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Paper:

Best, S. & Williams, S. (2018). Integrated care: mobilising professional identity. *Journal of Health Organization and Management*, 32(5), 726-740.
<http://dx.doi.org/10.1108/JHOM-01-2018-0008>

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Integrated Care: Mobilising professional identity

Abstract

Purpose: Integrated care has been identified as essential to delivering the reforms required in health and social care across the UK and other healthcare systems. Given this suggests new ways of working for health and social care professionals, little research has considered how different professions manage and mobilise their professional identity whilst working in an integrated team.

Design/methodology/approach: A qualitative cross-sectional study was designed using eight focus groups with community-based health and social care practitioners from across Wales in the UK during 2017.

Findings: Participants reported key factors influencing practice were communication, goal congruence and training. The key characteristics of professional identity that enabled integrated working were open-mindedness, professional trust, scope of practice and uniqueness. Blurring of boundaries was found to enable and hinder integrated working.

Research limitations/implications: This research was conducted in the UK which limits the geographic coverage of the study. Nevertheless, the insight provided on professional identity and integrated teams is relevant to other healthcare systems.

Practical implications: This study codifies for health and social care practitioners the enabling and inhibiting factors that influence professional identity when working in integrated teams.

Originality/value: Recommendations in terms of how healthcare professionals manage and mobilise their PI when working in integrated teams is somewhat scarce. This paper identifies the key factors that influence professional identity which could impact the performance of integrated teams and ultimately, patient care.

Keywords: professional identity, integration, mobilise, teams, healthcare, social care, UK

Article type: Research paper

Introduction

Integrated care has been identified as essential to delivering the reforms required in health and social care (Lê et al. 2016; Stokes et al., 2016) and is a priority across the UK (Ham et al. 2013) and other healthcare systems (e.g. Leichsenring, 2004; Ovretveit et al., 2010). The shift to integrated working needs to be not only financially effective but also to improve patient experience. Some suggest integrated care is complex and widely contested (Stokes et al.,

2016) and recommendations in terms of what form this takes and how best to prepare professionals to support these new structures and working practices are somewhat scarce. A recent National Audit Office report (2017) does point to some of the barriers to effective integrated team working and cites the lack of evidence for the sustainable impact of integrated care on patient outcomes. Similarly, Dickinson (2014) notes shifting mechanisms and ethos for the provision of care through integrated teams has not been without its challenges. Furthermore, Morgan and Ogbonna (2008), while recognising the differences and similarities of those working in healthcare, argue understanding the professional identity of professions within a team is a key component for successful change in health care. This paper specifically contributes to developing this understanding by inviting members of community-based integrated teams to share their experiences of managing and mobilizing their professional identity. Our research questions are:

- What does PI mean to health and social care practitioners and what significance is placed on this when working in integrated teams?
- What external factors enable or inhibit the management and mobilisation of PI when working in integrated teams?

We recognise that there is a body of literature on integrated care (e.g. Goodwin 2016 Ramsay et al 2009) and professional identity (e.g. Dadich et al., 2015; van Os et al., 2015) in healthcare generally. However, as alluded to above, there is little written on the intersection of these two bodies of knowledge, in other words how practitioners manage their professional identity when working in integrated teams. In this paper we present a summary of a scoping review (currently under review) the authors recently conducted of the literature to understand the discussion so far within this intersection. What is evident from this review and important

to highlight is that few papers focus on PI within the context of integrated teams. This is the gap that our empirical study starts to address.

The remainder of this paper is organized with a brief report on the key themes that emerged from the scoping review. Details of the context of the study and methodology are provided, followed by the findings and discussion of the results. The paper concludes with the implications of the research and areas of future studies.

Professional Identity and Integrated care

PI describes how people define themselves through their work role. Schein (1978) points to a “*constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role*” highlighting a multitude of potential influences over the generation of PI (cited in Ibarra, 1999, p764-765). While the mechanisms for some of the influences have not been established the link between gender and profession has been recognised (Adams et al. 2006). Work experience is believed to also customize professional identity (Pratt et al. 2006) by centering on two areas: One; activity, i.e. role identity, only doing what they can do and thereby exclusive in the eyes of colleagues and patients (Caza and Creay 2016). Two; Sense of uniqueness, Van Maanen and Barley (1984) explored the concept of work identities and how people develop and retain a ‘sense of uniqueness’ (p 295). They recognised work or professional social identity is constructed as an individual identifies themselves as belonging to a profession with other individuals who engage in the same approach to a form of work – for example, physiotherapists, dieticians. This is of interest but does not however explain why PI matters.

