of those on the frontline, allowing their voices and perspectives to take center stage in the theory that I developed. As described in the Methods chapter, many of my initial assumptions, gained from working in the field, were proven wrong (for example, the importance of health care policy). I have attempted to represent those taking part in the study, by providing excerpts of their transcripts, thus presenting the data in their own voices.

It transpired that this perspective, from the frontline, formed a fundamental part of the findings and theory: the process of change was driven by the professional groups themselves, rather than as the result of direct policy or organisational influence, as I had anticipated. The depth of the findings presented would not have evolved had I used, for example, a survey method of data collection, based upon existing knowledge

in the field. The central process described in the theory, of using definitions of tacit and explicit knowledge and clinical complexity to retain professional dominance, would never have surfaced had I relied on existing research into role extension.

### **9.10 Limitations of this study**

While recognising that my own position has without doubt influenced both data collection and analysis, I believe that my changing role within the health service has been advantageous to the research project. Since starting the PhD, I have moved from a clinical role, offering the working knowledge of the subject area and hence credibility, to a role in the commissioning side of health care. In this role I was no longer involved in the field of dysphagia. More recently, I have moved back into clinical practice, into a general dietetic role, with only a small amount of contact with stroke survivors and tube feeding. This may mitigate some of the distrust that could have resulted from an assumption that the aim of my research was to carve out a role for myself. Despite this, my own assumptions and position have played a pivotal role in the findings of this study, assumptions that I attempted to capture before starting the research through the model captured in Figure 3. I hope that I may, through the procedures described in the Methods chapter, have addressed this issue to the degree possible.

A further limitation of this research is in positioning the tacit knowledge and skills of the “expert” practitioners in an elevated position of knowledge and skill acquisition. An important aspect in acquiring tacit skill and knowledge is creating further tacit understandings of the subject area. In this respect, a greater understanding of the further tacit understandings in the field of dysphagia and related nutrition that is created when other types of workers are taught and take on some of the skills and knowledge from the “experts” in the area would be beneficial. Further tacit knowledge and understandings of the area are also created when patients themselves and their carers are instructed in elements of dysphagia and nutritional care, such as when an individual goes home from hospital. In these situations, it is the spouse or other carers who are developing further tacit and explicit knowledge in the area.

A further limitation is my assumption that a change in practice is the right thing to do. As Hammersley (2009) notes, there is a danger in “deriving an ‘ought’ from an ‘is’” (p. 2) in the sense that, just because we believe that there exists some “unmet need” (p. 3), that there must be a change. Nevertheless, participants in Haslem, as well as the North and the Midlands, reported that they could not conceive of working in any other way than the “new” way.

In respect of the research design and conduct itself, a limitation in this research is the lack of a systematic review prior to research design and following data collection and analysis. A review of the literature in relation to dietitians and SLTs extending their scope of practice using a systematic approach before designing the research had identified only two research papers (Brody et al. 2000; Huhmann et al. 2004). This was despite widening the search by hand searching for related papers through relevant journals. This demonstrates the dearth of evidence in the field. I remained up-to-date with developments in the field throughout the research, as described in Chapter 2, although I did not repeat the literature review systematically following data collection and analysis. It is therefore unlikely that I would have missed significant developments in the field. A few of the participants interviewed (most notably Phoebe, Michelle, Cheryl and Poppy) are also opinion leaders in this field.

I did not systematically review the literature relating to extended scope practice in healthcare, as I had identified two recent robust reviews on the topic (Sibbald et al. 2004; McPherson et al. 2004, 2006), and a further review while designing the research. Although remaining up-to-date with the field of role extension, I did not systematically review this literature following data collection. I did however identify a systematic review (Saxon et al. 2014) updating the previous review into role extension for AHPs by McPherson et al. (2004, 2006). Although (Saxon et al. 2014) identified 1,000 papers on the topic of AHP role extension since 2005, and extracted data from 21 of these for inclusion in the review, the authors concluded that:

“...despite the earlier review calling for more robust evaluations regarding the impact on patient outcomes, cost-effectiveness, training requirements, niche identification, or sustainability, there appears to be limited research reported on the topic in the last 7 years. (p. 479)

The new literature identified by the reviewers involved primarily physiotherapy and radiography, with some research into extended roles in occupational therapy and one in SLT, but neither of these involved dysphagia care.

It is possible that the lack of a systematic review relating to the concepts in the theoretical model may have meant that I missed existing literature related to the topic area. Nevertheless, the purpose of the research was to construct a useful and explanatory model of the process of enabling or preventing role extension in the area of dysphagia management, grounded in the data derived from the settings studied.

The choice of research settings will undoubtedly have influenced the codes and categories developed during this research. Although I initially evaluated all dietetic and SLT departments in the South West as the “usual-care” setting, I excluded those where staff were employed by one NHS organisation and contracted in to another for their service through Service Level Agreements (SLAs). This decision was taken so as to avoid including the lack of accountability and clear lines of management that Read et al. (2001) had identified in their research of extended roles. This may have meant that key issues facing dietetic and SLT departments working through SLAs that were relevant to the research questions may have been missed. Of those settings that remained after this exclusion in the South West, the setting that continued to express an interest and progressed to R&D and thus, became the “usual-care” setting, was to a degree self-selecting. Although they had not extended the roles of nurses beyond basic swallow screening, and were not leading research in the area of dysphagia, they were a stroke research centre. They may therefore have been more open to different ways of working and the substantive theory that was constructed through this research. Similarly, the research setting that was extending roles in dysphagia management (Haslem) was naturally self-selecting, as the SLTs and dietitians there had an interest in advancing and promoting their way of working.

The quotes that illustrate the findings presented in Chapters 6, 7 and 8 draw on a limited number of participants. This reflects the limited ability of many of the participants to engage with the topic on a conceptual level during interview. For example, I attempted to explore the drawbacks of further role extension for nurses in Billington with Amber, with one of the stroke nurses. She feared they would employ fewer staff to perform the work. Even when asked to expand on this topic, she was unable to provide any further thoughts.

The limited ability of many of the participants to reflect on the topic at a conceptual level was particularly evident in service user participants. The difficulties in interviewing service user and carer participants on this topic fell into two broad categories. The first was a difficulty, possibly exacerbated by the stroke itself for service users, to think conceptually about issues at the interview. The second issue was a focus on their immediate experience of the stroke and of the services provided, rather than of dysphagia service provision in stroke care more generally. This raises an interesting question of service user involvement in interview research that explores service provision, service redesign and health policy. The issue of how well service user participants (patients and carers) are able to explore generalised service issues, rather than their own immediate experiences of services, was reported by Harris et al. (2013)

in relation to interprofessional working. In this research, service user participants had either not taken notice of how services were provided, or this was not their priority. This raises an interesting question of to what degree service users are included in research, particularly interview research, where this explores service provision. It may be more pertinent to focus on service users' involvement that explores specifically experiences of services or conditions, rather than how services are organised.

### **9.11 Recommendations for practice**

In the first phase of the research, some participants looked to the professional bodies to take a lead on new ways of working. Although dietitians felt that their professional body now supported these new ways of working, it seemed that the message from the Royal College of Speech & Language Therapists was less clear. Some felt that, although their professional bodies were supportive, they were not leading on the issue. The professional bodies themselves seemed to expect that change should come from their members, and be communicated to the professional bodies, for dissemination to other members. The professional bodies arguably occupy a central "brokerage position" (Van Wijk 2008, p. 834) – they are in a position to locate and share knowledge between professional body members. It is therefore not satisfactory that the professional bodies rely so heavily on their members for knowledge sharing. Although both professional bodies may now be moving in this direction - sharing of innovative practice was at the centre of both their 2014 professional conferences, more should be done. It would be helpful if the professionals' bodies provide 'space' and opportunity for new initiatives to be shared. It is therefore proposed that, working together, the BDA and the RCSLT address this area by:

1. Conducting or commissioning a survey of role extension practice. Any such survey should include the possibility of follow-up open-ended interviews, probably by telephone. The purpose of this would be to establish actual practice, development and innovations in the field. This survey must include support workers, as well as registered professionals. It should also look to the future by identifying areas of potential and developing practice, as well as current developments.
2. Using the results of this survey to identify areas of concern, current and future practice and professional support needs.
3. Publicising existing practice widely among registrants. This should openly address assumptions and areas of concern, and how these have been

overcome in departments that have shifted the line in codifying and transferring skills and knowledge.

4. Working with NHS England, to identify ways in which Service Specifications can be adapted and created to incentivise skill and knowledge sharing in care provision, without penalising service providers financially (e.g. reducing the value of contracts to reflect these changes).
5. Reviewing professional guidance, taking account of current and future innovations.

The regulatory body for both dietitians and SLTs is the Health and Care Professions Council (HCPC). Although the HCPC has greater power over professional practice, through its ability to disbar practitioners, it does not offer specific guidance on clinical practice. Its role is in protection of the public from professional malpractice by ensuring that registrants are “fit to practise”. The HCPC defines fitness to practice as meaning “...that they [registrants] have the skills, knowledge, character and health to practise their profession safely and effectively.” (p. 15). It does not however “...dictate how you should meet our standards.” (p. 5)

Through its *Standards of Performance, Conduct and Ethics* (2008), it does set standards relating to skills and knowledge and role extension. Standard 6 states that:

“You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner. (p. 3)”

This standard allows much flexibility in how it is interpreted and the HCPC recognises that:

“The way in which you meet our standards might change over time because of improvements in technology or changes in your practice.... We recognise that your scope of practice may change over time.” (p. 10)

Thus, the regulator appears to anticipate changes in practice. It is up to the professional himself or herself to be able to justify how practice has been executed in the event that the HCPC receives a complaint against an applicant.

In relation to skill mix, standard 8 of *Standards of Performance, Conduct and Ethics* (2008) states: “You must effectively supervise tasks that you have asked other people to carry out.” (p.5). Standard 8 goes on to state that:

“Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice. You must always continue to give appropriate supervision to whoever you ask to carry out a task.” (p. 12)

The position of the HCPC on professional practice is therefore regulation according to current practice, rather than leadership on defining what expected practice might be. The definitions of what constitutes current and expected practice, and leadership for change, must therefore come from the professional bodies, the BDA and the RCSLT.

Given the importance of “having seen it be done somewhere else” as a catalyst in this process of change, this research proposes that the professional bodies must take a greater lead in communicating the benefits, as well as the “how to”, from other dietetic and SLT departments that have made the shift. They must also communicate that codifying and transferring skills and knowledge to other types of worker does NOT erode the role nor the value of the professions themselves.

Since completing data collection and analysis for this research, NHS England has published *The NHS Five Year Forward View* (2014), which urges:

“...over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign...” (p. 30, emphasis added).

This highlights both that health policy makers remain intent on creating the conditions for a more flexible NHS workforce and also that they perceive that the bodies representing the professions must work alongside health policy makers to achieve these objectives.

As the change in the line that had been drawn between explicit and tacit skills and knowledge was sparked from challenges in the service, and given evidence that these challenges are unlikely to abate in the years to come, the professional bodies must take the lead and facilitate communication in this area. Continuing to protect professional turf, or taking a position of agreeing with such change but not championing nor leading on this, will not suffice.

### **9.12 Directions for future research**

I described in the previous section the role that the professional bodies must take in leading the shift in defining explicit and tacit skills and knowledge, and in communicating the benefits of such change to their members. The professional bodies must also take a lead in carrying out evaluations of, and research into, these initiatives. Evaluations and research should centre on three key components:

1. Assessments of the difference in outcome measures of tasks performed by the original professional and the “receivers” of skills and knowledge (whether nurses, assistant staff, or other types of workers). In this particular arena, such measures could include for example modified texture diet and fluid prescriptions, chest infections, weight, diet texture on discharge, etc. This will allay the fears of other types of worker “overstepping the mark”.
2. The concept presented in this research of “more time to focus on the more complex aspects of one’s role”. Simple service improvement methodologies and evaluations of the time spent on various clinical and non-clinical activities of varying complexity, once these have been identified, would link to point 3) below.
3. Staff and job satisfaction in employing new and different ways of working in this arena. This would most usefully be conducted by using survey methods in departments with traditional and extended scope models of providing dysphagia and associated nutritional care.

Finally, the professional groups must come together, facilitated by their respective professional bodies, to identify and define an honest appraisal of the line between tacit and explicit skills and knowledge in their fields, and the conditions under which this line applies.

### **9.13 In conclusion**

This thesis, and the theory that I have developed, provides direction to health policy makers on facilitating the blurring of professional boundaries. Role extension remains as relevant today as it was at the start of my research journey, as *The NHS Five Year Forward View* (NHS England 2014) continues to make the case for new models of service delivery, utilising “new skills and roles” (p.19).

This thesis also presents a call to action for the professional bodies at the centre of this research. They must to take a lead in facilitating a shift in the line that their members

have drawn between explicit and tacit skills and knowledge, and thus the transfer of these to other types of worker. This will be of “practical value”, “relevant and beneficial” (Angen 2000, p. 392) to both SLTs and dietitians working in the field, and may spur change that I believe is needed for the professions to survive and thrive. As Nina, one of the professional body representatives, puts it:

“We have to keep moving forward. Dietetics will not look like this in 2020. I’d be mad if we looked like this in 2020, we have to move forward. (338 – 340)  
...Unfortunately when it’s challenged, when the services are challenged ...that’s when they’ll suddenly think ‘Oh I should have’... And that’s unfortunate.” (350 – 353)

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**BOURNEMOUTH UNIVERSITY**  
**THE FACULTY OF HEALTH AND SOCIAL SCIENCES**

**Barriers and enablers to new and different ways of  
working in dysphagia care**

by

**Elizabeth Roberts**

Thesis for the degree of Doctor of Philosophy

Volume 2 - Appendices

July 2016

## Appendix 1

Research Question	Databases searched	Search terms used
<p>1. Is it feasible for dietitians (population) to extend their scope of practice (intervention) into dysphagia care (outcome)?</p>	<ul style="list-style-type: none"> <li>• EMBASE</li> <li>• MEDLINE</li> <li>• The Cumulative Index to Nursing and Allied Health Literature (CINAHL)</li> <li>• British Nursing Index (BNI)</li> <li>• Allied and Complementary Database (AMED)</li> </ul>	<ul style="list-style-type: none"> <li>• “dietitian”, “dietician”, “dietetics”, “diet therapy” or “dietary services”</li> <li>• free text search using the terms: “extended role*” and “extended scope” as there were no appropriate and accurate MeSH headings</li> <li>• “dysphagia”, “swallow*”, “deglutition” or “deglutition disorders”</li> </ul>
<p>2. Is it feasible for Speech &amp; Language Therapist (SLTs) (population) to extend their scope of practice (intervention) into nutritional management (outcome)?</p>	<ul style="list-style-type: none"> <li>• EMBASE</li> <li>• MEDLINE</li> <li>• The Cumulative Index to Nursing and Allied Health Literature (CINAHL)</li> <li>• British Nursing Index (BNI)</li> <li>• Allied and Complementary Database (AMED)</li> </ul>	<ul style="list-style-type: none"> <li>• “speech-language pathology”, “speech therap*” or “speech patholog**”</li> <li>• free text search using the terms: “extended role*” and “extended scope” as there were no appropriate and accurate MeSH headings</li> <li>• “nutrition*”, “nutrition disorders”, “nutrition services”, “diet” or “geriatric nutrition”</li> </ul>
<p>3. Are there any benefits (outcome) to extended scope practice (intervention) in health</p>	<ul style="list-style-type: none"> <li>• EMBASE</li> <li>• MEDLINE</li> <li>• The Cumulative Index to Nursing and</li> </ul>	<ul style="list-style-type: none"> <li>• free text search using the terms: “benefit” as MeSH headings referred to cost-benefit</li> </ul>

<p>care (population)?</p>	<p>Allied Health Literature (CINAHL)</p> <ul style="list-style-type: none"> <li>• British Nursing Index (BNI)</li> <li>• Allied and Complementary Database (AMED)</li> </ul>	<p>analysis</p> <ul style="list-style-type: none"> <li>• free text search using the terms: “extended role*” and “extended scope” as there were no appropriate and accurate MeSH headings</li> <li>• “Healthcare” and “Health Care”</li> </ul>
<p>4. Are there any drawbacks (outcome) to extended scope practice in health care (intervention)?</p>	<ul style="list-style-type: none"> <li>• EMBASE</li> <li>• MEDLINE</li> <li>• The Cumulative Index to Nursing and Allied Health Literature (CINAHL)</li> <li>• British Nursing Index (BNI)</li> <li>• Allied and Complementary Database (AMED)</li> </ul>	<ul style="list-style-type: none"> <li>• free text search using the terms: “drawback*” and “drawback” as no appropriate MeSH headings and MeSH headings refer to cultural deprivation, respectively</li> <li>• free text search using the terms: “extended role*” and “extended scope” as there were no appropriate and accurate MeSH headings</li> <li>• “Healthcare” and “Health Care”</li> </ul>



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### South East Wales Research Ethics Committee - Panel D

Telephone: 02920 376823

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Ms Elizabeth Roberts  
90 Queensway  
Taunton  
Somerset  
**TA1 5QT**

19 November 2010

Dear Ms Roberts

**Study Title:** The care pathway for dysphagic stroke survivors –  
qualitative, exploratory study (phase 1) v1.  
**REC reference number:** 10/WSE04/46  
**Protocol number:** NA

Thank you for your letter of the 12 November 2010, responding to the Committee's request for further information on the above research and for submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

#### Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

#### Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Canolfan Gwasanaethau Busnes  
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### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.
- For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.
- Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.
- Sponsors are not required to notify the Committee of approvals from host organisations.
- It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Protocol	3	04 November 2010
Response to Request for Further Information		04 November 2010
Response to Request for Further Information	E Roberts	12 November 2010
Participant Information Sheet: Service Users	8	12 November 2010
REC application	IRAS 3.0	30 July 2010
Participant Consent Form: Consultees	1 - Undated	
Participant Consent Form: Carers	2	17 November 2010
Participant Consent Form: Staff	2	12 November 2010
SRN User Feedback Summary	1	
Staff	2	31 July 2010
Participant Information Sheet: Staff	4	12 November 2010
Participant Information Sheet: Consultees	6	12 November 2010
Participant Information Sheet: Carers	2	12 November 2010
Investigator CV	S J Ersser	15 July 2010
Investigator CV	J L Murphy	14 July 2010
Investigator CV	E J Roberts	31 July 2010
Participant Consent Form: Service Users	3	04 November 2010
Agreement Form	2	31 October 2010
Evidence of insurance or indemnity	UMAL	01 August 2009
Referees or other scientific critique report	School Postgraduate	16 December 2009

	Committee, Bournemouth University	
Covering Letter	E Roberts	02 August 2010
Letter from Sponsor	Bournemouth University	05 July 2010
Interview Schedule - Service Users	2	31 July 2010
Invitation Letter - Service User	1	04 November 2010
Invitation Letter - Staff	1	04 November 2010

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### **After ethical review**

Now that you have completed the application process please visit the National Research Ethics Service website > After Review. You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures. We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

<b>10/WSE04/46    Please quote this number on all correspondence</b>
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With the Committee's best wishes for the success of this project

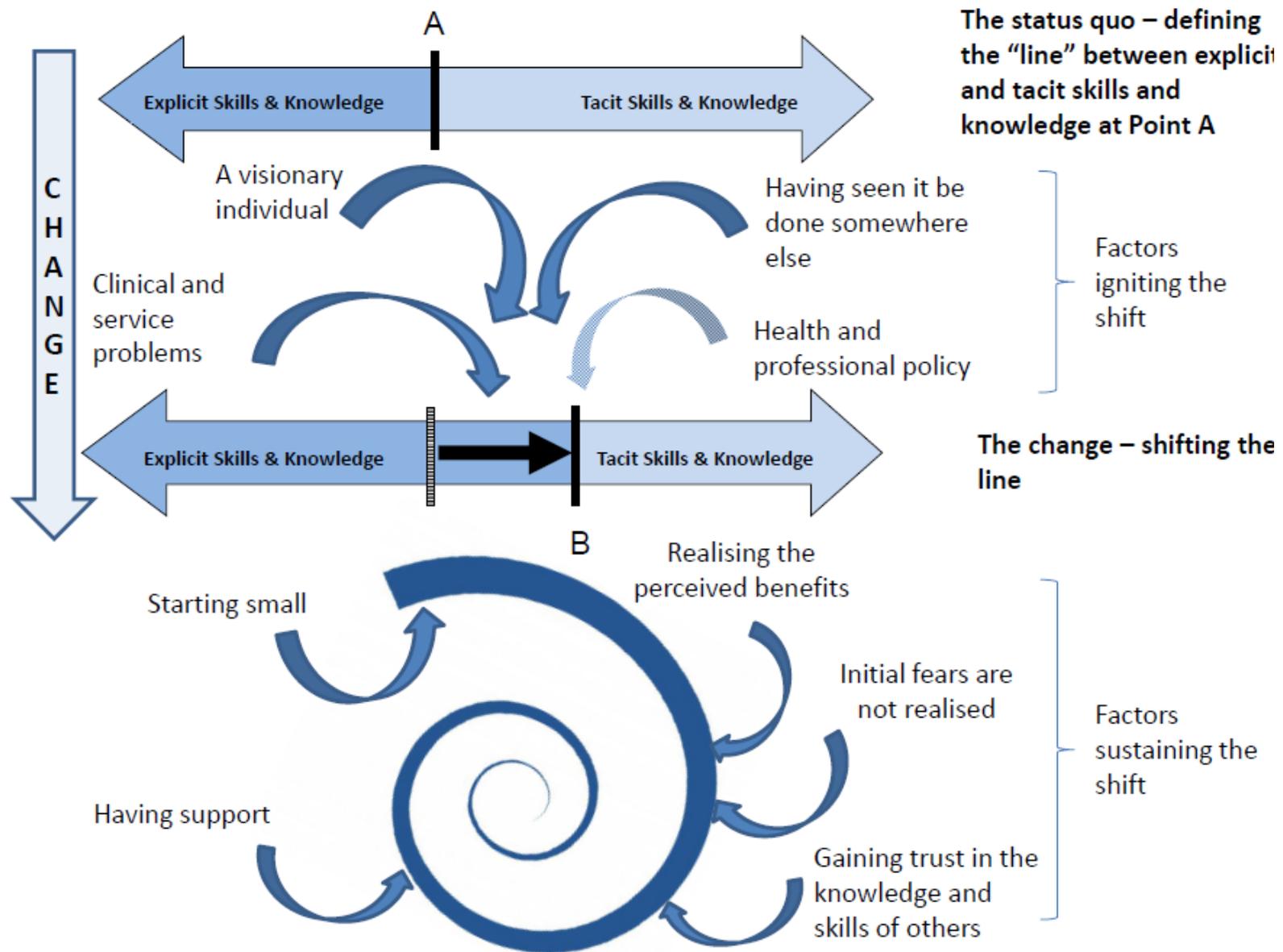
Yours sincerely



**Dr K J Craig  
Chair, Panel D  
South East Wales Research Ethics Committee**

Enclosures: "After ethical review – guidance for researchers" SL- AR2

Copy to: R&D office for Bournemouth University



### General Risk Assessment Form

Before completing this form, please read the associated guidance on 'I: Health & Safety/Public/Risk Assessment/Guidance'. This form should be used for all risks except from hazardous substances, manual handling & Display Screen Equipment (specific forms are available for these). If the risk is deemed to be 'trivial' there is no need to formally risk assess or record.

All completed forms must give details of the person completing the assessment and be dated. Risk assess the activity with its present controls (if any), then re-assess if action is to be taken and after further controls are put in place.

The completed form should be kept locally within the School/Professional Service.

<p><b>1. Describe the Activity being Risk Assessed:</b></p> <p>Qualitative field data collection and analysis.</p>
<p><b>2. Location(s)</b></p> <p>Research sites 1, 2 and 3 (Bournemouth and Christchurch Hospital, Derbyshire Community Services and NHS Banes).</p>
<p><b>3. Persons at potential Risk</b> (e.g. consider specific types of individuals)</p> <ul style="list-style-type: none"> <li>• Researcher</li> <li>• Service user research participants</li> <li>• Staff research participants</li> </ul>
<p><b>4. Potential Hazards</b> (e.g. list hazards without considering any existing controls):</p> <ol style="list-style-type: none"> <li>a) Breach of confidentiality/ loss of stored transcripts, interview sheets and/ or note review data collection sheets</li> <li>b) Difficulties communicating during interview (service users)</li> <li>c) Risk of upset during interview</li> <li>d) Risk of fatigue during interview (service users)</li> <li>e) Time commitment in working day to participate in interview (staff)</li> <li>f) Change of relationship with care professional (service users) and between colleagues (staff)</li> <li>g) Expectations that participation in research may improve nutrition and/ or dysphagia and/ or care that is received</li> <li>h) Unaccompanied domiciliary visits outside NHS premises (such as service user/ carer interviews in the home) to conduct data collection (researcher)</li> </ol>

**5. Any Control Measures Already In Place:**

- a) All written and recorded data collection materials (notes, tapes, transcriptions) will be stored in a locked filing cabinet on secure NHS premises. Transport of such materials between research site and storage site will be in a locked case out of public site. Signed consent forms will be stored in a separate, locked, filing drawer from data collection notes.
- b) It may be appropriate for aphasic individuals to participate in medical note review and carer interview only. An assessment of the patient’s ability to participate, in line with professional opinion regarding communication ability provided in the medical, nursing or other care notes, will be made as part of the process of consent and assessment of capacity.
- c) If the participant becomes upset during the interview, this will be suspended while the researcher confirms whether he/ she is able to continue and, if necessary, terminated or postponed. The interview room will be made available for 30 minutes after the interview should participants require a quiet space. The researcher will be present or available, depending on participant preference.
- d) Participants will be informed that the interview is expected to take up to 60 minutes and they will be sensitively asked whether they are able to take part. The interview will be suspended while the researcher confirms whether he/ she is able to continue and, if necessary, terminated or postponed.
- e) Participants will be informed that interview is expected to take up to 60 minutes and it will be confirmed as part of the consent process that they are able to make this commitment.
- f) The researcher will not disclose nor discuss matters around individual care between participants, other than the further exploration of themes as per the grounded theory approach.
- g) The participant information sheet makes clear that the purpose of the study is not to immediately effect treatment and care, but rather to explore issues around alternative models of care.
- h) Most data collection will occur on NHS premises within working hours. While it is not anticipated that the service user group pose a high risk of threat to the researcher, any data collection occurring outside NHS premises where the researcher is unaccompanied, will be conducted following the domiciliary visit policy of the NHS Trust with responsibility for the patient’s care. This will include notifying the Trust of the visit date and time of the visit, providing a mobile phone number and agreed alert code and notifying the Trust of the safe completion of data collection. The researcher will follow all local policies and procedures in relation to risk management, such as the control of infection, the safe handling of loads, conflict resolution and fire and safety. The researcher undertakes regular and statutory updates as required by her employing NHS Trust and has currently conducts domiciliary visits as part of her clinical role.

**6. Standards to be Achieved:** (ACOPs, Qualifications, Regulations, Industry Guides, Suppliers instructions etc)

i. **Estimating the Residual Risk** (e.g. remaining risk once existing control measures are taken into account)

Choose a category that best describes the degree of harm which could result from the hazard and then choose a category indicating what the likelihood is that a person(s) could be harmed.

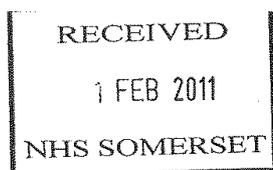
	<b>Slightly Harmful</b>	<b>Harmful</b>	<b>Extremely Harmful</b>
	(e.g. minor injuries)	(e.g. serious but short-term injuries)	(e.g. fatality, long-term injury or incurable disease)

<b>Highly Unlikely</b>	Trivial Risk <input checked="" type="checkbox"/>	Tolerable Risk <input type="checkbox"/>	Moderate Risk <input type="checkbox"/>
<b>Unlikely</b>	Tolerable Risk <input type="checkbox"/>	Moderate Risk <input type="checkbox"/>	Substantial Risk <input type="checkbox"/>
<b>Likely</b>	Moderate Risk <input type="checkbox"/>	Substantial Risk <input type="checkbox"/>	Intolerable Risk <input type="checkbox"/>

<b>8. Note the advice below on suggested actions and timescales:</b>	
<b>Risk (from No.7)</b>	<b>Action/Timescale</b>
Trivial Risk <input checked="" type="checkbox"/>	No action is required and no records need to be kept.
Tolerable Risk <input type="checkbox"/>	No additional controls are required, although consideration may be given to an improvement that imposes no additional cost/s. Monitoring is required to ensure that the controls are maintained.
Moderate Risk <input type="checkbox"/>	Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and limited. Any new measures should be implemented within a defined period. Where the moderate risk is associated with extremely harmful consequences, further assessment may be necessary to establish more precisely the likelihood of harm as a basis for determining the need for improved control measures.
Substantial Risk <input type="checkbox"/>	Work should NOT commence until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk. Where the risk involves work in progress, urgent action MUST be taken.
Intolerable Risk <input type="checkbox"/>	Work should not be started or continued until the risk has been reduced. If it is not possible to reduce the risk even with unlimited resources, work MUST remain prohibited.

<p><b>9. If 'Moderate' 'Substantial' or 'Intolerable':</b></p> <p>What New Control Measures are to be Considered to reduce risk?</p>	<p><b>10. Referred to:</b></p>	<p><b>11. Date:</b></p>
--	--------------------------------	-------------------------

<p><b>12. Ensure those affected are informed of the Risks &amp; Controls</b></p> <p>(Confirm how you have done this e.g. written instructions):</p>					
<b>13. Person who did Assessment:</b>	Elizabeth Roberts	<b>14. Date:</b>	22/11/2011	<b>15. Review Date:</b>	22/11/2012
<b>16. Checked or Assisted By:</b>		<b>17. Date:</b>		<b>18. Review Date:</b>	



The Royal Bournemouth and   
Christchurch Hospitals  
NHS Foundation Trust

The Royal Bournemouth Hospital  
Castle Lane East  
Bournemouth  
Dorset  
United Kingdom  
BH7 7DW

Tel: 01202 303626  
www.rbch.nhs.uk

Mrs Grainne Ford  
Senior Dietician  
Dieticians Office ppA05  
Royal Bournemouth & Christchurch NHS Foundation Trust  
Castle Lane East  
Bournemouth  
BH7 7DW

06/01/2011

Dear Mrs Ford,

Reference: The care pathway for dysphagic stroke - qualitative, exploratory study (phase 1) v1.  
REC reference: 10/WSE04/46  
UKCRN ID: N/A

I am pleased to inform you that this project has now received approvals from all parties and that you now have formal permission to start.

Please see the Terms and Conditions for undertaking research at the Trust at:  
[http://dorsetresearch.org/docs/drc/TC\\_for\\_research\\_within\\_DRC.pdf](http://dorsetresearch.org/docs/drc/TC_for_research_within_DRC.pdf).

Please let me know when you officially start and I would be grateful for a progress report annually.

Good luck with the study,

Dr R. M. Chapman  
Head of Research

Carbon Copy: (CI) Ms Elizabeth Roberts, NHS Somerset, Wynford House, Lufton Way, Yeovil, Somerset.  
BA22 8HR

## Appendix 6



Derbyshire Community Health Services **NHS**  
NHS Trust



### Research and Development Office TRUST APPROVAL LETTER

Headquarters  
Newholme Hospital  
Baslow Road  
Bakewell  
Derbyshire  
DE45 1AD

Tel: 01629 812 525  
Fax: 01629 817 890

<http://www.dchs.nhs.uk/>

5<sup>th</sup> May 2011

Ms Elizabeth Roberts  
Wynford House  
Lufton Way  
Yeovil  
Somerset  
BA22 8HR

Dear Ms Roberts

**Re: The care pathway for dysphagic stroke survivors – qualitative, exploratory study (phase 1)**  
**Ref. DCHS/2011/001**

Further to the Research Ethics Committee approval for the above study, I am pleased to confirm Derbyshire County PCT management approval for you to proceed in accordance with the agreed protocol, the PCT's financial procedures for research and development and the Research Governance Framework (which includes the Data Protection Act 1998 and the Health & Safety at Work Act 1974).

Please supply the following to Dr Teresa Grieve, Assistant Director of Research & Development, R&D Office, Derby Hospitals NHS Foundation Trust:

- the actual start and end dates of this study (**before the study commences**).
- details of any publications arising from this research project.
- a final report and a report every six months if the study duration is greater than six months.
- notification of any adverse event or changes to the protocol or if the trial is abandoned.

Chief Executive Tracy Allen

Chair Andrew Fry



Please note that approval for this study is dependent on full compliance with all of the above conditions.

I would like to take this opportunity to wish you every success with this study.

Yours sincerely,

**Stuart Marwood**  
**Head of Compliance**

Email [stuart.marwood@dchs.nhs.uk](mailto:stuart.marwood@dchs.nhs.uk)  
Direct line 01629 8178

Chief Executive Tracy Allen

Chair Andrew Fry



Centre for  
**Wellbeing & Quality of Life**  
promoting wellbeing and quality of life through  
research, education, practice and enterprise

Chair in Health Research  
Deputy Dean Research & Enterprise  
Professor Kathleen Galvin  
kgalvin@bournemouth.ac.uk  
Direct line +44 (0) 1202 962184

5<sup>th</sup> July 2010  
Ref:KG/vs

**To Whom It May Concern  
Research Ethics Committee**

**RE: Elizabeth Roberts  
A qualitative exploratory study (phase 1) of the care pathway for dysphagic  
stroke survivors.**

On behalf of Bournemouth University, School of Health & Social Care, we are very  
happy to be the sponsors for the above project.

Please find enclosed evidence of our Indemnity.

Yours faithfully

**Professor Kathleen Galvin  
Chair in Health Research  
Deputy Dean Research and Enterprise  
School of Health & Social Care**

### Southwest Stroke Research Network – Summary of comments received (22/07/2010)

A lay summary of the proposed research was distributed to a panel of stroke survivors and their carers by the southwest Stroke Research Network, along with a feedback form. A total of 17 surveys were returned. The results are presented in the table below, along with corrective actions taken as a result.

<b>Question 1: Do you think this is a research study that should be done?</b>	
Yes <b>14</b>	No <b>0</b> Don't know <b>1</b> Did not answer <b>2</b>
<b>Positive comments</b>	
<p>Yes, for the sake of future dysphagia sufferers and for economy of health care professionals in both time and money.</p> <p>I can see the benefits for the patient of simplifying the process of treating dysphagia.</p> <p>Patients often say how tiring they find it repeating information and they don't understand why different healthcare professionals can't share information more.</p> <p>Several comments throughout the five question topics that more research/ a better understanding of stroke care after hospital/ in the community is needed.</p> <p>[Research] that explores records and reports what happens from patient's / carer's perspective in the care pathway for stroke survivors is necessary and particularly where multiple health professional input is required.</p> <p>There isn't sufficient information about the experience of dysphagia.</p> <p>Several comments that the study would be useful/ helpful/ was needed.</p> <p>Glaringly lacking what normally happens in hospitals and at home when a stroke leaves a patient with dysphagia and what role each health professional plays in the treatment of dysphagia.</p>	
<b>Negative comments</b>	<b>Corrective action taken</b>
<p>The hypothesis is too closed, introducing the idea of "combined" work. This could influence patient's responses. It almost seems that you are looking to make savings in staff.</p>	<p>The interview schedule was subsequently structured to question the current pathway first, followed by questions about extended scope practice.</p> <p>The research is set against the need for gains in productivity – no changes have therefore been made to the design.</p>
<p>I do not think that this research will improve the care pathway of the particular dysphagic sufferer and</p>	<p>This is highlighted in the participant information leaflet.</p>

may cause more harm.	One respondent commented that this would hopefully help stroke survivors in the future.
Better if the carer was questioned in the presence of the patient who could nod or shake their head if applicable.	The participant information leaflet and study design were amended to suggest that if the research subject was a carer, we would ask the stroke survivor if they wished to be present at the interview.
<b>Question 2: Having read the lay summary, can you see any problems for people participating in the study?</b>	
Yes <b>7</b> No <b>6</b> Don't Know <b>0</b> Did not answer <b>4</b>	
<b>Positive comments</b>	
If patients and carers are supported and clear explanations are given, there should be no problems.  This study should bring together everyone involved with the care of such a patient...	
<b>Negative comments</b>	<b>Corrective action taken</b>
Why are doctors excluded from the list of professional workers?	Senior medical staff have been included in the study design as informants (practitioners directly involved in the care of dysphagic stroke survivors)
Communicating with a researcher for up to an hour.  Being aware of when the patient is tiring.	Stroke survivors unable to participate in a semi-structured interview of 60 minutes duration have been excluded from the study.  The study protocol has been amended to ensure that the interview is stopped if the participant shows any signs of distress, fatigue or reluctance or indicates that he/ she wishes to stop.
An unavoidable problem, albeit in a good cause: Participating in this study increases the number of healthcare professionals that people at this stage of recovering from stroke are likely to be seeing.	Study design has not been amended. The study aims to collect patient perspectives during dysphagia treatment, rather than when this has resolved – there is a danger otherwise in missing key themes that are important at the time but fade from patient memory.
Unexpected distress during the meeting.	Researcher is an experienced clinician. The study protocol and design already include a period of 30 minutes after the interview where the researcher and/ or the

	interview room will be available to the participant. (These factors were not presented in the Lay Summary.)
Feedback and clarity on the person's role in the study.	This information is provided in the participant information leaflet. The participant will receive a copy of the research report on completion. (This information was not made available with the Lay Summary due to brevity.)
Embarassment.	The researcher is an experienced clinician in the field of dysphagia and nutrition. (This factor was not presented in the Lay Summary.)
The summary doesn't give enough emphasis on the follow-up after the patient has left hospital.	The study will be conducted in three sites, one of which will be a community trust. The researcher will actively seek to recruit participants throughout the dysphagia pathway.
Having someone replying for the patient (if aphasic/ dysphasic).	Consent will be sought from the patient for carer interview. The participant information leaflet and study design were amended to suggest that if the research subject was a carer, we would ask the stroke survivor if they wished to be present at the interview.
It is a good opportunity to ask questions but only if staff are really listening, not just hearing and trying to absorb answers to fit the study.	The grounded nature of the study should mean that key themes, whether anticipated or not, will emerge from the interviews. Triangulating these themes by using four different types of participants should enrich the themes that are generated.
Only for those who couldn't get to the place where the study will be.	Participants will be interviewed in their home/place of residence if they are not in a hospital at the time of the study.
<b>Question 3: Please comment on anything good about the study.</b>	
<b>Positive comments</b>	
<p>I can see the benefit of determining the effectiveness of the various health professionals...decrease the overlapping of health professionals, freeing up their time for other work.</p> <p>There appears to be a desire to have a holistic approach..., taking in the whole medical history...and how [health professionals] can work together.</p> <p>Search for what normally happens (particularly at home).</p>	

<p>Interview time limited.</p> <p>Coordination between health professionals.</p> <p>Getting first hand, direct information.</p> <p>Highlight where multi-professional approach is not happening.</p> <p>It will be important to find out as much as you can for future treatment.</p>	
<p><b>Question 4: Please comment on anything bad about the study.</b></p>	
<p><b>Negative comments</b></p>	<p><b>Corrective action taken</b></p>
<p>It would be better to collate patients' views and convene meetings with the workers to share their reactions.</p>	<p>No amendments made. The grounded nature of the study wishes to independently generate theory from all perspectives, rather than generate theory from users and test with professionals.</p>
<p>There is a danger in diluting specialist skills.</p>	<p>No amendments made. If an important theme, this should emerge from the study and will be addressed through data analysis and presentation.</p>
<p>A further objective might be to promote advances in techniques in the treatment of dysphagia through interaction between health professionals.</p>	<p>No amendments made. Although this research is in its infancy, the researcher does acknowledge that there are potential clinical benefits to treating dysphagia and nutrition holistically. If an important theme, this should emerge from the study and will be addressed through data analysis and presentation.</p>
<p>A disproportionate response from those who have had a good or a bad experience, skewing findings.</p>	<p>The interview protocol includes questioning around positive and negative aspects in each of the key areas. The researcher will aim to explore the care pathway in its entirety with each participant. As this is a qualitative study, the purpose is to generate a variety of good and bad themes, which can then be tested in Phase 2 (the survey) with a representative sample of participants.</p>
<p>You are making the assumption that some of the survivors and relatives/carers will be upset.</p>	<p>While the research protocol and participant information leaflet warns of the risk of upset, the researcher is aware that this may not be the case for most participants and will record her reflections on this topic in her research diary.</p>
<p><b>Question 5: Please comment on the "Lay Summary" part of the attached</b></p>	

<b>summary – particularly whether it is easy to read and understand, and whether it clearly explains what the study is about.</b>	
<b>Positive comments</b>	
<p>Clear concise writing.</p> <p>Several comments that the summary was easy to read, understand and clearly explained the study.</p> <p>Some commented that they enjoyed reading it.</p> <p>Asking the carer about the incident is quite valid as most stroke survivors appear to have a hazy recollection of the first stages of stroke recovery.</p>	
<b>Negative comments</b>	<b>Corrective action taken</b>
Comments regarding typo's/ font/ layout.	Lay summary amended/ corrected accordingly.
Is it usual for anyone to be named in a research article? Isn't the usual practice for people to be described as Patient A etc. and crucial giveaway information withheld from the published study?	The researcher will not include patient names in any published material. While the researcher feels that names offer a more engaging narrative account, rather than a letter or number, the researcher will use a pseudonym in published material, ie a made-up name, rather than the person's real first name.