Professional identity affects individual behaviour in the workplace. Professional norms and values impact upon job attitudes and shape behaviour (Bunderson, 2001). As a role identity, one’s professional identity provides behavioural guidance in the workplace (Ibarra, 1999).

For instance, Leavitt et al. (2012) found individuals' professional identities determined their moral decision-making and behaviour. In other workplace studies, professional identification has shown to have positive performance outcomes such as career success (e.g. Arthur et al., 1989).

Interest in the significance practitioners place on PI when working in integrated teams lies in the impact on behaviour. Crucially the construction of one's identity is highly relevant for those providing care as it offers "*a shared/collective representation of who one is and how one should behave*" (Hogg and Abrams 1988, p. 3). Deciding how services are delivered is ultimately dependent on practitioners' behaviour that in turn establishes the quality of care received. Little is known about professional identities within the evolving world of integrated working (Mitchell and Boyle 2015). The literature suggests actively engaging with the mobilisation of professional identity is central to the smooth functioning of an integrated team (Kreindler et al 2012; Pate et al 2010). Ignoring the relevance of PI in integrated teams is not an option (Callan et al. 2007) for optimal management and leadership in an integrated team. For newer teams the challenge of the emergent shared team identity will need to be balanced with the shifting of multiple team members' PI. Our study centres on the practitioners' PI rather than the team and explores the gap in the evidence base to understand the influencing factors on PI and how these might impact on integrated working.

As previously noted, a scoping review of the existing literature highlighted three themes prominent in the literature; these being: creation and mobility of PI; challenges and barriers to PI; and implications for leadership and management. Given the aim of this paper is to report our empirical work it is not our intention to provide full details of the scoping review, however, for context we do feel it necessary to summarise the key literature within the three key themes.

1. Creation and Mobility of identity

Historically roles have been attributed to people because of the role they played with established power dynamics; roles were well understood. This can be seen with international health professions working overseas who strongly identify themselves with their role (Neiterman and Bourgeault, 2015). Payne (2006) looks at identity politics and argues the way identity is being constructed is changing. With the advent of the integrated teams, and the challenge of understanding PI in the context of a new collaborative identity within a team, roles now need to be negotiated due to the boundaries becoming more complex and the requirement of different team skills and resources. Often boundaries are seen to impede change however where trust is present the negotiation of PI is enabled.

Clark (2014) finds a narrative approach allows insight into the complexity of the multiple layers of professionals and recognises the need for a variety of voices (rather than uni-professional) in creating PI. This concept of voice draws on Clark's (1997, p 442) earlier work that focuses on values in health care professional socialisation, where socialisation is described as *'the acquisition of the knowledge, skills, values, roles and attitudes associated with the practice of a particular profession'*. Socialisation is argued to be conceptualised as the development of a distinctive viewpoint with different health care professionals having unique perspectives that combine at the point of making complex clinical decisions.

Open mindedness is noted as a key facet of creating identity (Mitchell et al., 2012) and can be defined as a willingness to question one's own position and find evidence against one's beliefs or perspectives (Sinkula et al., 1997). Within the context of PI open mindedness is often described as the backdrop, which enables discussion across professions. However, this has little impact where health professionals strongly identify with their own profession. In

contrast, where health professionals are aware of the different professional roles open mindedness can help facilitate healthy debate (Sinkula et al., 1997).

2. *Challenges: Integrated teams – threat to Professional Identity?*

The challenges to PI present in several ways. The policy context is explored by Pate et al. (2010 p. 203) who identify that change produces a fear of perceived dilution of PI with a need to ‘*defend their turf*’. The fight for PI is not new, with the concept of PI being long standing and highly valued by health professionals (Pate et al., 2010). Pate et al. (2010) offer a potential solution taken from the conflict resolution and negotiation literature: decategorisation (downplaying the significance of the profession), re-categorisation or dual identity. The first two are not considered in a positive light while dual identity is perceived to have greater possibilities, involving recognition of the identity of the professional and the collaborative identity of the team.