### Invitation Letter – service users v1



Centre for  
**Wellbeing & Quality of Life**  
promoting wellbeing and quality of life through  
research, education, practice and enterprise

Dear Sir/ Madam

**RE: The care pathway for dysphagic stroke survivors –  
qualitative exploratory study**

You are invited to take part in a research study looking at eating, drinking and swallowing after a stroke. You have been chosen because you, or someone that you care for, has trouble swallowing because of a stroke.

The researcher will be speaking to patients and their carers about their experience of care. This can take place at home if you prefer. The researcher may also ask to look in your medical and/ or nursing notes. The information leaflet gives you more information about the study, and what is involved.

If you would like to take part in this study, or you would like to ask more questions about the study, please contact the researcher, who will be happy to help.

Researcher: Elizabeth Roberts  
Address: Somerset Community Dietitians  
East Quay Medical Centre  
Bridgwater  
Somerset  
TA6 4GP  
E-mail: [Elizabeth.Roberts@somerset.nhs.uk](mailto:Elizabeth.Roberts@somerset.nhs.uk)  
Telephone: 01278 447 407  
Mobile: 07920 275 556

**Thank you for considering taking part in this study.**

### Invitation Letter – staff v1



Centre for  
**Wellbeing & Quality of Life**  
promoting wellbeing and quality of life through  
research, education, practice and enterprise

Dear Sir/ Madam

**RE: The care pathway for dysphagic stroke survivors –  
qualitative exploratory study**

You are invited to take part in a research study looking at the care pathway for dysphagic stroke survivors. You have been chosen because you provide clinical care and/ or treatment to stroke survivors, or because you manage and/ or commission these services.

The research involves speaking to patients, their carers and NHS staff about the care pathway, as well as clinical note review. The interviews will take up to an hour and will be arranged at a time and place to suit you. The information leaflet gives you more information about the study, and what is involved.

If you would like to take part in this study, or you would like to ask more questions about the study, please contact the researcher, who will be happy to help.

Researcher: Elizabeth Roberts  
Address: Somerset Community Dietitians  
East Quay Medical Centre  
Bridgwater  
Somerset  
TA6 4GP  
E-mail: [Elizabeth.Roberts@somerset.nhs.uk](mailto:Elizabeth.Roberts@somerset.nhs.uk)  
Telephone: 01278 447 407  
Mobile: 07920 275 556

**Thank you for considering taking part in this study.**

## Participant information leaflet – Service Users v8



Centre for  
**Wellbeing & Quality of Life**  
promoting wellbeing and quality of life through  
research, education, practice and enterprise

### **The care pathway for dysphagic stroke survivors – qualitative exploratory study**

#### **Information for Participants (Service Users)**

Version 8, Date 12/11/2010

#### **Introduction**

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. **The researcher will go through the information sheet with you and answer any questions you have.** We'd suggest this should take about 10-15 minutes. Talk to others about the study if you wish.

Part 1 of this information sheet tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Ask us if there is anything that is not clear.

#### **Part 1**

#### **What is the purpose of the study?**

After a stroke, some people have trouble swallowing food and fluids (called dysphagia). Help is provided for eating and drinking from different health care professionals, including dietitians, speech and language therapists, nurses and others. This study will look at whether health care professionals can learn skills from each other and combine some of the work that they do. To do this, we must first understand what normally happens in hospitals and at home when a person has had a stroke, and what the different people do.

#### **Why have I been chosen?**

You have been chosen because you have trouble swallowing because of a stroke.

### **Do I have to take part?**

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You will be given a copy of this signed consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

### **What will happen to me if I take part?**

The researcher will be meeting and speaking to patients and their carers. We will be asking about your experience of care – what happened, who you saw and what they did, what has worked well, and what could be done better or differently. We will meet with you once. The meetings will last for up to an hour. You can have somebody with you if you prefer. The meeting will be tape recorded and then typed into a computer. The researcher may have to contact you again to check her understanding of your responses.

We may also like to look at your medical and nursing notes. This is so that the researcher can see who has seen you about eating and drinking, how often, and what happened.

### **What are the possible disadvantages and risks of taking part?**

If you have trouble eating and drinking, it may be upsetting talking about it. It can also be upsetting for those who care for you. However, the researcher is an experienced clinician and you can stop at any time.

### **What are the possible benefits of taking part?**

We cannot promise the study will help you, but the information we get from this study may help improve the treatment of people who have trouble swallowing after a stroke.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

### **Will my taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time, without giving a reason, and this will not affect the treatment that you receive. Once the meeting has started, you can still ask the researcher to stop at any time. If you do decide to stop taking part, the researcher will use any information already collected in her analysis.

### **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions. If you remain unhappy and wish to complain formally, you can do this Bournemouth University (Dr Jane Murphy). Contact details can be found at the end of this information leaflet.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence, then you may have grounds for a legal action for compensation against Bournemouth University, but you may have to pay your legal costs.

### **Will my taking part in the study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you will have your name and address removed so that you cannot be recognised. The research information (tape recordings, transcriptions, consent forms and research notes) will be stored in a locked filing cabinet. Your information will be given a number before it is entered onto the computer. Only the researcher will be able to access this information. If the researcher uses any direct quotations from you when presenting the study, these will be given a different name, so that you cannot be recognised from it. The research information will be stored for 12 months before it is destroyed securely.

We will not normally tell your GP or consultant that you are taking part in this study. This is because we are not carrying out any procedures. You can discuss the research with your healthcare professional if you wish to – it may be helpful to show them this sheet if you do. If they have any questions about the study, they are welcome to contact the researcher.

### **What will happen to the results of the research study?**

The results of the study will be published in a research report, international journals and at scientific meetings. In this way, other researchers and those who look after people who have had a stroke can learn about the findings. You will not be identified in any publications or presentation.

You will also be provided a copy of the final report at the end of the study. Any further questions can be addressed to the researcher.

### **Who is organising the research study?**

The research study is organised by Bournemouth University School of Health and Social Care.

### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the South East Wales Research Ethics Committee.

### **What happens if I have consented and am unable to continue to consent to take part in the study?**

If you have consented to take part in the study, and are not able to continue to give your consent, we will normally still include you in the study. If this happens, the researcher will only interview your carer and collect information from your notes – she will not interview you. She will speak with a member of your family, spouse or significant other first, to make sure he/ she thinks that you would have wished to continue. The consent form will ask you to indicate who she should ask if this should happen. If this person does not believe that you would have wished to continue, then no further information will be collected. Information that has already been collected with your consent will still be used in the study.

### **Who should I contact for further information?**

If you have any further questions about this study before deciding whether to take part, you can contact the researcher on the numbers below. If you decide to take part, you should keep hold of this sheet, in case you have any questions afterwards. The researcher will only be able to answer questions in relation to this study.

For questions related to your care and treatment, you should talk to your doctor, nurse or other health care professional.

If you are unhappy about the study, you should discuss this with the researcher. If you remain unhappy with the study, or wish to complain formally, then please contact Dr Jane Murphy.

<b>Researcher:</b>	Elizabeth Roberts
Address:	Somerset Community Dietitians East Quay Medical Centre Bridgwater Somerset TA6 4GP
E-mail:	<a href="mailto:Elizabeth.Roberts@somerset.nhs.uk">Elizabeth.Roberts@somerset.nhs.uk</a>
Telephone:	01278 447 407
Mobile:	07920 275 556

<b>Academic supervisor:</b>	Dr Jane Murphy
Address:	Framework Lead – Nutrition & Exercise Science School of Health & Social Care Bournemouth University Royal London House Christchurch Road Bournemouth Dorset BH1 3LT
E-mail:	<a href="mailto:jmurphy@bournemouth.ac.uk">jmurphy@bournemouth.ac.uk</a>
Telephone:	01202 962 805
<b>Bournemouth University representative:</b>	Professor Kathleen Galvin

Address:	Deputy Dean and Head of Research School of Health & Social Care Bournemouth University Royal London House Christchurch Road Bournemouth Dorset BH1 3LT
E-mail:	<a href="mailto:kgalvin@bournemouth.ac.uk"><u>kgalvin@bournemouth.ac.uk</u></a>
Telephone:	01202 962 167

**Thank you for considering taking part in this study.**



### **The care pathway for dysphagic stroke survivors – qualitative exploratory study**

#### **Information for Participants (Staff)**

Version 4, Date 12/11/2010

#### **Introduction**

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. **The researcher will go through the information sheet with you and answer any questions you have.** We'd suggest this should take about 10-15 minutes. Talk to others about the study if you wish.

Part 1 of this information sheet tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Ask us if there is anything that is not clear.

#### **Part 1**

#### **What is the purpose of the study?**

After a stroke, some patients experience dysphagia. Assessment and advice on nutrition and fluids is provided by different health care professionals, including dietitians, speech and language therapists, nurses and others. This study will look at whether health care professionals can learn skills from each other and combine some of the work that they do. To do this, we must first understand what normally happens in hospitals and at home when a person has had a stroke, and what the different professionals do.

#### **Why have I been chosen?**

You have been chosen because you provide clinical care to dysphagic stroke survivors.

### **Do I have to take part?**

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You will be given a copy of this signed consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

### **What will happen to me if I take part?**

The researcher will be meeting and speaking to patients, their carers, as well as clinical and managerial staff. We will be asking about the management of dysphagic stroke survivors - what happens, who sees the patient and what they do, what works well, and what could be done better or differently. We will meet with you once. The meetings will last for up to an hour. You can have somebody with you if you prefer. The meeting will be tape recorded and then typed into a computer. The researcher may have to contact you again to check her understanding of your responses.

### **What are the possible disadvantages and risks of taking part?**

If you agree to take part, you must be available to take part in a meeting that will last up to one hour. You may also be required to be available by telephone for up to fourteen weeks after the meeting if the researcher needs to check her understanding of your responses.

### **What are the possible benefits of taking part?**

We cannot promise the study will help you, but the information we get from this study may help improve the treatment of people who have trouble swallowing after a stroke.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

### **Will my taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time, without giving a reason. Once the meeting has started, you can still ask the researcher to stop at any time. If you do decide to stop taking part, the researcher will use any information already collected in her analysis.

### **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions. If you remain unhappy and wish to complain formally, you can do this Bournemouth University (Dr Jane Murphy). Contact details can be found at the end of this information leaflet.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence, then you may have grounds for a legal action for compensation against Bournemouth University, but you may have to pay your legal costs.

### **Will my taking part in the study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you will have your name and contact details removed so that you cannot be recognised. The research information (tape recordings, transcriptions, consent forms and research notes) will be stored in a locked filing cabinet. Your information will be given a number before it is entered onto the computer. Only the researcher will be able to access this information. If the researcher uses any direct quotations from you when presenting the study, these will be given a different name, so that you cannot be recognised from it. The research information will be stored for 12 months before it is destroyed securely.

## **What will happen to the results of the research study?**

The results of the study will be published in a research report, international journals and at scientific meetings. In this way, other researchers and clinicians can learn about the findings. You will not be identified in any publications or presentation.

You will also be provided a copy of the final report at the end of the study. Any further questions can be addressed to the researcher.

## **Who is organising the research study?**

The research study is organised by Bournemouth University School of Health and Social Care.

## **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the South East Wales Research Ethics Committee.

## **Who should I contact for further information?**

If you have any further questions about this study before deciding whether to take part, you can contact the researcher on the numbers below. If you decide to take part, you should keep hold of this sheet, in case you have any questions afterwards. The researcher will only be able to answer questions in relation to this study.

If you are unhappy about the study, you should discuss this with the researcher. If you remain unhappy with the study, or wish to complain formally, then please contact Dr Jane Murphy.

<b>Researcher:</b>	Elizabeth Roberts
Address:	NHS Somerset Wynford House Lufton Way Yeovil Somerset BA22 8HR
E-mail:	<a href="mailto:Elizabeth.Roberts@somerset.nhs.uk">Elizabeth.Roberts@somerset.nhs.uk</a>
Telephone:	01935 384 000
Mobile:	07920 275 556

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**Thank you for considering taking part in this study.**





Centre Number: \_\_\_\_\_ Study Number: \_\_\_\_\_  
Participant Identification Number for this study: \_\_\_\_\_

**CONSENT FORM FOR RESEARCH STUDY (STAFF)**

**Title of Study:** The care pathway for dysphagic stroke survivors – qualitative exploratory study

**Name of Researcher:** Elizabeth Roberts, Registered Dietitian

**Please initial to confirm**

- I confirm that I have read and understand the information sheet dated 12/11/2010, version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without legal rights being affected.
- I understand that relevant sections of the data collected during the study may be looked at by individuals from Bournemouth University, from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my research data.
- I agree to take part in the above research study.

\_\_\_\_\_  
Name of Participant                      Date                      Signature

\_\_\_\_\_  
Name of Person taking consent      Date                      Signature

When completed: 1 (original) for participant, 1 for researcher site file.

## Interview Schedule Service Users v2

<b>Interview Schedule (Service users)</b>		
Interviewer:	Participant number:	
Venue:		
Date:	Start time:	Finish time:
<b>Preamble:</b> Permission to record		
<b>Introduction – diagnosis and current situation:</b>		
<ul style="list-style-type: none"> <li>• When and where stroke was diagnosed.</li> <li>• Where treatment (and rehabilitation) took place.</li> <li>• Ability to eat and drink at the moment.</li> <li>• Ability to eat and drink at diagnosis.</li> <li>• Help with meal preparation, shopping etc.</li> <li>• Help with eating and drinking.</li> </ul>		
<b>Section 1 – the process of dysphagia and nutritional care/ fluids.</b>		
In acute hospital/ initial diagnosis/ first days on the wards (where applicable):		
<ul style="list-style-type: none"> <li>• The professionals that were involved.</li> <li>• How often they visited.</li> <li>• What the professionals did.</li> <li>• What happened after each of these visits?</li> </ul>		
During rehabilitation in acute/ community hospital (where applicable):		
<ul style="list-style-type: none"> <li>• The professionals that were involved.</li> <li>• How often they visited.</li> <li>• What the professionals did.</li> <li>• What happened after each of these visits?</li> </ul>		
Community care/ at home/ nursing/ residential care (where applicable):		
<ul style="list-style-type: none"> <li>• The professionals that were involved.</li> <li>• How often they visited.</li> <li>• What the professionals did.</li> <li>• What happened after each of these visits?</li> </ul>		
<b>Section 2 – Views on care pathway/ processes.</b>		

- What is good about the care received – acute care, rehabilitation, community/ at home?
- Why?
- What is lacking/ missing – acute care, rehabilitation, community/ at home?
- Why?
- What is unnecessary/ superfluous - acute care, rehabilitation, community/ at home?
- Why?
- What could be done differently/ improved upon – acute care, rehabilitation, community/ at home?
- Why and how?

**Section 3 – views on extended roles.**

- What would be good/ improve upon the service user experience.
- What would not be good/ disadvantageous.
- The factors that have to be considered from a service user perspective if change were to happen.

**Section 4 – other thoughts/ areas not covered.**

**Post-interview notes:**

- thoughts about the setting (busy/quiet, other people around, venue, etc),
- impressions of the interviewee (s) (talkative, nervous, speech and ability to communicate, etc),
- feelings about the interview content (did it open up new themes, were there unexplored issues/ unanswered questions?),
- reflective observations on how my engagement effected the quality of data collected,
- other points to note.

## Interview Schedule Staff v2

Interview Schedule (Staff)		
Interviewer:	Participant number:	
Venue:		
Date:	Start time:	Finish time:
<b>Preamble:</b> Permission to record		
<b>Introduction – background and experience:</b> <ul style="list-style-type: none"> <li>• Current position.</li> <li>• Current area of responsibilities in relation to stroke.</li> <li>• Professional background.</li> <li>• Years qualified.</li> <li>• Additional stroke/ nutrition/ dysphagia-related qualifications where applicable).</li> <li>• Years in clinical practice (where applicable).</li> <li>• Years in managerial role (where applicable).</li> <li>• Clinical experience of stroke care (where applicable).</li> <li>• Current stroke caseload (contacts/ weekly sessions/ percentage of total caseload) (where applicable).</li> </ul>		
<b>Section 1 – the process of dysphagia and nutritional care/ fluids.</b>		
In acute hospital/ initial diagnosis/ first days on the wards (where applicable):		
<ul style="list-style-type: none"> <li>• The professionals that are involved.</li> <li>• How often they visit/ service users are reviewed.</li> <li>• What the professionals do.</li> <li>• What happens as a result of these visits?</li> </ul>		
During rehabilitation in acute/ community hospital (where applicable):		
<ul style="list-style-type: none"> <li>• The professionals that are involved.</li> <li>• How often they visit/ service users are reviewed.</li> <li>• What the professionals do.</li> <li>• What happens as a result of these visits?</li> </ul>		
Community care/ at home/ nursing/ residential care (where applicable):		
<ul style="list-style-type: none"> <li>• The professionals that are involved.</li> <li>• How often they visit/ service users are reviewed.</li> <li>• What the professionals do.</li> <li>• What happens as a result of these visits?</li> </ul>		

**Section 2 – Views on care pathway/ processes.**

- What is good about the current/ typical care pathway – acute care, rehabilitation, community/ at home (service user, clinician, system as a whole)?
- Why?
- What is lacking/ missing – acute care, rehabilitation, community/ at home (service user, clinician, system as a whole)?
- Why?
- What is unnecessary/ superfluous - acute care, rehabilitation, community/ at home (service user, clinician, system as a whole)?
- Why?
- What could be done differently/ improved upon – acute care, rehabilitation, community/ at home?
- Why and how?

**Section 3 – views on extended roles.**

- What would be/ is beneficial from the perspective of the service user (user experience, clinical care).
- What would be/ is beneficial from the perspective of the clinicians providing care (Dietitians, SLTs, nurses, doctors, others).
- What would be/ is beneficial from the perspective of the service/ system as a whole.
- What would not be beneficial/ disadvantageous from the perspective of the service user (user experience/ clinical care).
- What would not be beneficial/ disadvantageous from the perspective of the clinicians providing care (Dietitians, SLTs, nurses, doctors, others). (user experience/ clinical care).
- What would not be beneficial/ disadvantageous from the perspective of the service/ system as a whole.
- The factors that have to be considered/ be in place if change were to happen.
- Factors that would prevent change.
- Factors that would encourage change.

**Section 4 – other thoughts/ areas not covered.****Post-interview notes:**

- thoughts about the setting (busy/quiet, other people around, venue, etc),
- impressions of the interviewee (s) (talkative, nervous, speech and ability to communicate, etc),
- feelings about the interview content (did it open up new themes, were there unexplored issues/ unanswered questions?),

- reflective observations on how my engagement effected the quality of data collected,
- other points to note.

### Participant 02

#### Interview Date: 20/4/2011

Qualified 2000, started working in Bournemouth, been there ever since, working on stroke unit for 8 years, now works part-time, 2 days stroke unit (on ward + service development), 1 day celiac clinic.

No out-patient clinic for stroke, general clinic only and home visits if unable to come in, patient given information on leaving hospital. If dysphagia on discharge, then SLTs would follow up and refer to dietitians for out-patient clinic if needed. Or to community dietitians service. Patients can contact if within a year for telephone advice.

Waiting list for general clinic around 10 weeks. Most patients stable on discharge.

On wards referrals can be referred by SLTs or DTNs. Swallow screen ideally within 24 hrs, but up to 48 hrs. MUST score within 48 hrs.

1 Dietitians will get referrals without patient having seen SLT – Hayley will refuse to see until SLTs seen, unless have had failed DTN screen and has NGT, or have passed swallow screen. If unsure about screen, will need to see SLT first. This doesn't really happen often, as ward staff know, "not a big turnover of staff so they know".

2 What does dietitian do, apart from NGT and prevention advice? Food records charts, "topping up" with supplements, go back and review in 2-3 days. How many reviews? Depends on consistency, will be reviewed as long as patient is on ward. Can be reviewed daily, especially more complex ones, ie NGTs.

3 Supplements – relies on these here, she thinks possibly less so at Ch, where they have more time for food. "food has more time"

4 Her thoughts on SLTs assessing food record charts<sup>1</sup> – SLTs will say they are not dietitians, they will say "it looks like they are doing well, but I still want you to do an assessment", so Dietitians will assess how many calories they are having, so although it might look like they are having a lot, what they are having is not particularly nutrient dense. Does it come from SLTs, the "they are not dietitians"? They still want our input, so obviously it's more of a specialised thing that we do, compared to what they do" (ie assessing nutrient content/ energy density/ kcal content of someone's diet).

Is it SLTs who say, they will want dietitian to see patient? "I think it is mutual respect (min 14)" "there is some overlap, but there is mutual respect" i.e. respect that their expertise is swallowing and dietitians is nutrition, artificial feeding. From their training they would not be able to look at a food record chart and estimate how many calories were in it. **So she doesn't really answer the question, but justifies why they each do what they do.** "Putting our expertise together"

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<sup>1</sup> Minute 13: in relating back to an SLT talking about them doing more nutritional assessment with food record charts.

Are there parts that could be learnt – “I suppose they could look at calorie content if they wanted to”, but it’s not part of their training, i.e. to look at kcal content, “it becomes almost second nature”.

She also mentions that SLTs have “more practical hands-on training”, and Dietitians generally don’t.

Then she comes back to food record chart, these sometimes aren’t filled in, and dietitian will need food record chart to make full assessment. (She picks up on the food record chart based assessment in quite some detail.)

5 If on modified consistency, difficult to find things for people to eat, which is why we rely so much on supplements. You’re very limited with a modified consistency diet, if she could just have a little trolley with different suitable foods, we wouldn’t rely on them so much. They get taste fatigue from supps. “It’s awful to say”, but sometimes, if they have an NG, you keep it for a bit longer, because that way you know they are getting the nutrition. The problems are that they get tired, so spilt up meals, and making it more nutrient dense, assistance and/ or encouragement, i.e. talk to them while they are eating. People aren’t getting the assistance, because of staffing. Even with protected meal times, with a 28-bed ward, there just aren’t enough staff at mealtimes. They did have volunteer feeder scheme, but they can’t assist people who are under SLT, because they aren’t trained. SLTs most anxious to not allow a volunteer(s) to feed. So trained nurses and HCAs can feed, HCAs have done stroke care NVQ (which also means they can set up NGTs). (I need to check whether this is always the case.)

Feeding by families: not allowed while in acute hospital, because they are acutely unwell, monitoring chest, etc. SLT/ Dietitians happy for carers to help with feeding at rehab unit (i.e. Ch).

Her thoughts on an enhanced role in dysphagia:

“stepping on people’s toes” (min 30), “nurse roles”, not sure how confident she would be. More suited to nursing, more experienced of being hands-on with patients, more in-depth knowledge physiologically, “doing smth to a patient”, worried about “doing smth wrong”, not to do with touching them, wouldn’t want to put herself in that position, doesn’t have the training, possibly if there was appropriate training she would consider it. Maybe more useful if there was a need, they have nurses and SLTs who do a good job.

6 The waiting time (10 weeks) doesn’t constitute a need, they are not inundated with calls, and the community team are good.

SLTs have more of an input when they are at home, and they will refer them on “if they have an inkling that someone isn’t doing very well”. It may help for out-patients if SLTs could weigh pts and do a MUST score. They can be referred to either community diet team “how useful is it for them to know what a patient’s requirements are, the calorie content of what they are eating” patients seem to be referred by SLTs if SLTs are concerned (what happens if they are not under SLT?)

6 SLTs will refer to hospital diets for out-patient appt or community diets for home visit, “it all takes time”, can be days, can be weeks, depending on priority.

No need for SLTs to look at food records, as enough staff, and if nutrition care was being held up, then perhaps yes, but then even physio or OT could do it.

7 There is an understanding of what each other's role is, an MDT approach. Respect for boundaries is part of team working. Stepping on toes: "If somebody started doing what I'm doing, then you don't really need me, then!" "It would have to be agreed team thing". It would make her uncomfortable if somebody started doing this tomorrow. She would want to know what their background and training is, why they want to do it, does the ward want it, is that how the ward should be working. "Is that right, do they know what they are doing?" "You would have to challenge it". "Is that what you trained to do?" It is important to have different roles, if you are too general, things "slip" a bit, you don't get the quality, different bits of input adds to the care. "We're always saying there aren't enough dietitians on the ward, they're always saying that we need more input, staffing can be more difficult for us to be on the ward more. (This is important, because she says this, but in contrast says that there would be no benefit from extended roles.) If it were needed, "we could work together", OK if it were joint working, but not if someone" went and did it behind my back", "at the end of the day, we're trying to care for the patient, it's got to be right for the patient".

8 Nurses will pick up a supplement because they think they need smth, but it might not be the right one, someone might be diabetic, and there is a protocol on the ward "it's not how we should be doing things", to make sure it is right for the patient. SLTs will sometimes pick up a Forticreme or smth and they can have this or that, "but the policy is", you can't just do things. She then queries whether SLTs can prescribe (but can diets???)

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**Theoretical sampling:** To explore further for interview 3, which is with a dietitian –

- 6 Do we therefore need more dietitians?
- 7 What are some of the things that would concern you with SLTs doing some of our (i.e. dietitians) job? (stepping on toes, boundaries)
- 7 Stop you? (hands-on, confidence, doing harm)

---

**Post-interview notes:** This interview went much better in the sense that I did probe more than in the previous one, and I felt comfortable doing so. I got a strange sense of power, which gave me the confidence to probe, but I must keep this in check, if I am to gain good data during collection (I think this sense will come across and may impact upon participants' feeling of confidence with me).

What struck me during this interview was the way in which the dietitians have created a sense that ward staff cannot use supplements, because only the dietitian or a doctor can prescribe these. As far as I am aware, these products are ACBS and dietitians are not supplementary/ independent prescribers – need to check this out. Does this expand what seems to be a developing concept of CONTROL – does "owning" the rights to prescribe supplement s infer some sort of control? I will check this out with the nurse I have been invited to research later on.

A further thing that struck me was a real question over, not the role of the SLT during this, but the role of the dietitian. This stood out again when I was recording data from the service user's medical records. The SLT makes a thorough assessment of motor functions, cranial nerves, etc, but the dietitian merely notes bowels, weight, fluid intake etc. This is interesting and quite in contrast to my thoughts on starting with the research question. What I did consider during and after the day, was whether the dietitian's role in swallow therapy would improve care in the community setting, as we are referred people for poor eating. In the acute setting however, perhaps the SLT should be the one to manage the entire nutrition pathway. **There is a paper about SLTs understanding poorly the limited benefit on aspiration of I think jejunal tubes**, but query dietitians are much better in this respect? Does the research become more about the role of the dietitian more generally? I remember a paper by Rick Wilson, about dietitians spending 4 years in training to determine why a little old lady wasn't eating well, which the ward could have done, and that the dietitian should be more involved in public health. On this note, is it not bizarre, that a Dietitian can be trained to insert nasogastric tubes (and she refers to this in the interview), but an SLT will not. And yet, their assessment is putting patients at risk of aspiration and they should be more aware of the signs and symptoms of aspiration than a dietitian routinely. Conversely, if a dietitian can place tube safely, this adds again to the argument that perhaps they could do more with swallowing assessment.

Interesting the sense of the researcher's role in the research process. I am inclining towards Charmaz's position, of interpretive grounded theory. How I am analysing the data, and then "constructing" (to quote Charmaz's title) further data collection, is dependent on where I am personally in terms of my career. That is not to say this is incorrect, and that the "truth" as it were is out there, but perhaps what part of the truth you uncover depends on where the researcher is in space and time.

## Appendix 18

<b>SURNAME</b>		<b>FORENAME</b>		<b>NAME OF DTN</b>	
<b>D.O.B</b>		<b>NHS No.</b>		<b>HOSPITAL/ WARD/CARE HOME</b>	

### SPEECH AND LANGUAGE THERAPY SERVICES SCREENING FOR DYSPHAGIA

Date and Time of Assessment \_\_\_\_\_

State main diagnosis here \_\_\_\_\_

Pre-assessment  
Tick Action Box

circle 'yes' or 'no'

is mouth clear?	→	no	→	oral care	→	<input type="checkbox"/>
↓ yes						
is patient alert?	→	no	→	postpone assessment	→	<input type="checkbox"/>
↓ yes						
can patient be sat upright?	→	no	→	postpone assessment	→	<input type="checkbox"/>
↓ yes						
<b>PRELIMINARY OBSERVATIONS</b>						
is facial expression normal and symmetrical?	→	no	→	note here and continue assessment with care	→	<input type="checkbox"/>
↓ yes						
does patient open and close lips and mouth?	→	no	→	note here and continue assessment with care	→	<input type="checkbox"/>
↓ yes						
can patient control saliva?	→	no	→	note here and continue assessment with care	→	<input type="checkbox"/>
↓ yes						
is breathing normal?	→	no	→	note here and continue assessment with care	→	<input type="checkbox"/>
↓ yes						
is chest clear?	→	no	→	note here and continue assessment with care	→	<input type="checkbox"/>
↓ yes						
can patient cough to command?	→	no	→	note here and continue assessment with care	→	<input type="checkbox"/>

↓  
yes  
↓

can patient cough spontaneously?	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
----------------------------------	------	---	---	----------------------------

↓  
yes  
↓

is cough strong?	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
------------------	------	---	---	----------------------------

↓  
yes  
↓

is voice quality normal? Listen for 'gurgly' sounds	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
--	------	---	---	----------------------------

↓  
yes  
↓

**ORAL STAGE**

is mouth clear of infection?	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
------------------------------	------	---	---	----------------------------

↓  
yes  
↓

can patient achieve:	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
- lip seal	→ no	→		
- lip spread	→ no	→		
- lip rounding	→ no	→		

↓  
yes  
↓

can patient achieve:	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
- tongue elevation	→ no	→		
- lateral tongue movement	→ no	→		

↓  
yes  
↓

can patient stick tongue out?	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
can patient say /k/?	→ no	→		

↓  
yes  
↓

**ORAL/PHARYNGEAL STAGE**

On each occasion feel for laryngeal elevation. if the patient becomes distressed, STOP THE ASSESSMENT, and consider direct referral to Speech & Language Therapist.

1)	- is there any laryngeal elevation?	→ no	→	note here and continue assessment with care	→ <input type="checkbox"/>
	- is breathing pattern normal?	→ no	→		
	- is voice quality unchanged?	→ no	→		
	- Did patient swallow without coughing				
	- for up to 2 minutes afterwards?	→ no	→		
	- Did patient swallow within 5 seconds?	→ no	→		

↓  
yes  
↓

3 x one teaspoon	- is there any laryngeal elevation?	→ no	→		
	- is breathing pattern normal?	→ no	→		
	- is voice quality unchanged?	→ no	→		
	- Did patient swallow without coughing			go to 2) →	→ <input type="checkbox"/>
	- for up to 2 minutes afterwards?	→ no	→		
	- Did patient swallow within 5 seconds?	→ no	→		

↓  
yes  
↓  
GO TO 3)

<b>SURNAME</b>		<b>FORENAME</b>		<b>NAME OF DTN</b>	
<b>D.O.B</b>		<b>NHS No.</b>		<b>HOSPITAL/ WARD/CARE HOME</b>	

<b>2)</b> custard consistency drinks 3 x one teaspoon	- is there any laryngeal elevation? - is breathing pattern normal? - is voice quality unchanged? - did patient swallow without coughing for up to 2 minutes afterwards? - did patient swallow within 5 seconds?	→	no	→	discuss with multidisciplinary team & speech & language therapist re:	
		→	no	→	dysphagia	
		→	no	→	management plan →	<input type="checkbox"/>

↓  
yes  
↓

start teaspoons of custard consistency fluids → continue at 4) and 5)

<b>3)</b> sips of normal fluids from a ordinary cup	- is there any laryngeal elevation? - is breathing pattern normal? - is voice quality unchanged? - did patient swallow without coughing for up to 2 minutes afterwards? - did patient swallow within 5 seconds?	→	no	→	start teaspoons of normal fluids continue at 5) →	
		→	no	→		<input type="checkbox"/>
		→	no	→		<input type="checkbox"/>

↓  
yes  
↓

start normal liquids from a normal cup and continue assessment for diet consistencies at 5)

**4) ASSESSMENT FOR SIPS OF CUSTARD THICKENED FLUIDS**

**You may assess with SIPS of custard thickened fluids if:**

teaspoons of custard have been recommended at stage 2 of assessment and has been observed to manage a minimum of 10 teaspoons demonstrating: consistent laryngeal elevation; voice and breathing unchanged; no coughing post swallow. (If problems with teaspoons of custard fluid will need to consider re-assessment and referral to SLT)

**Date/time of assessment with sips:**

<b>sips of custard</b>	- is there laryngeal elevation - is breathing pattern normal - is voice quality unchanged - did patient swallow without coughing - did patient swallow within 5 seconds	→	no	→	Maintain on Teaspoons of custard continue at 5)	
		→	no	→		<input type="checkbox"/>
		→	no	→		<input type="checkbox"/>

↓  
yes  
↓

Start supervised trial with sips of custard consistency

<b>5)</b> give patient mousse/set yoghurt using a 5ml teaspoon 6 x one teaspoon	- is there any laryngeal elevation? - is breathing pattern normal? - is voice quality unchanged? - did patient swallow without coughing for up to 2 minutes afterwards? - did patient swallow within 5	→	no	→	<b>STOP ASSESSMENT</b> Discuss with multidisciplinary team and speech & language therapist re: dysphagia	
		→	no	→		<input type="checkbox"/>
		→	no	→		<input type="checkbox"/>

↓  
yes to all questions →

**CONTINUED**

**IF SAFE TO DO SO CONTINUE TO ASSESS FOR SAFEST DIET CONSISTENCY:**

is patient's mouth clear?	→	no	→	discuss with speech & language therapist	
can patient chew and clear mouth adequately for a smooth diet (i.e. mouth is clear)	→	no	→		→ <input type="checkbox"/>

↓  
yes

can patient chew sufficiently for a fork mashable diet and clear mouth?	→	no	→	start smooth dysphagia diet	→ <input type="checkbox"/>
---	---	----	---	-----------------------------	----------------------------

↓  
yes

can patient chew sufficiently for a soft diet and clear mouth?	→	no	→	start fork mashable diet	→ <input type="checkbox"/>
--	---	----	---	--------------------------	----------------------------

↓  
yes

can patient chew sufficiently for a normal diet and clear mouth?	→	no	→	start soft options	→ <input type="checkbox"/>
--	---	----	---	--------------------	----------------------------

↓  
yes

can patient control food well enough to eat mouthfuls?	→	no	→	start with teaspoons	→ <input type="checkbox"/>
--	---	----	---	----------------------	----------------------------

↓  
yes

**POST ASSESSMENT**

is patient's mouth clear after assessment?	→	no	→	carry out oral care	→ <input type="checkbox"/>
--	---	----	---	---------------------	----------------------------

↓  
yes

**SUMMARY** (refer back to the difficulties you have noted when ticking the action boxes)

**RECOMMENDATIONS RE: ORAL INTAKE** (include whether supervision needed)

**COMMUNICATE WITH:**

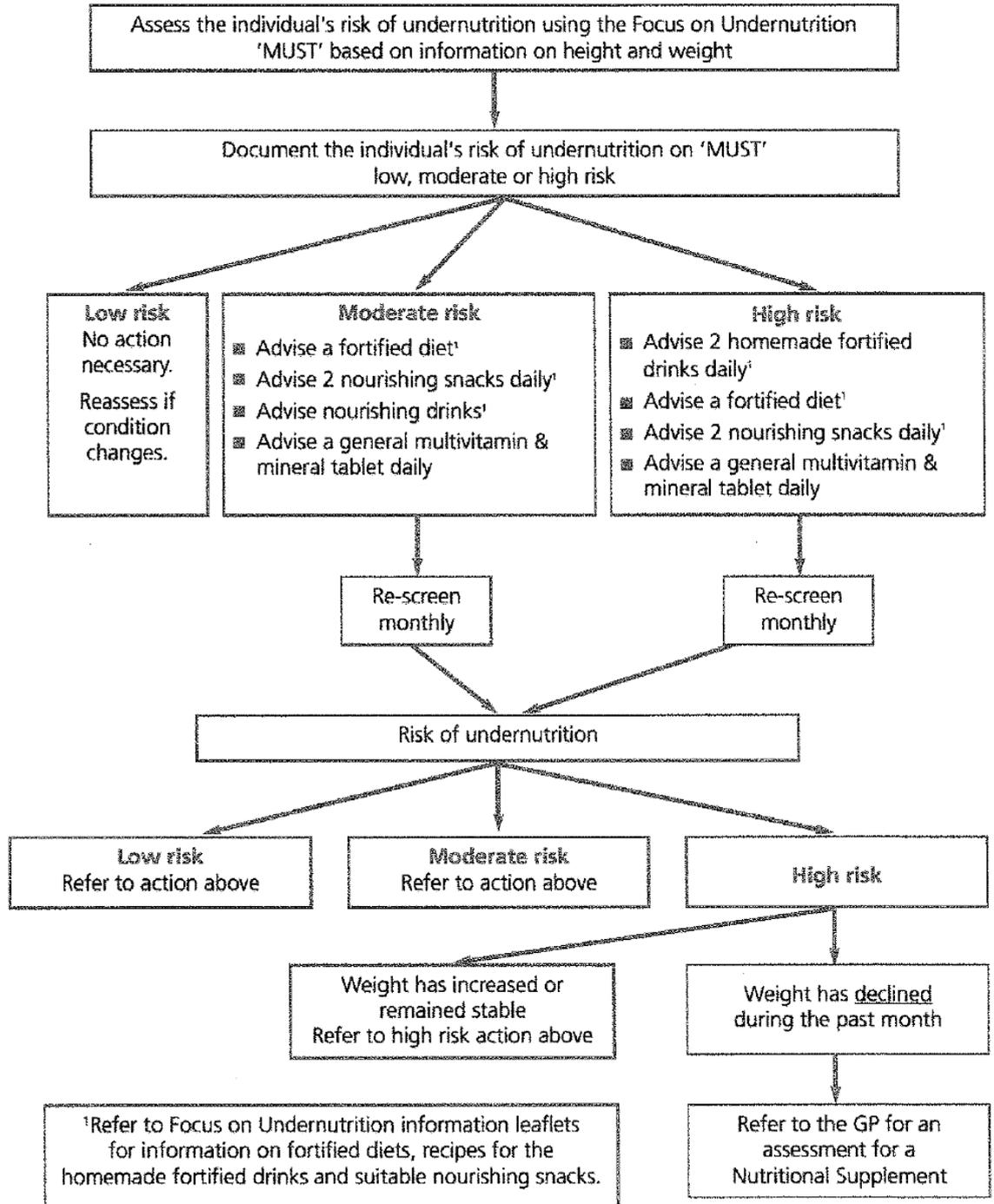
**OTHER ACTIONS:**

Signature of Dysphagia Trained Nurse ..... Date \_\_/\_\_/\_\_\_\_  
Time \_\_\_\_\_