Mitchell et al. (2011) note the challenge of diversity, with a focus on the impact on team effectiveness. An increase in the diversity of a team formed a threat to PI and impacted on performance. McNeil et al. (2013) identify five triggers of PI conflict: differential treatment, different values, assimilation, insulting or humiliating action, and simple contact. The need for mutual reliance is highlighted by Holmeland et al. (2010) who demonstrate for integrated teams to function practitioners need insight of their own role and that of others. The traditions of specialisation, the difficulty in letting go of ones’ own role is found to be impacted by stereotypical anticipation of roles by those unfamiliar with the potential breadth of others’ work. The idea of a culture of professional hierarchy through PI is drawn out as a barrier to integrated working (Neiterman and Bourgeault, 2015).

While the challenges of PI within an integrated team are highlighted in the literature the potential for positivity can also be found. Hall (2005), exploring the culture of health

professionals, notes the challenges of each profession having different cognitive maps and holding different values but identifies that these traditional barriers can be overcome. Hudson (2002, 2007) divides interprofessional working by a pessimism (e.g. distinctiveness of knowledge and culture) or an optimism (e.g. commonality of location and values) model of integrated working. He points to the use of communities of practice (CoP) (Lave and Wenger, 1991) as a vehicle to develop knowledge and shared understanding. CoPs are employed by Kislov et al (2011) to unpack the challenges of interprofessional working within Collaborations for Leadership in Applied Health Research and Care (CLAHRCs)– partnerships between the universities and National Health Service (NHS) Trusts. Kislov and colleagues indicate the need to create a collaborative identity, both professional and organisational, to engender a shared vision.

3. Implications for leadership and management

The essential role of leadership for integrating services is recognised (Best, 2017) and the need to actively manage the integration of different professionals, not leaving it to chance, is also noted. Some of the fears of integrated working can be negated by two management strategies: i) effective planning and ii) reporting the benefits back to staff to ensure they retained confidence in the change (Workman and Pickard, 2008). Callan et al. (2007) argue for the need to actively manage integrated teams though from a different perspective. This study explores the multiple identities of health professionals in the context of change.

Although practitioners may be members of many different work groups, leading to multiple identities, Callan et al (2007) argues PI is the primary identity. When change threatens professional distinctiveness and attempts to ignore a threatened identity in favour of the identity required for the change it will reinforce the old identity – especially in lower status groups. Callan et al. (2007) note PI during the process of change needs active management

and suggest endorsing both the previous identity and the new one required. This is in line with the concept of dual identity from Pate et al. (2010).

Brown et al. (2000) identify arguments for and against blurring roles and boundaries between professions. ‘Creeping genericism’ is noted as one of the challenges and the need to retain a professional voice. In contrast the importance of identity mobilisation is also noted along with the need to see changes in service delivery (Kreindler et al., 2012). Without a shift in PI change is less likely to succeed. Therefore, actively managing PI within integrated teams is fundamental to overcome silo working in favour of effective service delivery (Kreindler et al., 2012).

Study context and methods

The context for this qualitative cross-sectional study is the UK focusing specifically on the principality of Wales, where there is a devolved government with responsibilities for 20 areas including health, housing, education and training, fire and rescue services, local government, social welfare, and the environment. As a result, strategic decisions about health and social care are made in Wales rather than from the Westminster parliament. Health and social care are administered via different mechanisms. Social care is provided through local government (of which there are 22 local authorities in Wales) while health is delivered via the National Health Service (NHS) through seven Local Health Boards and three NHS Trusts with an all Wales focus.

Wales recognises the need for integration with a series of publications stretching back to *Designed for Life* (Welsh Assembly Government, 2005). This seminal strategy sought to achieve world-class care delivery and has been supported by subsequent policy documents (including the *Wellbeing and Future Generations Act (2015)* and the *Social Services and Well-Being (Wales) Act 2014*) and funding (such as, the *Intermediate Care Fund, 2014*)).