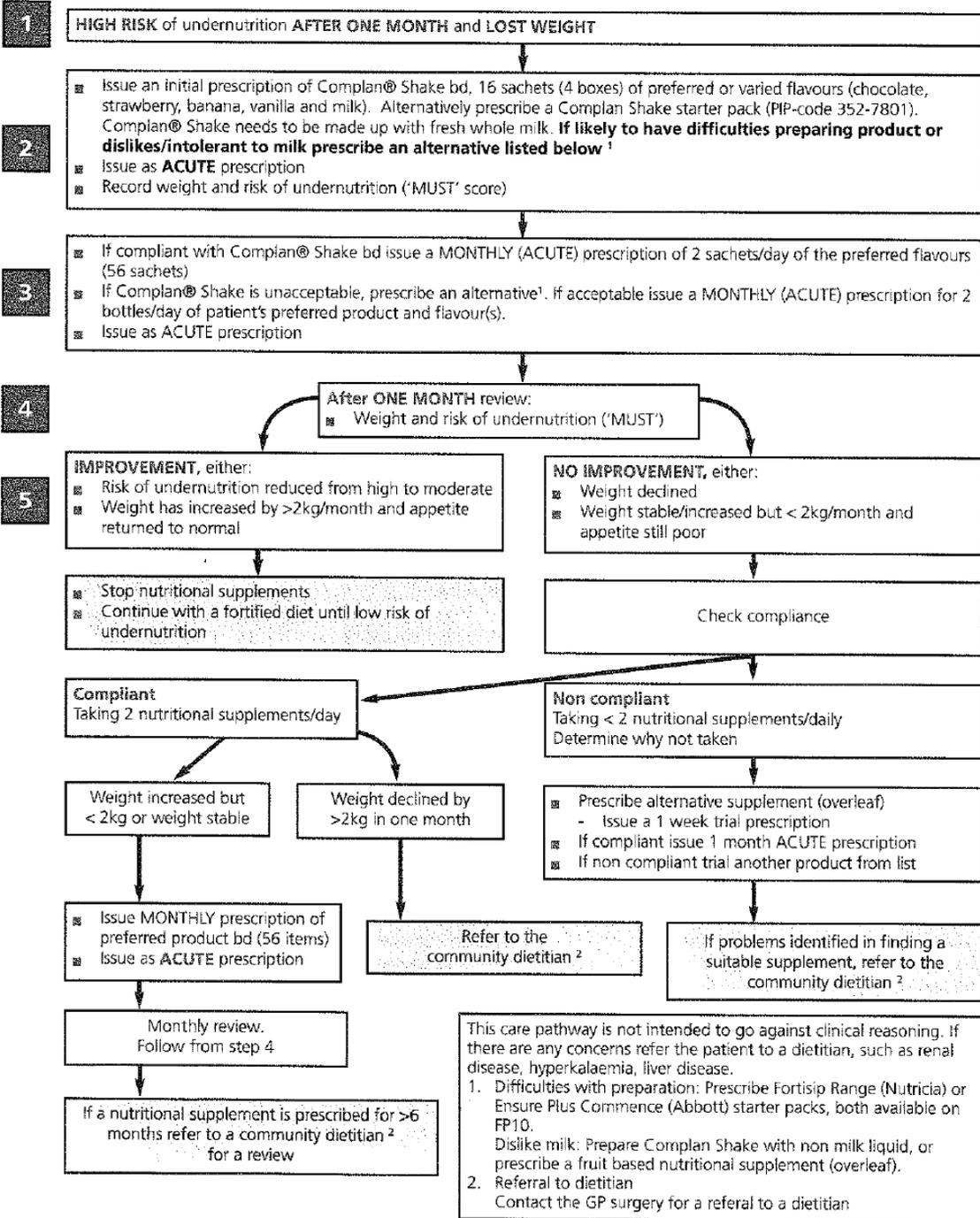
## Care pathway for undernutrition

This care pathway summarises the recommendations of Focus on Undernutrition interventions for individual's identified as moderate or high risk of undernutrition.

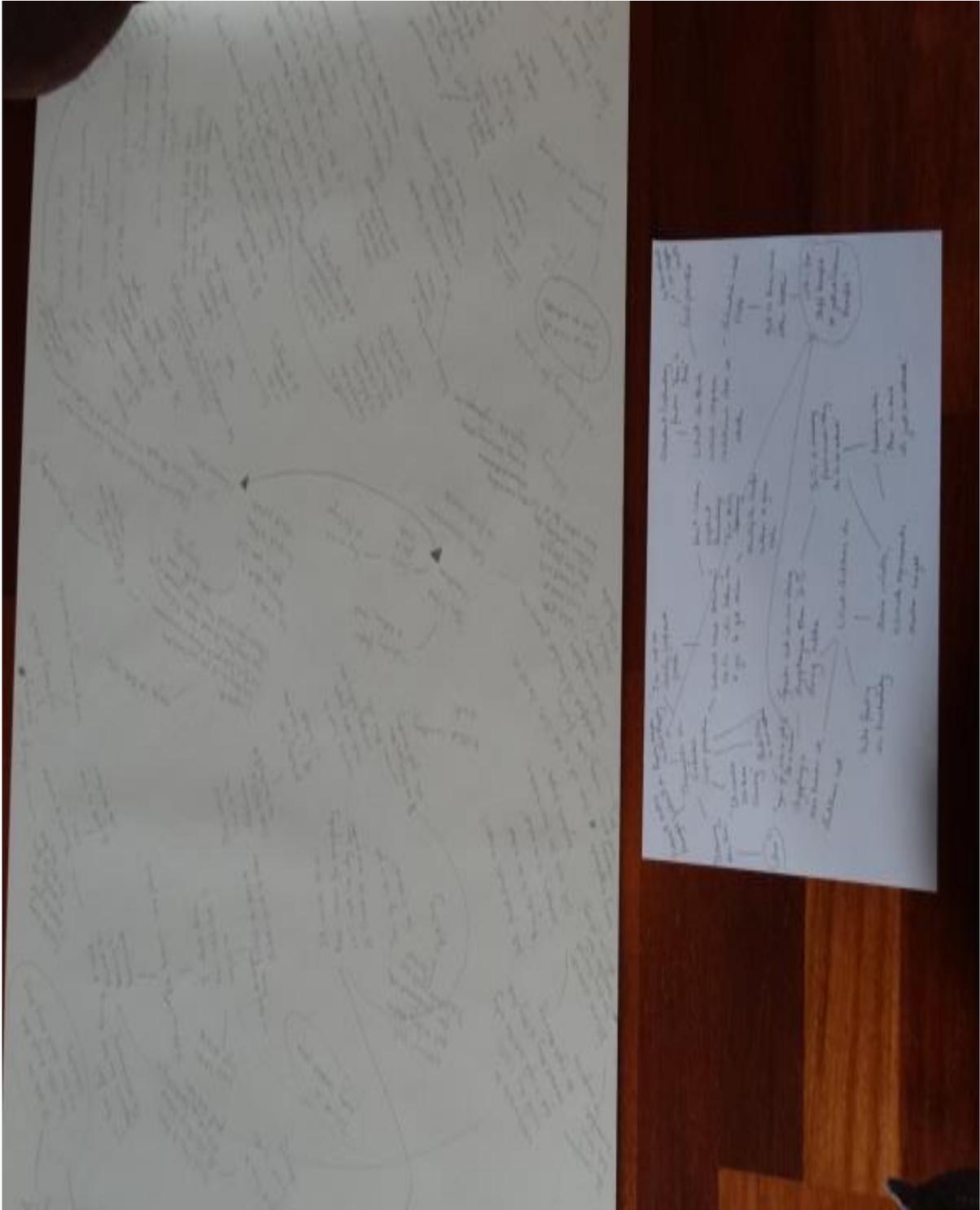


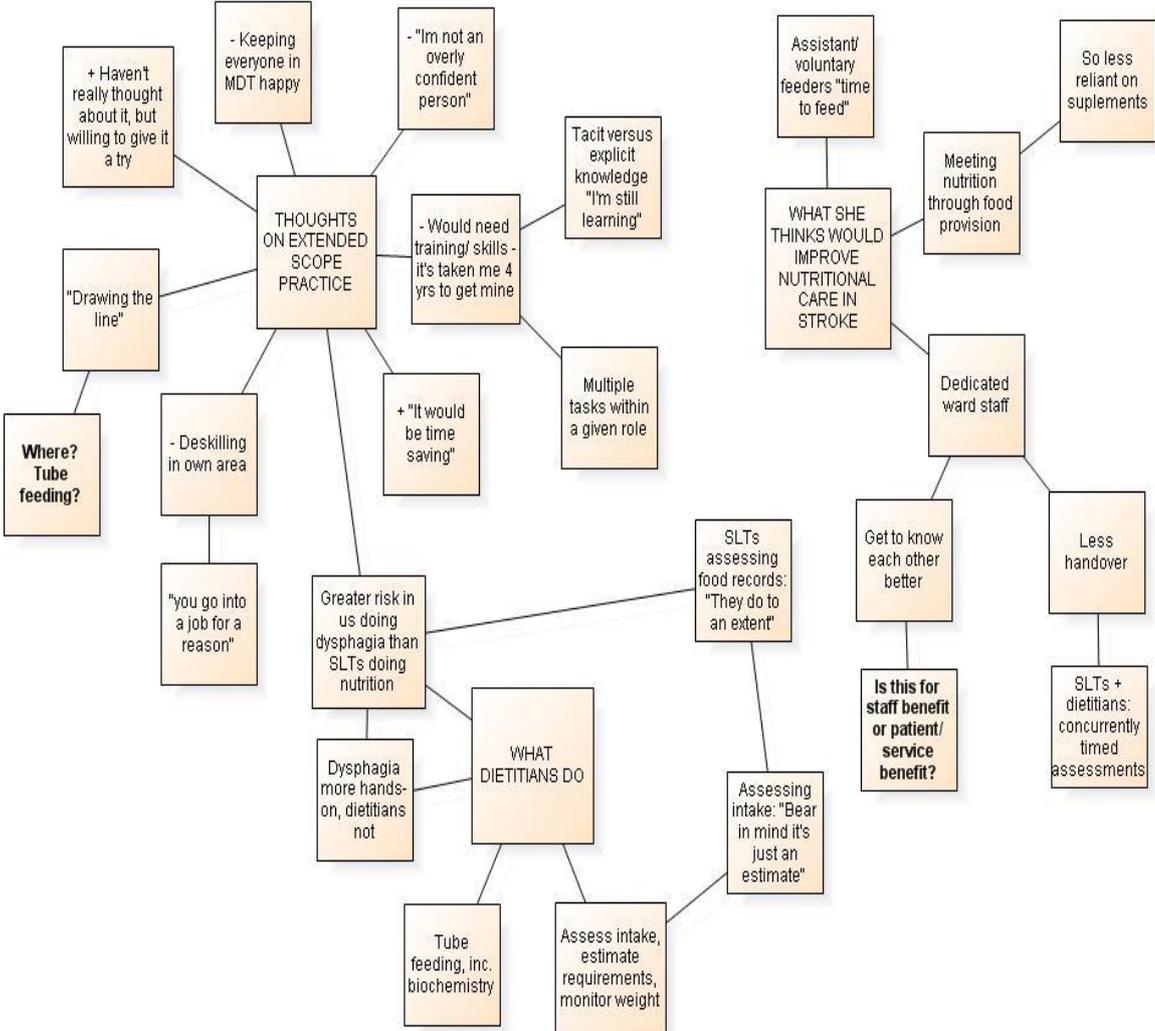
**Nutritional supplements should not be prescribed without:**

- placing a fortified diet for at least one month (see overleaf)
- being identified as high risk of undernutrition according to **MUST** (Malnutrition Universal Screening Tool) and having ongoing weight loss despite following a fortified diet for one month
- after one month if still high risk and losing weight refer the individual for an assessment for Complan® shake



Appendix 20





## Appendix 22

Visual outline of the data collection and analysis process

Conceptual Analytical Phase	Grounded Theory Data Analysis Phase	Physical Task	Memo/ Field Note Writing	NVIVO Function/ Task
		Data Collection	Field Note Reflections on data collection: the process, the role of the researcher, reflections on the interviews, data collection from clinical notes	
		Listen to interview recordings	Memo writing about emerging codes to inform the NVIVO Sets and further data collection requirements	Build the initial Sets inductively (based on the memos from the data) and deductively (based on the interview schedule key areas)
		Transcription of interview tapes and field notes		Import data into Case Nodes <sup>2</sup> .
	Attribute Coding <sup>3</sup>			Assign Attributes to Case Nodes <sup>4</sup> .
	Initial (Open) Coding: In Vivo and Process Coding.	An initial phase involving naming each word, line, or segment of data. Data should be split into 12-60 initial codes. Wherever possible "... code data as actions" and with gerunds <sup>5</sup> – this prevents us from making "... conceptual leaps" (Charmaz, 2006, p. 48)	Early Memo Writing re coding: "Record what you see happening in the data ... Maintain a focus on process ..." p 80 "... chart observed and predicted relationships in your data and between your emergent categories." Charmaz, 2006, p. 81)	Assign data sections to 12-60 Free Nodes.
	Focussed Coding	"As you raise a code to a category, write memos which: Define the category • Explicate the properties of	Advanced Memo Writing re coding • "Trace and categorise data subsumed by your topic • Describe how your category emerges	Turn Free Nodes into Tree Nodes (Parent and Child) by running Queries (mainly Coding Query), as related to:

<sup>2</sup> A Case Node = an individual participant (interview transcript, clinical notes and field notes) or documental data (extant texts) and related field notes

<sup>3</sup> This task is not strictly speaking a process of the grounded theory method, but is included as an Initial Coding method in Jonny Saldana and through the NVIVO software and will facilitate later analysis with NVIVO, specifically in running Queries.

<sup>4</sup> **Attribute 1** = patient, carer, SLT, dietitian, ward nurse, specialist nurse, doctor, other health professional, service manager, directorate manager, commissioner; **Attribute 2** = male, female; **Attribute 3** = acute Trust employed, PCT provider employed, PCT commissioning employed, home resident (patients), nursing/ residential home resident; **Attribute 4** = acute hospital location (stroke specialist ward), acute hospital location (other rehabilitation ward), acute hospital location (general ward), community hospital location (specialist stroke ward), community hospital location (other rehabilitation ward), community hospital location (other ward location), nursing home location, residential home location, own home location.

<sup>5</sup> Although Holloway & Wheeler (2009) do not appear to advocate this, both Saldana (2009) and Charmaz (2005) advocate initial coding in gerunds.

		<p>the category</p> <ul style="list-style-type: none"> <li>Specify the conditions under which the category arises, is maintained, and changes</li> <li>Describe its consequences</li> <li>Show how this category relates to other categories.” (Charmaz, 2006, p. 92)</li> </ul>	<p>and changes</p> <ul style="list-style-type: none"> <li>Identify the beliefs and assumptions that support it</li> <li>Tell what the topic looks and feels like from various vantage points</li> <li>Place it within an argument</li> <li>Make comparisons” (Charmaz, 2006, p. 81)</li> </ul>	<ol style="list-style-type: none"> <li>Processes, Causes and Consequences</li> <li>Properties and Dimensions<sup>6</sup></li> </ol>
	<p>Theoretical Coding - “... progresses toward discovering the central/ core category that identifies the primary theme of the research.” (Saldana, 2009, p. 151)  “...begins with finding the primary theme of the research...the <i>central</i> or <i>core category</i>...” (Saldana, 2009, p. 163)</p>	<p>“Additional or selective sampling of new or existing participant data is encouraged to identify any variations within the developing theory. Diagram refinement of the categories, process, and theory...is encouraged...to develop an operational model of the phenomenon or process and to map the complexity of the story...” (Saldana, 2009, p. 166)</p>	<p>“<b>The study’s ‘trinity’</b> - What are the three...major codes, categories, themes, and/ or concepts...arrange the three bins in a triangle. Which one...is the apex or dominant item and why? In what way does this apex influence and affect or interrelate with the other two...</p> <p><b>The ‘touch test’</b> - ...you can touch someone who’s a mother, but you cannot physically touch the concept of ‘motherhood’....Those things that cannot literally be touched are conceptual, phenomenological, and processual...</p> <p><b>From codes to themes</b> - ...add the verbs ‘means’ and ‘is’ after the phenomenon under investigation. “i.e. ‘Negotiating means/ is...’” (Saldana, 2009, p. 187)</p>	<ol style="list-style-type: none"> <li>Create Sets and assign Nodes to Sets</li> <li>Build the Models</li> </ol>

<sup>6</sup> Axial Coding is excluded from the analysis of this project, as the method has become somewhat contested in later writings.” (Saldana, 2009, p. 160). “Charmaz (2006) and Dey (1999) take issue with Axial Coding. Charmaz perceives it as a cumbersome step that may stifle analytical progress achieved from previous Initial Coding toward Theoretical Coding. Dey feels the logics of categorization and process have not been fully developed by grounded theory’s originators. Even as grounded theory evolved, the methodological utility of Axial Coding became a controversial issue between Glaser, Strauss, and Corbin (Kendall, 1999). Corbin herself downplays the method in her later edition of grounded theory’s procedures (Corbin & Strauss, 2008).” (Saldana, 2009, p. 163).

## Appendix 23

Name	Sources	References	Created On	Created By	Modified On	Modified By
		Name		Sources	References	Created On
advancing stroke knowledge	1	1	22/08/2012 16:29	EJR	22/08/2012 16:29	EJR
all CRT team members being involved in nutrition	2	9	03/03/2013 12:08	EJR	12/03/2013 16:31	EJR
all staff being dysphagia aware	1	4	04/12/2012 15:05	EJR	04/12/2012 15:08	EJR
anyone can extend role with training, support, etc	1	2	01/12/2012 19:22	EJR	04/12/2012 13:25	EJR
asking each other for advice	1	2	11/07/2012 20:10	EJR	11/07/2012 20:15	EJR
assessing nutrition the same day	1	2	19/08/2012 15:59	EJR	19/08/2012 16:00	EJR
assessing or providing communication	1	1	05/07/2012 10:21	EJR	05/07/2012 10:21	EJR
assessing potential to recover swallow	1	2	03/03/2013 11:37	EJR	03/03/2013 11:38	EJR
assessing swallow	1	2	19/08/2012 17:03	EJR	19/08/2012 19:35	EJR
assisting people at mealtimes	1	1	27/08/2012 19:18	EJR	15/10/2012 18:07	EJR
auditing MUST screening	1	2	03/09/2012 19:21	EJR	03/09/2012 19:24	EJR
auditing speed of dysphagia assessments	1	1	03/09/2012 19:15	EJR	03/09/2012 19:15	EJR
bedside assessment having limitations	1	4	10/07/2012 09:50	EJR	10/07/2012 09:55	EJR
before the HPC	2	2	26/02/2013 17:34	EJR	27/02/2013 14:38	EJR
being able to weigh self	1	1	19/02/2013 14:27	EJR	19/02/2013 14:27	EJR
being anxious that mum hadn't had swallow screen	1	1	24/10/2012 18:54	EJR	24/10/2012 18:54	EJR
being at greater nutritional risk on modified texture	2	2	02/09/2012 17:41	EJR	04/12/2012 13:17	EJR
being careful about extending roles	1	1	11/07/2012 13:07	EJR	11/07/2012 13:07	EJR
being careful with feeding in early stage of stroke	1	1	12/08/2012 15:03	EJR	12/08/2012 15:03	EJR
being comfortable with what you know	1	1	12/08/2012 16:04	EJR	12/08/2012 16:04	EJR
being first admitted to hospital with stroke	2	5	24/10/2012 16:41	EJR	24/11/2012 20:37	EJR
being followed up at home	1	6	19/02/2013 09:28	EJR	19/02/2013 10:16	EJR
being given information really important	1	1	24/10/2012 20:40	EJR	24/10/2012 20:40	EJR
being in favour of extending roles	2	2	11/07/2012 13:06	EJR	24/08/2012 11:25	EJR
Being in hospital	1	1	18/08/2012 12:26	EJR	18/08/2012 12:26	EJR
being in hospital a long time	2	3	19/02/2013 09:31	EJR	19/02/2013 14:18	EJR
being in the same location	1	3	03/03/2013 15:15	EJR	03/03/2013 15:16	EJR
being involved in the FOOD trial	1	2	03/09/2012 19:29	EJR	03/09/2012 19:29	EJR
being more isolated in community role	1	3	03/03/2013 15:05	EJR	03/03/2013 15:14	EJR
being NG fed for a long time	1	1	24/10/2012 18:58	EJR	24/10/2012 18:58	EJR

being nil by mouth	1	2	18/08/2012 12:34	EJR	18/08/2012 12:35	EJR
being on a tube feed	2	3	18/08/2012 16:50	EJR	24/10/2012 20:42	EJR
Being on texture modified diet	2	2	18/08/2012 12:35	EJR	19/02/2013 14:14	EJR
being on the ward every day	1	1	23/08/2012 20:15	EJR	23/08/2012 20:15	EJR
being part of the CRT	1	1	27/02/2013 14:51	EJR	27/02/2013 14:51	EJR
being part of the MDT	1	1	22/11/2012 09:10	EJR	22/11/2012 09:10	EJR
being referred to CRT	1	4	27/02/2013 14:58	EJR	27/02/2013 15:31	EJR
being referred to the community SLT team	1	6	27/02/2013 15:06	EJR	27/02/2013 15:11	EJR
being reliant on staff	1	1	19/08/2012 19:34	EJR	19/08/2012 19:34	EJR
Being sent to another hospital	2	8	18/08/2012 12:24	EJR	19/02/2013 09:24	EJR
being told risks of dysphagia	1	1	19/02/2013 09:29	EJR	19/02/2013 09:29	EJR
being told to drink plenty of water	1	1	19/02/2013 14:20	EJR	19/02/2013 14:20	EJR
being used to working in a more extended role way in CRT team	1	2	03/03/2013 14:16	EJR	03/03/2013 14:16	EJR
being weighed	1	1	19/02/2013 12:20	EJR	19/02/2013 12:20	EJR
benefits for patients in moving to more of a training role	1	1	06/02/2013 16:58	EJR	06/02/2013 17:00	EJR
benefits of extending dysphagia role	1	1	04/12/2012 14:50	EJR	04/12/2012 14:50	EJR
benefits of increasing time SLT is on the ward	5	10	09/07/2012 10:04	EJR	23/01/2013 16:36	EJR
better access to VFSS having benefits	1	6	10/07/2012 09:48	EJR	10/07/2012 09:55	EJR
broadening nurses dysphagia skills	3	8	01/12/2012 18:53	EJR	04/12/2012 18:00	EJR
building relationships	1	3	09/07/2012 10:10	EJR	09/07/2012 10:13	EJR
calling SLTs in early on	1	1	03/09/2012 19:15	EJR	03/09/2012 19:15	EJR
care homes taking action after screening	1	1	07/02/2013 18:34	EJR	07/02/2013 18:34	EJR
carers assisting at mealtimes	1	2	29/07/2012 19:57	EJR	29/07/2012 19:58	EJR
caring for patients that are discharged	1	1	22/08/2012 17:32	EJR	22/08/2012 17:32	EJR
Causing the stroke	1	1	18/08/2012 12:25	EJR	18/08/2012 12:25	EJR
challenging why somebody would want to extend their role into mine	1	1	12/08/2012 18:28	EJR	12/08/2012 18:28	EJR
cheating	1	2	19/02/2013 14:16	EJR	19/02/2013 14:23	EJR
checking that the medical team have done things	1	2	22/11/2012 09:11	EJR	22/11/2012 09:11	EJR
close monitoring for signs of aspiration in acute phase of stroke	1	1	12/08/2012 15:02	EJR	12/08/2012 15:02	EJR
coinciding SLT and dietitian visits	2	7	23/08/2012 20:16	EJR	03/09/2012 15:36	EJR
combining acute and rehab stroke units	1	2	24/10/2012 15:09	EJR	24/10/2012 15:09	EJR
communication being important for family	1	1	11/07/2012 12:41	EJR	11/07/2012 12:41	EJR
communication referrals slipping through the net	1	9	11/07/2012 12:28	EJR	11/07/2012 12:33	EJR
communication taking longer than dysphagia to recover	1	1	03/03/2013 10:20	EJR	03/03/2013 10:20	EJR
communication work needing more time and intensity	1	1	27/02/2013 15:53	EJR	27/02/2013 15:53	EJR
community rehab - having lots of people doing similar roles	1	4	27/02/2013 15:46	EJR	27/02/2013 15:48	EJR

consultant doctor suggesting greater dietitian and SLT role overlap and expansion	1	4	07/02/2013 12:48	EJR	07/02/2013 12:52	EJR
crossing over roles needing trial and assessment	1	1	19/08/2012 19:43	EJR	19/08/2012 19:43	EJR
CRT having defined time period	1	3	27/02/2013 15:44	EJR	27/02/2013 15:54	EJR
CRT team being more integrated	3	4	03/03/2013 15:30	EJR	12/03/2013 16:31	EJR
CRT team focussing on goals	1	3	03/03/2013 12:06	EJR	03/03/2013 13:58	EJR
deciding who can assist with meals	1	1	12/08/2012 15:29	EJR	12/08/2012 15:29	EJR
decisionmaking about nutrition	2	11	09/07/2012 09:56	EJR	11/07/2012 20:19	EJR
defining extended roles	1	1	04/12/2012 15:09	EJR	04/12/2012 15:09	EJR
defining specialist from basic	2	4	01/12/2012 18:12	EJR	04/12/2012 17:35	EJR
dementia taking up biggest proportion in homes	1	1	06/02/2013 15:56	EJR	06/02/2013 15:56	EJR
describing different skills needed in community versus acute care	1	2	04/12/2012 18:19	EJR	04/12/2012 18:22	EJR
describing dysphagia assessment process	2	4	04/12/2012 15:21	EJR	19/02/2013 09:57	EJR
describing onset of stroke symptoms	3	8	18/08/2012 12:21	EJR	19/02/2013 09:23	EJR
describing symptoms of dysphagia	1	5	19/02/2013 09:28	EJR	19/02/2013 14:22	EJR
describing the first symptoms of dysphagia	4	19	18/08/2012 12:34	EJR	19/02/2013 09:26	EJR
describing the history and purpose of dysphagia screening	1	4	18/11/2012 19:27	EJR	18/11/2012 19:29	EJR
describing the history of dysphagia care	1	3	18/11/2012 19:26	EJR	18/11/2012 19:26	EJR
describing videofluoroscopy	1	4	19/02/2013 09:29	EJR	19/02/2013 09:30	EJR
deskilling	1	2	27/08/2012 19:48	EJR	27/08/2012 19:50	EJR
developing a robust dysphagia screening training package	1	4	18/11/2012 19:14	EJR	18/11/2012 19:14	EJR
dietetic assistants developing competence	1	3	06/02/2013 16:02	EJR	06/02/2013 16:02	EJR
dietitian being referred people who haven't had SLT assessment	3	15	11/07/2012 18:34	EJR	07/02/2013 16:31	EJR
dietitians and SLTs being closely linked professions	2	3	30/10/2012 16:47	EJR	30/10/2012 16:47	EJR
dietitians doing dysphagia screening having to be service-wide	1	1	07/02/2013 18:11	EJR	07/02/2013 18:15	EJR
dietitians doing dysphagia screening if other staff doing nutritional screening	1	3	07/02/2013 18:25	EJR	07/02/2013 18:27	EJR
dietitians following SLT recommendations	4	10	11/07/2012 18:46	EJR	07/02/2013 18:14	EJR
dietitians happy to mess with Thick N Easy in training, but not with patients	1	1	07/02/2013 14:34	EJR	07/02/2013 14:34	EJR
dietitians not being hands-on	3	5	12/08/2012 16:08	EJR	27/08/2012 19:18	EJR
dietitians not being on stroke ward as much as SLTs	1	1	12/08/2012 16:44	EJR	12/08/2012 16:44	EJR
dietitians not seeing people with low MUST score	1	1	23/08/2012 18:28	EJR	23/08/2012 18:28	EJR
dietitians taking a role in dysphagia	6	29	03/09/2012 13:13	EJR	07/02/2013 13:37	EJR
differing SLT and dietitian perspectives on supplements	1	1	27/08/2012 15:54	EJR	27/08/2012 15:54	EJR

(Continues for 16 pages)

## Appendix 24

Concept	Number and type of Interviewees providing data on the concept (i.e. where is it located in the data?)	Examples (i.e. quotations)	How does this concept need to be developed further?	Possible informants to further develop the concept?
<p><u>Core concept/ central phenomenon:</u></p> <p>The <b>barrier</b> to different ways of working in dysphagia care is the creation and/ or maintenance of explicit skills &amp; knowledge as tacit skills &amp; knowledge.</p> <p>The <b>enabler</b> is the codification of explicit skills &amp; knowledge and the passing on of these to other types of worker, either</p>	<p>All dietitian and SLT interviews describe the processes of assessment and review, i.e. the particular tasks that they perform.</p> <p>Interviewee 01, 02, 03, 04, 05, 06, 08, 09, 14, 15, 18, 19, 20, 21, 23, 26, 27</p>	<p>01: "...then we would do our initial assessment...it might be from that that we can safely start them on something...we would write safe swallow plans above people's beds, talk to the nurses...then review them accordingly...sometimes...we might put in the notes, you know, are they for the option of nil by mouth and NG, or are they for the option of eating and drinking at risk...is to look at how much, you know, and how much they're having, and you know, are they fatiguing, is that the reason why and, you know, we do have conversations with people to try and establish why they might not be eating..."</p> <p>01: "...we have quite a defined initial assessment...we have got an initial assessment that looks at, you know, their kind of their seating, their oral status, so for oral hygiene, but then looks at whether they can follow basic commands...trailing certain types of food and fluid depending on what you think is going to be the most safe for that person."</p> <p>01: "...often then we will sort of review people and see if their swallow has changed, can we upgrade them..."</p> <p>02: "...it's a big part, a big part of our jobs is to prescribe these things [nutritional supplements]... then we would look at the appropriate ones and prescribe those to meet their requirements"</p> <p>03: "...the nutritionist comes along, just monitors your weight, your food levels...Speech and therapy are assessing my swallowing, the physical</p>	<p>This concept needs to be shared with staff who have already been interviewed and have played a key role in codifying, or not, skills and knowledge, to gain their feedback and thoughts on the/ this central phenomenon.</p>	<p>Previous staff Interviewees who understand the processes of care for either nutritional or swallowing care (i.e. SLTs and dietitians), who have already contributed to, or would be able to further contribute/ develop the concepts from a higher level position (i.e. managers, staff who have played a key role in codifying explicit knowledge and</p>

<p>through protocols and/ or through training. This phenomenon can be visualised as a continuum, where the actual point of transition of skills &amp; knowledge from tacit to explicit is presented at <b>Point A</b>, but the professional groups assert that the transition point is at <b>Point B</b>. The space in between is the contested space – the place where change can happen.</p>		<p>side of it and as I say the speech itself, whereas the nutritionists...it's purely nutrition, your regime, monitoring your body mass, whether you've got the right feeds and whether you're being fed...they then assessed what flow rates and how much nutrition needs to go through the pump, so...They were coming every 2 to 3 days to see how I was progressing and then they weighed me once a week to see whether I was losing weight or gaining weight and then to just readdress the regime. ...there was the um, the nutritionalist would ask for it [his weight] and then would sign for the next one and then they would go and they would weigh me, whenever it was due, so, it was then that they did the physical weighing, then the bolus should be monitored, then the nutritionalist would say right ok his levels seem to be ok and they'd come and see me and see if I'd had any problems with the food or whatever and then reassess afterwards.”</p> <p>03: “And assessed how much I needed, they just, they did my body mass and weighed me and then they, whatever calculation they do, to see how many calories I needed and what rate and flow would be needed for the pump for the bag feed. So then after a few days whenever they weighed me again then realized that the levels were about right...”</p> <p><b>User perspective...03:</b> “...just as long as they've got the experience levels and know what they're talking about, that's the important thing....It doesn't matter who's doing it, as long as they've got the corresponding level of experience and skills themselves...As long as someone knows what they're doing, and have got those expertise levels, whether you get a SALT team, training nutrition or combining the SALT and nutritional team into one team, um, that's obviously for our assessment, but as long as someone can come, they can do it all at the same time, they could do a swallow assessment, what my speech and language levels are and also do a nutritional test, that's for them to, doesn't make any difference from my point of view....and they're all trained up to that level of each other's standard, as long as they know what they're talking about then it doesn't make any difference to me does it?...you don't care who drives your bus as long as they can drive your bus, or who services your car as long as they can service your car. For myself, no one cares who's flying the airplane as long as they're trained to fly the airplane.”</p>	<p>This concept also needs to be explored with new participants in this and other research sites who have been instrumental in codifying skills and knowledge in their area.</p> <p>What is the position and role of the professional</p>	<p>passing to others (e.g. through training and/ or protocols) or have chosen to not, are still in post and are willing to take part in a further interview. (Interviewees 08, 09, 12, 15, 23, 26 and/ or 27).</p> <p>New sites and participants at existing sites who have codified/ been instrumental in the codification of skills &amp; knowledge, as identified (already) by existing participants, e.g. RC, MH, Durham, SP.</p> <p>Representatives of both</p>
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		<p>04: "...if the patient needs an NG feed and um, if we want to increase the weight the dietitian is the one to decide, whether they are safer to go up, they will check the blood results and....and of course the weight loss we always inform the dietitian, if we are thinking they are not, like we think they might need some forticreme, some fortisips, some additional food regime, yeah."</p> <p>04: "...start an emergency regime, which is standard 50 ml per hour, which can carry around until either seen by a dietitian..."</p> <p>05: "So you would make the assessment of how much they were taking through oral trials and then balance the feed if they had a feeding tube..."</p> <p>05: "if they are an NG patient, um, and they're a new referral then we'd almost see them every day as they're building up, um, to what they will be able to tolerate...especially if they're a bolus regime...we could write them, say two days and maybe see them two days rather than every day...if there's somebody on a modified consistency diet and I didn't think they were doing too badly and they were on supplements then I would see them maybe every three or four days, or if it was somebody that just had a MUST score of 2, but was on a normal diet then I'd see them once a week..."</p>	<p>bodies on this phenomenon?</p>	<p>professional bodies, (i.e. new participants), e.g. the British Dietetic Association (BDA) and the Royal College of Speech &amp; Language Therapists (RCSLT).</p>
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## Appendix 25

Interview Topic Guide		
Interviewer:	Participant number:	
Venue:		
Date:	Start time:	Finish time:
<b>Preamble:</b> Permission to record		
<b>Section 1 – overall response and thoughts on developing theoretical model.</b>		
<p>A print-out of the developing model will be shared with/ shown to participants. They will be asked to discuss/ reflect on any thoughts they have regarding the resonance of the model with their own experience(s), thoughts on usefulness/ usability/ application of the model, thoughts and reflections on the core phenomenon.</p>		
<b>Section 2 – Thoughts/ responses/ reflections on the specific concepts/ categories within the model.</b>		
<p>Participants will be asked to discuss/ reflect on the concepts and gaps in the developing model, covering the following main areas:</p> <ul style="list-style-type: none"> <li>• What are the views and responses of all participants to the concept “No sense of time as collaborative between departments and/ or professions/ work groups”? How could this be addressed?</li> <li>• How do participants at Site 2 and new research sites address “giving away” skills &amp; knowledge? How do participants at Site 1 view how Site 2 and new sites have responded to this?</li> <li>• What is the line/ what constitutes complexity? How have participants at Site 2 and new sites defined this? How do participants at Site 1 respond to the line that has been drawn in other sites?</li> <li>• What is it that makes some places &amp; people extend their role and not others – the “at the beginning factor(s)/ catalyst”? What could/ would make this happen in places not already codifying skills &amp; knowledge to a greater degree?</li> <li>• What is the position and role of the professional bodies on this phenomenon? What role do the professional bodies and service commissioners/ managers play in facilitating the shift?</li> <li>• What is it that gives Site 2 and new sites the confidence in the skills of others? How could this be replicated in other places? What can we do about this, to enable/ facilitate this in other places?</li> <li>• How do participants in Site 1 respond to the position taken by Site 2 and new sites in respect of the time spent codifying skills &amp;</li> </ul>		

knowledge?

- How has working in this way impacted on job satisfaction for participants in Site 2 and new sites?