We conducted eight focus groups with health and social care practitioners (n= 48). The criteria for inclusion were registered health or social care professionals; working or worked in an integrated team; based in the locality of one of four University Health Boards in south Wales. An initial contact from each of the Health Boards referred researchers to potential integrated teams that might have an interest in participating in the study. The team leads were contacted with details of the research and how they might participate. Once the team agreed to participate, further information was emailed about the structure of the focus group. The groups were conducted in venues convenient to the staff and audio recorded with participants' consent. Focus groups ranged from four to twelve participants. The researchers developed a schedule to guide the focus group discussion, which was informed by the scoping review. There were three stages to the focus group:

1. Completion of a brief questionnaire to capture the biographical information and work experience of participants,
2. Discussion on defining PI from the perspectives of the different professions represented by the participants and the enablers and barriers to managing and mobilising their identity.
3. Discussion and ranking of specific activities or support used to manage their PI.

The 48 participants that took part in the study represented nine different professional backgrounds from the health and social care setting therefore generating varying views on PI (see table 1). Participants on average had 17 years experience of working in health and social care and experience of working in an integrated team was 6 years on average.

Insert Table 1 about here

Using Valentijn et al's (2013) conceptual framework we classify each of the teams in relation to where they were based, the focus of their provision (person or population), duration of commitment, extent of shared decision-making and level of integration (from micro to macro) (see table 2). All but one of the teams were based in primary care working fulltime across health and social care. The exception was a relatively newly formed (6 months) hospital-based team that worked together several times a week, with shorter duration for commitment and lower-levels of shared decision making. The majority of teams were focused on population based health with high levels of shared decision making. The types of integration were largely professional, with two teams operating at a clinical level and one being organisationally integrated. Valentijn et al's (2013) framework refers to organisational and professional integration to operate at a meso level and clinical integration to operate at a micro level.

Insert Table 2 about here

We analysed focus group data using the thematic analysis approach of Braun and Clarke (2006). Audio recordings were transcribed and reviewed by the researchers for accuracy. This activity fed into the first of the six-phase analysis approach: 1. Familiarisation with the data, 2. Initial coding, 3. Searching for themes, 4. Reviewing themes, 5. Defining and naming themes, 6. Writing up. Clarke and Braun (2013) acknowledge this approach takes time (recognising the 'messy reality' (p121) inherent in qualitative research) but offers rigour at this significant stage of the research. The analysis was an iterative approach given the focus groups were conducted over a six months period. The coding was conducted and cross checked by the authors. Extracts from the recordings are included where appropriate. The results are presented in relation to the research questions presented earlier in the paper.

Ethical approval was provided by Swansea University's College of Human and Health Science Ethics Committee (11.3.16) and organisational approval for staff to participate was provided by each organisation involved. Written consent was taken from participants at the workshops following review of the participant information sheet and opportunity to ask questions about the study. On completion of the data analysis participants were provided with a synopsis of the results of the study.

Findings

This research focuses on the link between PI and integrated team working. As integrated health and social care is elevated as a solution to some of the challenges faced by the UK NHS and other global healthcare systems. It is important, therefore, that we understand how PI is defined and managed within integrated teams and identify what factors support and inhibit such working. We present our findings based on the two key research questions proposed earlier in the paper which include the key themes that emerged from our analysis of the focus group data.

Defining and managing PI when working in integrated teams

Responding to the first research question, we asked participants to define what PI meant to them and to share their experiences of managing their PI whilst working in an integrated team. Three key themes emerged from the data. First was scope of practice which is guided by the standards of practice developed by professional bodies. For working in an integrated team, the need to retain core skills while widening scope of practice was highlighted, "*I think even though we've got our core skills, the scope of those skills has changed and grown (agreement) as the team has grown as well (agreement)... I've still got my core skills but the scope has widened*" (Focus group 4). One participant noted "*I think we have each got our own kind of boundary as far as our profession and what is expected and what our standards*