**Section 3 – other thoughts/ areas not covered.**

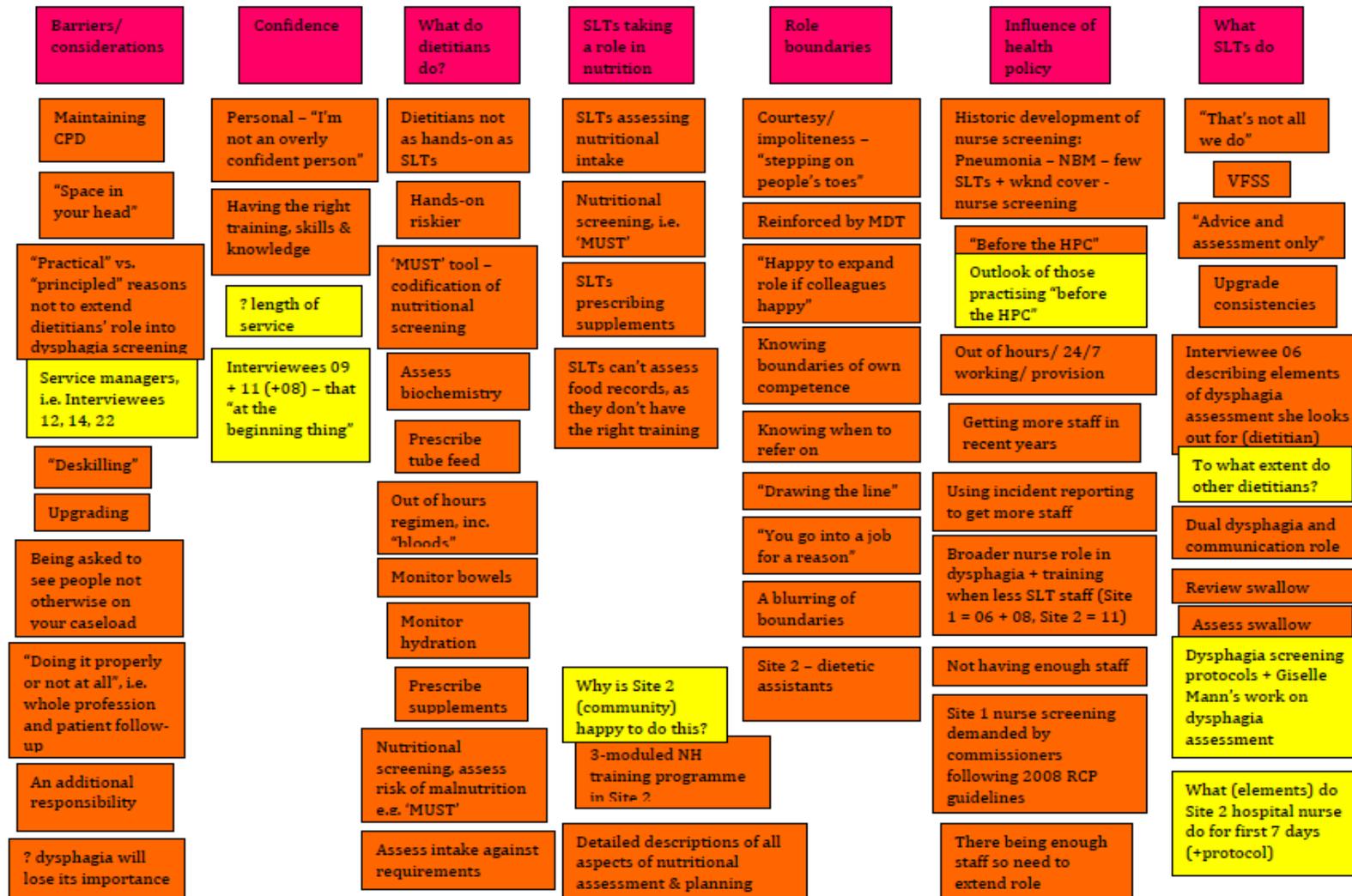
**Post-interview notes:**

- thoughts about the setting (busy/quiet, other people around, venue, etc),
- impressions of the interviewee (s) (talkative, nervous, speech and ability to communicate, etc),
- feelings about the interview content (did it open up new themes, were there unexplored issues/ unanswered questions?),
- reflective observations on how my engagement effected the quality of data collected,
- other points to note.



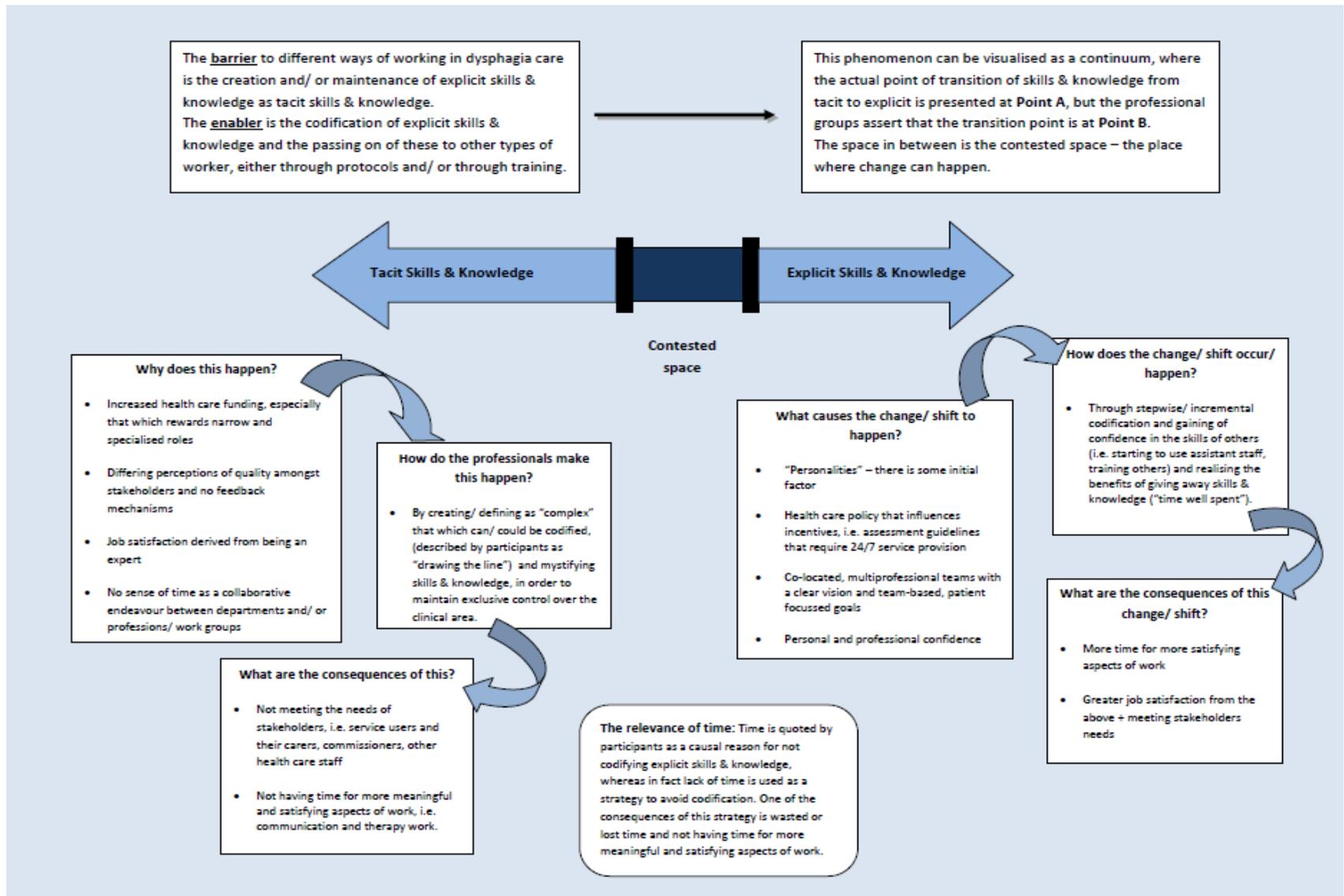
# Appendix 27

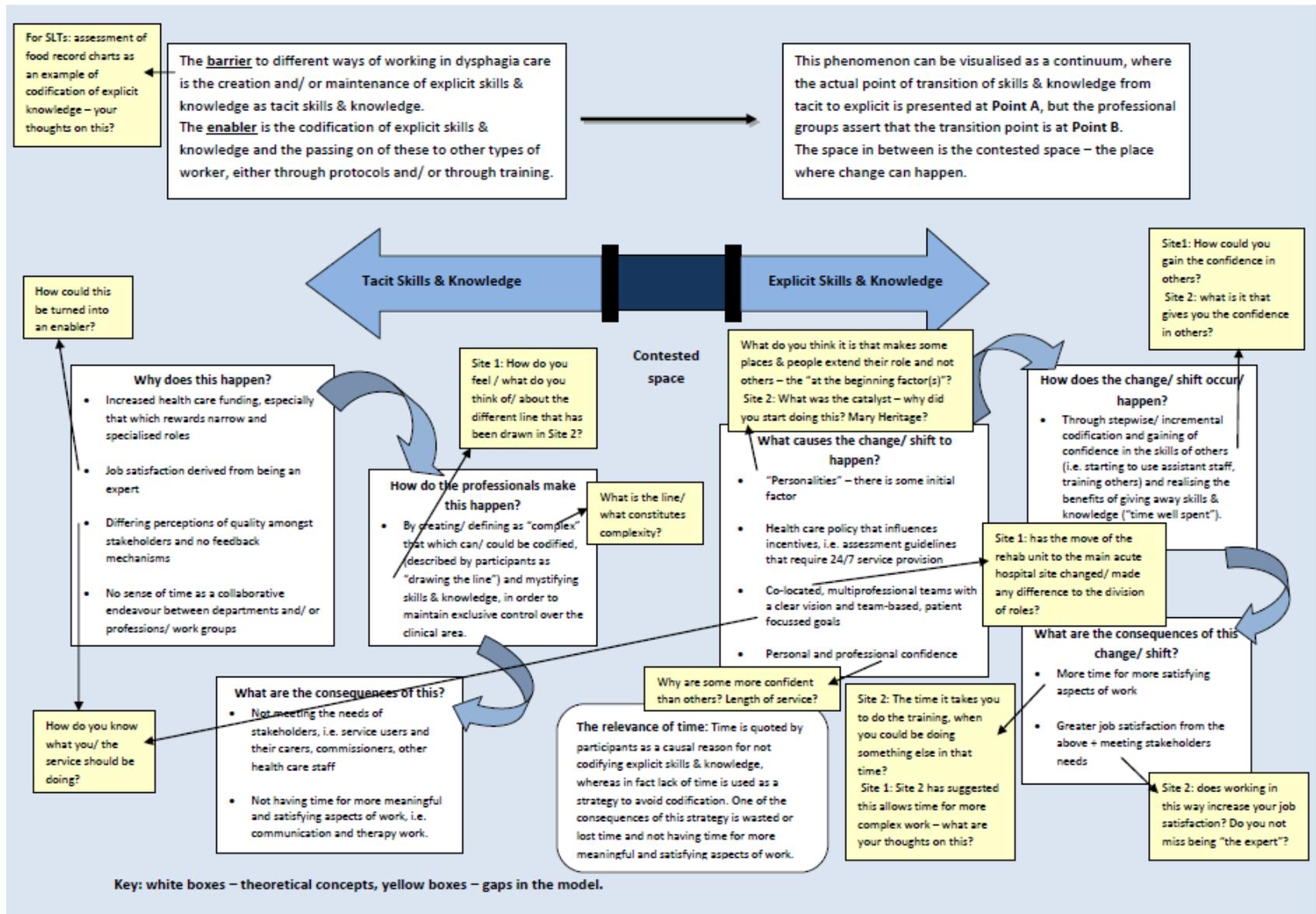
Open Coding: **Categories, Dimensions** and **Gaps (or Missing Data)** - 15032013.











## Appendix 30

### Further Data Collection/ Re-Interview Schedule

Location	Interviewees (plus order)	What other information or contacts do I need to get from this interviewee?	Interview date arranged, and date?	Interview completed?
Haslem	Michelle (1)	MH, commissioner of hospital DTN programme, RCLST contact, ward nurse	28 <sup>th</sup> Jan 2014, 13.30	Yes
	Karen (1)	Definitions of complexity documents, hospital and community DTN commissioner, Mary Heritage, ward nurse	12 <sup>th</sup> Feb 2014, 09.00	
	Linda (1) MH (1)	Definitions of complexity, nursing home nurse	29 <sup>th</sup> Jan 2014, 09.00	Yes
	Emma (1) - message left 4/2/14	Community and hospital DTN commissioner	Declined interview	N/A
	Carla (1)	Community DTN commissioner, nursing home nurse		
	Phoebe (1)		11 <sup>th</sup> Feb 2014, 13.00	
	Mavis (1)		18 <sup>th</sup> Feb 2014, 14.00	
	1 nursing home nurse (1 or 2)	? knows commissioner of DTN programme	26 <sup>th</sup> Feb 2014, 11.00	
	1 ward nurse (1 or 2)			
	Other DA (1 or 2) (Eve)			
	Commissioner of hospital DTN programme (1 or 2)		11 <sup>TH</sup> Feb 2014, 15.00	
	Commissioner of community/ nursing home DTN programme (1 or 2)	? Jenny, ? a Helen		
Billingdon	Susan (1)	Commissioner of DTN programme		
	1 ward nurse re-interviewee (Sarah, Alexis or Margaret) or new interviewee (1 or 2)	Their dysphagia (yellow) form.		
	1 commissioner of nurse DTN programme (1 or 2)			
The Midlands	Poppy (1)			
The North	Cheryl (1)		25 <sup>th</sup> Feb 2014, 11.00	
Probably Birmingham	BDA representative (2)			
Probably London	RCLST representative (2)			

# Appendix 31

Part of the research infrastructure for Wales funded by the National Institute for Social Care and Health Research, Welsh Government.  
Yn rhan o seilwaith ymchwil Cymru a anannir gan y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd, Llywodraeth Cymru



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South East Wales Research Ethics Committee D

17 January 2014

Ms Elizabeth Roberts  
Clinical Specialist Dietitian - Home Enteral Feeding  
NHS Somerset/ Somerset Community Health  
Wynford House  
Lufton Way  
Yeovil  
BA22 8HR

Dear Ms Roberts

**Study title:** The care pathway for dysphagic stroke survivors – qualitative, exploratory study (phase 1) v1.  
**REC reference:** 10/WSE04/46  
**Protocol number:** NA  
**Amendment number:** Amendment 1  
**Amendment date:** 03 December 2013  
**IRAS project ID:** 58930

The above amendment was reviewed at the meeting of the Sub-Committee held on 16 January 2014.

## Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

## Approved documents

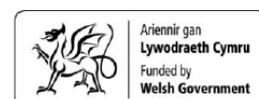
The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Consent Form	3	19 November 2013
Notice of Substantial Amendment (non-CTIMPs)	Amendment 1	03 December 2013
Protocol	4	19 November 2013
Developing Theory Model	4	13 December 2013
Participant Information Sheet	5	19 November 2013
Interview Topic Guide	1	13 November 2013



Cynhelir Cydweithrediad Gwyddor Iechyd Academaidd y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys

The National Institute for Social Care and Health Research Academic Health Science Collaboration is hosted by Powys Teaching Health Board



### Membership of the Committee

The members of the Committee who took part in the review are listed below.

### R&D approval

*All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.*

### Statement of compliance

*The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.*

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

10/WSE04/46:	Please quote this number on all correspondence
--------------	--

Yours sincerely



pp  
**Dr K J Craig**  
**Chair**

E-mail: [jagit.sidhu@wales.nhs.uk](mailto:jagit.sidhu@wales.nhs.uk)

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### South East Wales Research Ethics Committee D

#### Attendance at Sub-Committee of the REC meeting on 16 January 2014

<i>Name</i>	<i>Profession</i>	<i>Capacity</i>
Dr K J Craig	Nurse	Expert
Mrs A McGowan	Lay Member	Lay

#### Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs J Sidhu	Co-ordinator

*All studies are subject to the requirements of the DoH's Research Governance Framework 2005 Second Edition and subsequent amendments. If you have not read this document, or are unfamiliar with its contents you are strongly advised to refer to it before commencing with any research or data collection. You may not commence data collection until you have written formal authorisation from the Chair of the Research Review Board and an appropriate ethics committee.*

*Private & Confidential*

26 February 2014

**Elizabeth Roberts  
Community Hospitals & Nutritional Support  
East Quay Medical Centre  
Bridgwater  
Somerset  
TA6 4GP**

Dear Elizabeth

**Letter of access for research –  
Interview Rachael Masters – Senior Specialist Dietitian**

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through County Durham & Darlington NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on **26 February 2014** and ends on **31 December 2014** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to County Durham & Darlington NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

*Version 2.1, September 2010  
Research in the NHS: HR Good Practice Resource Pack  
[www.cddft.nhs.uk](http://www.cddft.nhs.uk)*

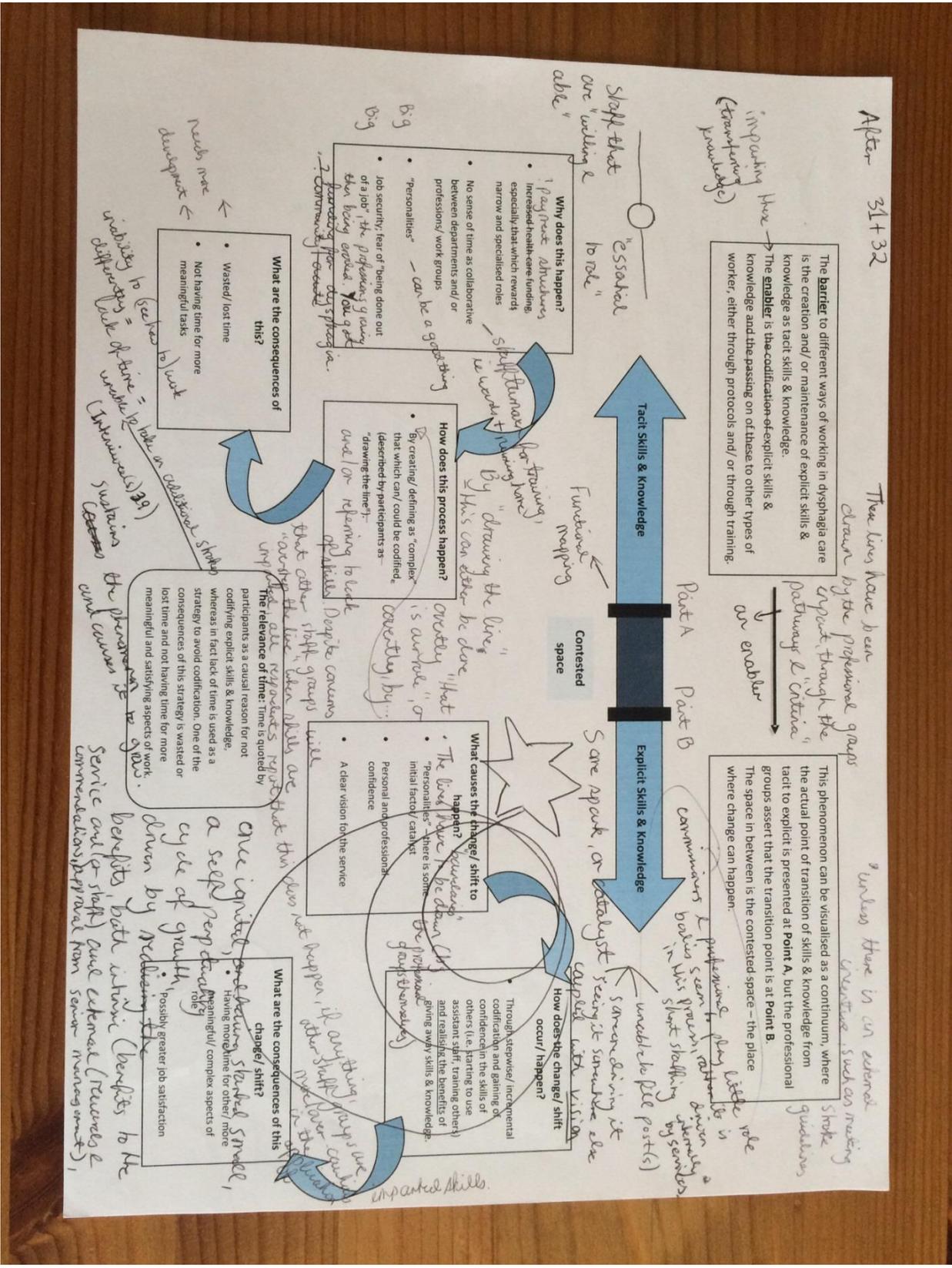
with you  
all the way

immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or ISA registration, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



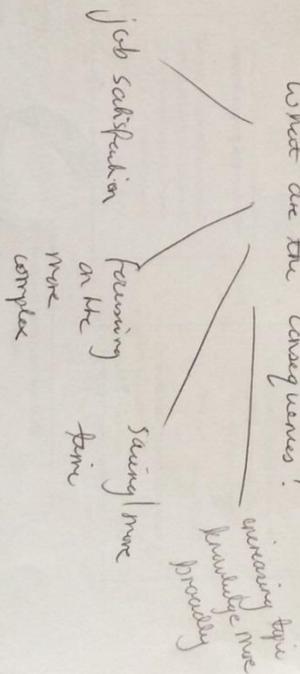
Sharing professionally, not the practical side  
 But the benefits that the process were not  
 realized.  
 How can we ignite the spark?