are, but I think there is a great overlap between all the therapy professions within that as well. I think that's where it comes in, the scope of your practice isn't it? ... because I think of my identity in what your scope is I suppose, but it is, it can be quite blurred within the team sometimes." (Focus group 2). Participants also reported there is often an internal conflict due to the blurring of boundaries which are evident in integrated team. For example, one respondent stated, "I think there is a push to have a more blurred role focus on us and that can be quite difficult, because obviously we respect the experience and skills of the other professionals and we feel they're best placed to carry out those tasks. So, when we're being asked to do stuff that perhaps isn't really what we're trained to do, it can cause a bit of a conflict." (Focus group 3). Payne (2006) warns of the complexity of defining roles and boundaries with the introduction of integrated team and the requirement of trust and flexibility in the negotiations, skills and resources to support such changes.

The second theme was associated with developing inter-professional trust, which required the trusting of others in the team and the need to generate respect and flexibility within the multi-disciplinary team (MDT) – against a background of pre-existing PIs. As one participant comments "*learning to work with other people and learning to trust their assessments and that they are at the same level or standard or you know from the, you know because of the core values or your own professional, you know, identity Trust and sharing same values with others*" (focus group 6). Developing the interdependence required for integrated team work finds practitioners drawing on core values from their own profession but also attempting to identify values in common with others.

The third theme was about providing uniqueness to the team. Although there is blurring of roles, having a PI helped individuals to codify their unique contribution to the team by understanding the core skills that they bring. As one participant comments "*I think we have each got our own kind of boundary as far as our profession and what is expected and what*

our standards are, but I think there is a great overlap between all the therapy professions within that as well.” (Focus group 5). Brown et al. (2000) warn of ‘creeping genericism’ and the need to retain a professional voice, as noted by one participant *“You’re trained to a level and within that you have roles and responsibilities and you’re accountable to your governing body.”* (Focus group 8).

External factors enabling mobility of PI when working in integrated teams

In terms of what participants considered the reinforcing factors of PI in an MDT to be was overwhelming the improvements in patient care. This was a key driver for being part of an integrated team for many of the participants. The benefit of working with other professions also enabled shared decision making which linked to the ability of members being able to communicate clearly what their professional remit was within the team. As one participant stated *“It’s saying to yourself this is beyond my remit now, I need to pass this over, and being comfortable saying that to people.”* (Focus group 4). This clarity of the professional scope of the MDT members, which could be interpreted as an emerging collaborative identity, reinforces the ability to make appropriate (internal) referrals and encourages participants to see the service not as being functionally driven but wider than their own profession – in other words – promoted systems thinking. The ability to share and see the wider scope of the MDT suggests that PIs are being mobilised from a uni-professional dimension to a more collaborative PI. As noted by Mitchell et al’s, (2012) this shift in PI reinforces the importance of open-mindedness. One participant states *“having a greater understanding of what they do [other members of the team], why they do it, means that I refer to them appropriately, I get them involved when I need to, I don’t waste their time when I don’t need to because it can be addressed in other ways. So, it’s having that openness to know what, be confident in yourself to know what your skills are but be willing to share information openly with others.”* (Focus group 1).

The areas that inhibit the mobilisation of PI when working as part of a MDT were noted as causing confusion to patients, diluting the role and acting outside of one's professional remit. Representing a MDT, participants believed at times can be confusing for patients; although patients/relatives might easily recall the colour of the uniform that a health professional was wearing they might be unclear of the specific role of the team member. As one participant notes *"the only thing that worries me is that you might end up with a situation where the patient is overwhelmed with the information and I guess possibly almost feeling like they don't know who to approach with a particular problem."* (Focus group 1).

Some participants felt it was important not to dilute the professional role of team members and any requirements to act outside of one's professional remit needed to be carefully managed. Participants accepted over time and as they understood one another's role there was some blurring of roles as previously noted and individual PIs had been mobilised. .

Figure 1 illustrates the key factors that influence the co-existence of collaborative and professional identity of health and social care integrated teams. Further explanation of these inhibiting and enabling factors is provided in table 3 with the former including the in-patient setting being seen to reinforce stereotypical uniprofessional identity silos as was the need to tightly define roles thus preventing any mobility of activity and identity. The culture and size of the team were also mentioned as being possible barriers to mobilising professional identity particularly where the team membership changed and increased. Participants felt there needed to be a period of time for the team to embed and adjust to their new collaborative identity before further changes were made.

Insert Figure 1 about here

The role of joint activities such as training and patient care were amongst the enablers identified as facilitating a common understanding of other professions' roles and deepening

confidence in articulating one's own role. As a result, participants could allow their PI to flex to meet the demands of working within an integrated team.

Insert Table 3 about here

Alongside the external factors discussed above, we asked participants about the activities they undertook to manage their individual PIs. To provide a sense of the most important activities we asked participants to rank them (see table 4). Notably, those factors ranked as being most important – professional supervision/mentoring, professional training and understanding the role of others are all areas in which professional bodies and educators have a role to play. The next important factors included the membership of their respective professional bodies and related activities such as meetings, code of practice/standards. Reviewing profession specific evidence and the opportunity to participate in joint clinical working with other professionals enabled participants to maintain but also mobilise their professional identity and also facilitated understanding the wider scope of the team. Other factors mentioned included wearing a uniform, supervision of students and continual professional development all of which are clearly defined by profession. Participants also noted that organisational structures often reinforced individual professional groups, although much of the rhetoric was focused on providing integrated services. This was more prominent when looking at health and social care – where professions could be employed by healthcare organisations and local authorities.

Insert Table 4 about here

From our analysis of the literature and this study we have identified key factors that can influence the management and mobilisation of professional identity of health and social care professionals when working in an integrated team (see figure 2).

Insert Figure 2 about here

Discussion

Defining PI was the starting point for our focus group discussions. Marrying with Schein's definition of PI our participants referred to how their experiences, values and education had shaped their professional identity. Three themes emerged in relation to how they defined PI: scope of practice; inter-professional trust and a unique role in the team. Figure 3 illustrates how our findings can be linked to this well-established definition. For example, scope of practice can be linked to the attributes and beliefs associated with PI. Trust is implicit to the values and motives of PI. The uniqueness of a profession is understood and shaped by experiences, beliefs and attributes of PI.

Insert figure 3 about here

The focus of our research was to examine the enablers and barriers to managing and mobilising professional identity when working in integrated teams. Our study revealed the significance of allowing flex in the construction of health and social care professionals' PI to facilitate working closely alongside colleagues in integrated teams. Retaining a rigid sense of PI, as reported for example in ward settings, did not engender inter-professional working required for successful integrated delivery of care.

Participants identified several themes that facilitate a sense of PI while working with an integrated team. Professional trust was seen as being a core enabler and if absent then this is likely to inhibit the level of integration. Reflecting Mayer et al's (1995) ability, benevolence and integrity model of trust, understanding the role of others was identified by the participants as being important to integrated team working and one of the factors that supported the development of professional trust. In addition, the need for open mindedness

(Mitchell et al., 2012), a sense of uniqueness (Van Maanen and Barley (1984) and understanding scope of practice were all felt to foster the retention and management of PI in the team setting.

In contrast, the blurring of professional boundaries held the potential to have dual impact on PI. On one hand the blurring of professional boundaries and roles can act as an enabling force for those health and social care professionals who have an open-mind as to how the team will work in addition to their and others' contributions to the team. Some of the participants in this study spoke of the importance of joint visits to patients with other professionals in team. This helped them to see where the blurring of boundaries and roles might occur and how best to manage these.

Equally blurring of boundaries and roles could also be interpreted as an inhibitor to integrated team working, especially if team members hold a strong professional identity and an intolerance of professional differences (McNeil et al., 2013) and look to 'protect their turf' rather than look for areas of joint working (Pate et al., 2010). This reinforces the need to proactively manage PI in inter-professional teams (Best, 2017), allowing opportunities for team members to recognise the value and individual contribution from each profession. While we focus on professional boundaries the two-fold nature of boundary blurring may extend across to organisations, clinical settings and professional hierarchies. This is an area that requires further study.