- Measurement of outcomes
- telling each other about it
- professional belief supporting (contract BDT and KC SLT).

Supplements? → there are the lines that have been drawn. In order to  
 avoid feeding) realize these lines, further parts of the decision are  
 would need to be captured in a core pathway.  
 What prevents it?

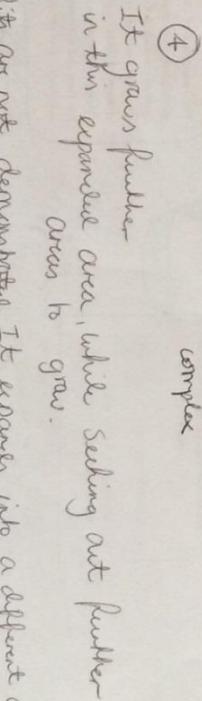
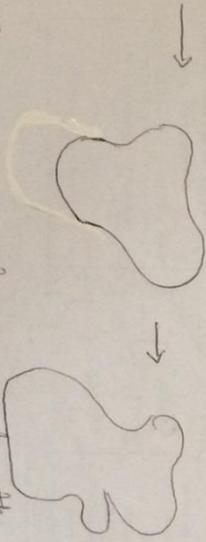
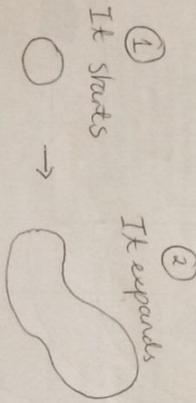
- fear of job loss (loss of funding - not been realized in research side.
- "dunking down" of profession(s) - also not been realized, rather raised profile.

What are the convergences?



It grows further in thin expanded area, while seeking out further areas to grow.

It contracts back from areas where the benefits are not demonstrated. It expands into a different one.



### Interviewee 34

What I want to talk with Mavis (Interviewee 34) about:

Time - as a barrier, created as a barrier

Extended roles – contracting back in now, used to be “fashionable”, now using clinical practitioners for i.e. cannulation, SLTs for dysphagia, now nursing time more precious, looking back in to basic nursing.

? extended roles moving more into the community setting?

Mavis has done a lot of work working across organisational boundaries/ barriers, and supervising other people, including voluntary sector and assistant roles/ support workers + sharing i.e. ADL screening with her job-share/ part-time physio colleague.

Mavis works across acute and community stroke, so may have a view/ have seen the impact of recent changes, such as shift to community based services.

Professional generic working!!

Professional bodies not supporting generic, broader working.

Extended practitioner roles – some have said that the whole profession needs to be signed up to extended roles, or not at all.

I also highlighted on my Interview Topic Guide that I wanted to talk with her about points 1, 4 (and specifically linking this to the developing model) and 6, the latter both in relation to the professional bodies and the service commissioners.

### How did this interview go?

Why do I even feel the need to pose the question of how did this interview go? I’m not sure what I think, that’s why. On the one hand, she was very chatty, and seemed much more relaxed, open and willing to talk than the last time I met her, but on the other hand, she did waffle quite a lot. She did say that she perhaps wasn’t in the right place to be talking about this now, or anything much to be doing with work, as she had lost her passion, I sensed both because of disillusionment (she refers to her conspiracy theory) and her own personal circumstances right now.

What do I think about how the interview went? Apart for that sort of “strangeness”, I’m not entirely sure. I get the feeling that it didn’t go as well as I perhaps thought, and I can’t quite put my finger on why. After I turned off the recoding, she was asking me about stroke strategies and how things are progressing (such as ESSD) – I wasn’t sure whether this was to get back in the loop as it were. Or whether she was testing my knowledge of this. I say this because I get the feeling that she might have been a bit irritated that my research has moved away from, stroke, or perhaps rather that it has moved away from stroke and yet I am still asking to speak with her. Or maybe I am just imagining that, because I do feel that I am a little “fraudulent” perhaps, as my focus isn’t really what is best for stroke survivors, but rather how we can get services to work differently. Is this how all, or at least most researchers (possibly

qualitative more so?) feel?? Thinking about it later: I wonder if some of it, was that she sort of felt the need to demonstrate that she was still “in the game” – she referred frequently to that she had lost her vision and motivation, and I wonder if she felt a bit left out in a way. She refers to the new leaders coming through, I think she even says “people like you”.

Axial coding 17122013

Now I am really doing axial coding (From Ian Dey):

Analyzing Data

- Generate categories by coding observations
- Use categories that are analytic and sensitizing rather than representational
- Identify the properties of categories
- Develop integrative hypotheses about the relations between categories and their properties), contrasting and comparing the codes and discovering the dimensions of the codes! Taken from my strength of evidence, gaps and further data collection table:

Core concept/ central phenomenon:

The **barrier** to different ways of working in dysphagia care is the creation and/ or maintenance of explicit skills & knowledge as tacit skills & knowledge.

The **enabler** is the codification of explicit skills & knowledge and the passing on of these to other types of worker, either through protocols and/ or through training.

This phenomenon can be visualised as a continuum, where the actual point of transition of skills & knowledge from tacit to explicit is presented at **Point A**, but the professional groups assert that the transition point is at **Point B**.

The space in between is the contested space – the place where change can happen.

02: "...particularly with an NG, if someone's improving, you don't wanna be, you know, ploughing in loads of feed, when they could actually be eating..." 05: "So you would make the assessment of how much they were taking through oral trials and then balance the feed if they had a feeding tube..."

06: **An example of codification:** "...'cause again that's one good thing, as time's moved on (laughing) that we have got MUST, years ago when I first started I just used to have to somehow cobble something together to try and sort of suss out a nutritional assessment, whereas now we've got the nationally agreed one..."

15: "So um, if somebody, I mean anybody can have a stroke, can't they, so if you've got an MS patient with complex needs or say somebody with a spinal injury where they've got, um, their spine fused and complicated swallowing's from that, then they happen to have a stroke...you know it's a bit too complicated for a dysphagia trained nurse; it's not a straightforward stroke so, um, in the last update I've been training them more in Parkinson's Disease, those patients that have a stroke or dementia then have a stroke so that they've got that understanding and we're saying yes, we can include that now in your remit....Because we had a patient that was on the respiratory ward with a tracheostomy and a dysphagia trained nurse was (pauses) pressurised (emphasis in voice) to go and see the patient and try and do an assessment and it was way outside her scope of practice because not all speech therapists, um, actually assess patients with tracheostomies; I haven't trained everybody up, a Band 5 wouldn't do that." **Contrast with Interviewee 08 re dementia, etc:** "I think when you start broadening out onto acute assessment units and MFE and you start bringing in dementia and vocal chord palsies and psychological problems and feeding problems, a

lot of our training is all sitting there in the back of our heads to go really, you really think it's just that? Let's kind of dig a little bit."

It has been/ is being proposed that professional groups create/ define as "complex" that which can/ could be codified, (described by participants as "drawing the line").

05: "...in terms of like tube feeding, thinking about you know everybody's different in terms of their requirements and what they need, rather than just saying yeah here's your feeding regime, I don't know how you'd start teaching them..." **contrast with:** "Obviously bearing in mind it's [your assessment of nutritional intake] just an estimate, so you're looking at biochemistry for hydration and weight and other things as well."

26: **Site 2 definition of where the line is:** "The skills they've [the nurses that have been trained to do the more advanced dysphagia screening and management in nursing homes] got involve them doing a basic assessment/screening and basic management and the same thing with like dysphagia therapy..." **Site 1 definition:** 02: "It would have to be a basic like the nurses, you know, either they pass the water swallow or they don't."

Increased health care funding, especially that which rewards narrow and specialised roles.

**Contrast with this Interviewee, Site 2, where they want to influence the commissioners to enable training rather than just one-to-one contact** 27: "So we need to influence the commissioners really to say we need allocated time to do that because if we're going to do this model of DTNs doing more and more then we need the time to support them, make sure that they're confident and they're skilled and that we've got confidence in what they're doing."

Job security; fear of "being done out of a job".

02: "...maybe, you know, because if somebody started doing things that I would do, "well you don't really need me then!" **Contrast with Interviewee 14, Site 2:** "No (laughs), I don't think so; I think there's going to be enough work for all of us and it is that, you know, that the demographics are that they're going to be a lot more older people with long term conditions, having strokes unfortunately and developing dementia..."

Note added 20122013:

I am continuing to compare and contrast the codes/ nodes, which I see as identifying/ exploring the dimensions of the concepts/ categories. For example, under the category "Core concept/ central phenomenon:

The **barrier** to different ways of working in dysphagia care is the creation and/ or maintenance of explicit skills & knowledge as tacit skills & knowledge.

The **enabler** is the codification of explicit skills & knowledge and the passing on of these to other types of worker, either through protocols and/ or through training.

This phenomenon can be visualised as a continuum, where the actual point of transition of skills & knowledge from tacit to explicit is presented at **Point A**, but the professional groups assert that the transition point is at **Point B**.

The space in between is the contested space – the place where change can happen.":

**Defining tacit skills...06:** "I think sometimes you do it subconsciously too don't you, you don't always necessarily have a tick list of things to do (laughing)...you do hear something different or you notice that somebody's coughing or you just you know automatically...Yeah like you do, just by chatting to somebody don't you, you pick up so much just by sort of speaking and looking at somebody, you know, so I think you just do don't you really....Yes, I think if I heard wet, sort of gurgly voice straight away I think alarm bells would begin to..." **20:** "...we're doing this day in, day out...So (pauses), you often, you get more of a feel for if you're giving somebody teaspoons and they're fatiguing, you're sort of looking at the bigger picture of things whereas the nurses are going in basically to check whether the swallows safe or not..." **20:** "So yeah it took a while for it to feel like it clicked but then when it did click it all kind of came together but initially I remember thinking, "I'm never going to get the hang of this," (both laugh) but yeah, gradually did."

And the category "It has been/ is being proposed that professional groups create/ define as "complex" that which can/ could be codified, (described by participants as "drawing the line").":

01: "if they fail on a weak or absent cough, so obviously for their protection of their airway, so if they fail on that, often that becomes a referral to us, but then we take that in consideration along with all the other factors we're looking for. So they may not be able to cough to command because they've got dyspraxia so it's then thinking about, well, what's their actual elevation of their swallow like, how quick is it, are they presenting with any other subtle signs of aspiration which we're not getting the nurses to look for...they don't think about all the things that are influencing our judgement about that...trying different techniques out or trying therapy strategies...so you try to say to people "well, have you felt their laryngeal elevation?", and they're going "hmmm, what?""

### **Contrast with Site 2, what they are getting the DTNs to do.**

And under the category "'Personalities" – there is some initial factor/ catalyst. Personal and professional confidence."

**Having a protocol seems to increase confidence... 02:** "...perhaps I would change my mind, if I had been given the appropriate training..." **04:** "Like, we are starting with the teaspoons, I would make sure the patient had a good, had a lovely coughing, in case he had a choke and he could cough it out, and he had a clear voice for me, rather than a wet voice, or like you know a gurgly voice, then I would carry on, then I would have to follow certain steps to make sure he is safe to have that. If I feel like he's uncomfortable or not confident in what you and one step I wouldn't carry on, I would just fail them instantly. And if the patient is having something pre-existing swallow difficulty or some progressing neurological deficit I wouldn't carry on. I'd just fail them immediately. Low GCS and that sort of stuff. There's lots of criteria I have to follow and I think that if you follow that criterias you will be safer..."

### Theoretical sampling 07032014 + further data collection.

OK, so where I am right at this moment in time (see data collection schedule), I am thinking that I need to add in another SLT from Site 1 (i.e. Billington), as I have an over-reliance on Site 2 and as I am not "allowed" to use information (not to be called data!!) from the feedback sessions. I am thinking perhaps the Band 7 for stroke might be the best bet/ appropriate.

I am also thinking that, if Emma is not back from sick leave (I telephoned again today, it went on to voicemail), then I am thinking to try and speak to LO, who at the time also provided the SHINE programme. I am also thinking that I may need to speak to Lisa Salton, (I was thinking about interviewing her again herself, but then decided against this - I think I was/ am just looking to fill in the gaps for all the rejections that I have had.), to get a nursing home nurse on board.

I got a contact from the matron at Haslem Hospital, another nurse that is also a DTN. I got two in fact. I was thinking about speaking to one of these, but I am not sure that they are going to add anything to the mix, nor where. I think I have got what I need about the current programme, the concept of expanding then contracting again.

I do need a Billington nurse - I am going to look over my transcripts and see which one I think will give me the most data. I think it may be the one whose mum had had a stroke also. She was quite "rules-based" if you like, and adamant that they should not overstep the mark.

I also need to chase the Midlands R&D lot, and then get on and book Poppy. I then need to book the two professional body reps also.

So, in looking at the order of things, I am thinking:

1. Emma.
2. LO, if needed.
3. Lauren, if needed for a nursing home nurse.
4. Susan.
5. Get commissioner name from Susan, book.
6. Ward nurse Billington.
7. Chase up the Midlands R&D, book Poppy.
8. Other SLT Billington.
9. The two professional body reps.
10. See if I need the other ward nurse in Haslem.

### Note added 08042014

While in interview with Susan and Olivia, I had a missed call from HF, to say that Julie was off sick today, and so would not be able to see me. It seems to me, right here right now, that perhaps the most benefit is going to be derived from speaking with Julie, rather than with HF, and this is because I think it would be most helpful to speak to a more junior member of staff. At the moment, I am speaking with more senior staff, those have that been around for a while (and this was purposefully so, as I was wanting to explore length of service as an intervening or causal condition), and I think it would

be particularly helpful in terms of the role of the professional bodies, how they experience this phenomenon from being more recently into the profession(s) and where they take their influence from, e.g. what would inspire them to start thinking about working in different ways.

Note added 09042014

Driving back from Billington today, and having picked up an e-mail saying yes from Julie, I was thinking again about the Julie versus HF, thinking again that I kinda feel I have exhausted the more senior people. I am also wondering whether there is really any benefit/ more data to be collected/ derived from interviewing Eve, the DA in Haslem, but this is also already set up, and so I will. I was just thinking, if I had to answer the question "Who do I really need to speak to now?" it would be the two professional body reps, there is quite a lot to explore with them, and a dysphagia trained nurse in Haslem, to explore further the causal and intervening conditions and consequences from their point of view. And that is it. Possibly a commissioner in Billington, although Susan has not been able to put me in touch with one.

Note added 15042014

After having had my supervisory today, we discussed the sampling framework here. I spoke in some depth with them today why I needed these informants. The professional body reps in terms of what is their role in disseminating these innovations and also on collecting the desired/ required outcomes by Derby so that this can be included in commissioning frameworks/ intentions. The commissioner in Billington, because I want to contrast with Haslem, what would encourage them to commission such a programme in Billington.

Date: 24/02/2014

Rebecca, rehab (stroke) matron and manager of DTNs, Haslem

After this interview, I had a few thoughts/ reflections:

1. My confidence continues to grow in interviewing. Now I do not feel the need to “pussy-foot” around sometimes tricky themes, and feel so much more confident at just going in and discussing them. Raising them. I feel that I am doing this in a non-confrontational, but just a sort of factual, way. This perhaps has something to do, as I have noted before, with the fact that my own future career does not hinge upon the results of this research; right now, my priority is to get it done, and the findings out there, whatever they may be. I have no real motivation one way or the other (although I am thinking about perhaps organising a BDA conference on the topic of innovative ways of working / running dietetic services...!) Incidentally, I think my confidence is also helped by doing the analysis simultaneously – I can really see why this is the way to do it in GT – you can then get in there and discuss topics in more depth with the next person/ interviewee.
2. What is striking me, beyond my last interview (about the igniting factor), is that it seems that there is something that ignites the change, as I had noted before, this “flame” (or whatever you want to call it) then expands, as happened in Haslem with the DTN programme at the hospital, but then contracts where the benefits are not realised (but then can/ does expand further into areas where there are the benefits). So, for example, Haslem started it small, then expanded to all over the hospital, but then realised that there weren’t the benefits there, and so it has contracted in all the areas where there were not felt to be the benefits, but has remained in the areas where there are (what the newer interviewees refer to as selected areas), e.g. ITU and stroke, but is then expanding into the community (hospitals and nursing homes) and encompassing dementia also.
3. Reflections on this particular interview/ interview technique: I should have expanded more with her on how to expand their way of working into other Trusts.
4. Towards the end of our interview, I noticed that this interviewee was clock-watching. When I mentioned that we were getting towards the end, she did say that she had another meeting at 2 O’clock.

On listening through interview afterwards, I missed the question about confidence, as in I didn’t explain clearly what I meant by this, and she took it to understand that I meant why some nurse choose dysphagia as an area of interest or extended practice, whereas others choose other areas of interest, such as i.e. continence.

My interview style is much better now. I am asking, for example, “If you were to put this in place in a different Trust, what would you say to those people?”

It was good that I did pick up the issue of staff/ professionals being able to pick and choose what they do – I was debating whether to include this in the interviewing/ analysis or not, but it came naturally around to this in the interview, so it was an opportune moment. Good also asking directly about feasibility of codifying dietitians knowledge re prescribing supplements.

The question of where this interviewee sees the DTN programme going was a good question.

Theoretical sampling – perhaps I need to speak to a DTN in a community hospital also. Perhaps I could access this through Lauren. I might also be able to access a nursing home nurse through Lauren if I have no luck with Emma getting back to me.

It strikes me that participants seem to interpret complexity more in terms of complexity of patients, rather than skills and they define drawing the line more in terms of your own skills (i.e. as an individual), rather than conceptual as a range of tasks.

Important note: the line is drawn by the professions, i.e. the line, the criteria of what DTNs can and cannot do.

## List of Abbreviations

<b>A&amp;E</b>	Accident and Emergency
<b>AHPs</b>	Allied Health Professions
<b>BDA</b>	British Dietetic Association
<b>BSA</b>	Bedside Swallow Assessment
<b>CAS</b>	Central Allocation Service
<b>CWP</b>	Changing Workforce Programme
<b>CQUIN</b>	Commissioning for Quality and Innovation
<b>DH</b>	Department of Health
<b>DTN</b>	Dysphagia Trained Nurse
<b>ENRiP</b>	Exploring New Roles in Practice
<b>ESP</b>	Extended Scope Practitioner
<b>FEES</b>	Fibreoptic endoscopic evaluation of swallowing
<b>FOOD</b>	Feed Or Ordinary Diet
<b>GP</b>	General Practitioner
<b>GPwSI</b>	GPs with a special interest
<b>HCAs</b>	Health Care Assistants
<b>HEI</b>	Higher Education Institute
<b>HR</b>	Human Resources
<b>ICU</b>	Intensive Care Unit
<b>IV</b>	intravenous
<b>MASA</b>	Mann Assessment of Swallowing Ability
<b>MDT</b>	Multidisciplinary Team
<b>MUST</b>	Malnutrition Universal Screening Tool
<b>NG</b>	nasogastric
<b>NHS</b>	National Health Service
<b>NICE</b>	National Institute for Health and Care Excellence
<b>NRES</b>	National Research Ethics Service
<b>NPV</b>	negative predictive value
<b>OT</b>	occupational therapist
<b>PIL</b>	participant information leaflet
<b>NBM</b>	Nil By Mouth
<b>PEG</b>	Percutaneous Endoscopic Gastrostomy
<b>PPV</b>	positive predictive value
<b>R&amp;D</b>	Research & Development
<b>RAE</b>	Research Assessment Exercise
<b>REC</b>	Research Ethics Committee
<b>RCP</b>	Royal College of Physicians
<b>RCSLT</b>	Royal College of Speech & Language Therapists
<b>SBR</b>	scientifically based research
<b>STD</b>	Self Determination Theory
<b>SIG</b>	Special Interest Group
<b>SLT</b>	Speech and Language Therapist
<b>TIA</b>	transient ischaemic attack
<b>VFSS or VF</b>	videofluoroscopy