Our empirical study provides insight to how PIs are managed and mobilised by integrated health and social care teams. It is important however to note that some findings from previous studies are not evident here. For example, Voci (2006) refers to instances where (social) professional identity is threatened within an interprofessional teams, which leads to the exacerbation of social categorisation and stereotyping and potentially resulting in

defensive actions and conflict (Hornsey & Hogg, 2000). Although stereotyping was mentioned none of the participants spoke specifically about their PI being threatened. This may reflect that the majority of teams were well-established or perhaps participants were unwilling to share this within a group setting. When PI is under threat Amason (1996) reports members may withdraw from the team or withhold information. Although the participants recognised that integrated working may not suit everyone there were no reports of information being withheld. Frustrations associated with information were largely due to incompatible IT systems rather than other professions withhold information. It is important to note our study did not include participants who were no longer working in integrated teams and who could perhaps comment more on what McNeil et al (2013) and others refer to as faultlines, which are described as “hypothetical dividing lines that may split a group into subgroups based on one or more subgroups” (Lau & Murnighan, 1998, p328).

The traditional “healthcare hierarchy” where medicine is seen as the dominant profession (Reeves, 2011) has been reported to inhibit the mobilisation of PI within integrated teams (McNeil et al., 2013). This was not the case in this study, but this may reflect the fact only one team included a medical consultant. No reference was made to the hierarchy of professions by the participants.

Conclusion and implications

The purpose of the study was to empirically examine the intersection between PI and integrated working. As we highlight in this paper there is limited research that occupies this intersection and even fewer studies that are empirical. This paper provides an insight to how practitioners from health and social care view PI when working in integrated teams, which has helped us to start to address the dearth in the literature between two bodies of literature: PI and integrated working. Our empirical work has focused on two key questions. First, we

have identified what PI means to practitioners and the significance they place on this when working within integrated teams. Improving patient care was a key motivation for participants choosing to work in integrated teams and they had several strategies in place to help them maintain and mobilise their professional identity whilst working in integrated teams. Second, we have identified the enabling and inhibiting factors to mobilizing professional identity and examined how practitioners manage these factors as they continue to deliver care for patients.

We recognise that the sample of our participants is somewhat biased as we only included those that are currently members of integrated teams. We wanted to include participants that had experience of working in integrated teams but were no longer doing so. However, the key links with each of the Health Boards were unable to identify such participants. We believe this group of participants would have some interesting insights into working in integrated teams and the potential faultlines. We intend to work more closely with key stakeholders associated with health and social care to try and identify potential participants for our future study in this area. In addition, this study is UK (Wales)-centric; although we believe that some of our insights into PI in integrated teams are generalisable we intend to broaden the scope of our work to include other teams from inside and outside of the UK. Previous research has indicated that drivers such as gender have a role to play in managing professional identity. We have not explored the impact of these drivers here but recognize are an area of further research.

In relation to the implications for practitioners thinking about or currently working within an integrated team, we highlight some of the enablers and barriers for managing and mobilising one's PI to facilitate the development of a collaborative identity and teamworking (see Figure 2 and tables 3 and 4). A range of internal and external influences were raised from the role of professional supervision and professional specific training to joint working. These have

implications for managers who need to understand the importance of enabling mobility of individual professional identities and at the same time being able to facilitate the development of a collaborative team identity. Here we have focused largely on a single (individual) profession identity within the context of integrated teams, some reference has been made to a collaborative identity, but further research is needed to examine team identity. We recognise from this research that some participants occupied professional and managerial roles and were therefore managing dual professional identities, which requires further exploration within this context.

Emerging from this research is a role for education providers and professional bodies as to how best to prepare and support health and social care practitioners to manage and mobilise their PI when working in integrated teams. This may take the form of an education intervention. It is now our intention to engage with these organisations to discuss what this might entail.

The literature that underpins our discussions identifies there is more academic research needed here to draw out what we mean by mobilisation of PI in an integrated care setting and what can we learn from other professions. This research is particularly timely given the universal desire to deliver well-integrated and seamless healthcare systems. Developing an understanding of how we can best prepare healthcare professionals for these interprofessional roles should be a priority for educationalists, policy makers and professional bodies, as well as those involved in the (re)design and development of services.

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Table 1. Details of participants

Summary: Eight focus groups, 44 participants across nine professions		
Professions	Occupational Therapy	15
	Physiotherapy	11
	Speech & Language Therapy	3
	Dietetics	2
	Social Work	4
	Medicine	3
	Nursing	4
	Clinical Psychology	1
	Pharmacy	1
Years employed as a H&SC professional? N= 42	Range: two to 36 years Average: 17 years	
Years working in an integrated team N=42	Range: less than one year to 36 years Average 6.9 years	

Table 2: Types of integrated teams involved in study (adapted from Valentijn et al 2013)

Group Number		Person/Population focus	Duration of commitment	Extent of Shared decision making	Types of integration Organisational/Professional/Clinical
1	Community based	Population	Long	High	Professional
2	community based	Population	Long	High	Professional
3	community based	Population	Long	High	Professional
4	community based	Population	Long	High	Professional
5	Hospital based	Population	Short	Low	Organisational
6	Community based	Person	Long	High	Clinical
7	Community based	Population	Long	High	Clinical
8	Community based	Population	Long	High	Professional

Table 3. External enablers and inhibitors to mobility of professional identity

Enablers	Inhibitors
Communication/shared language	Ward environment
Goal congruence within MDT (e.g. common aim for patient/clients' outcome)	Tightly defined roles
Training – inter-professional and training other professionals about one's own role/contribution to the team	Culture of team which limits innovation, enquiry and thwarts the development of inter-professional working
Joint working (e.g. Home visits)	Size of team/growing too quickly
Confidence in interpreting own role and being able to share this with other team members	Blurring of boundaries/negotiation of roles
Blurring of boundaries/negotiation of roles	

Table 4. Activities facilitating mobility of professional identity for while working in integrated teams, identified and ranked by participants in order of significance

Ranking	Sub themes
First	Professional Supervision/mentoring Profession specific training Understanding of others (role)
Second	Professional body (standards, meetings, scope of practice-clarity) Joint clinical working Team meetings Reviewing profession specific evidence
Third	Professional bodies - PR national Uniform Organisational structure Student supervision Recognition by others CPD

Figure 1. Factors influencing the co-existence of collaborative and professional identity of health and social care integrated teams

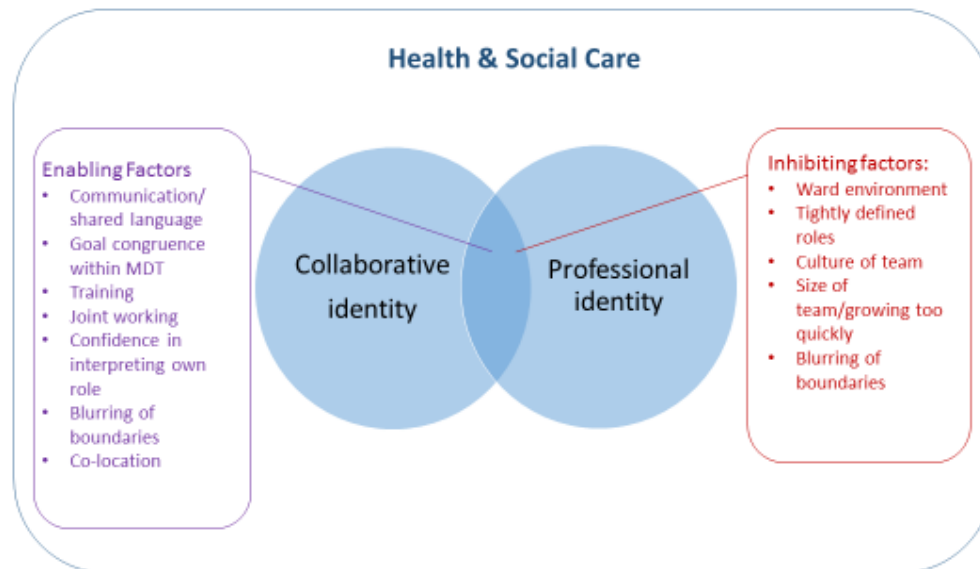


Figure 2. Factors influencing professional identity of health and social care integrated teams

