What Impacts the Implementation of Tikanga Ako Hono-Tāngata/Relationship-Centred Practice by Allied Health Professionals within Hawkes Bay District Health Board?

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Abstract

Tikanga Ako Hono-Tāngata, or relationship-centred practice (RCP), is an Aotearoa New Zealand approach to practice developed at Hawkes Bay District Health Board (HBDHB). It weaves together principles of person-centred care (PCC) and Te Ao Māori engagement approaches. Anecdotal feedback from health professionals who have undertaken the RCP training indicated they found it challenging to embed and sustain this relational way of working. This doctoral research sought to understand allied health practitioners' experiences of embedding RCP into their clinical practice, to explore what helped or hindered the implementation of RCP, and to develop rich understandings of what is required for health professionals to sustain this way of working.

Using interpretive descriptive methodology, semi-structured interviews were completed with eight purposefully sampled allied health professionals (AHPs) from across disciplines and practice contexts. Data were analysed using reflexive thematic analysis. Following preliminary analysis, participants participated in a focus group to sense check if preliminary findings resonated, test assumptions, and generate a collective social knowledge from their shared perspectives. A key informant group was established, including programme facilitators who were clinical practitioners and cultural advisors, and assisted me to engage reflexively with my data and interpretation, further supporting theme development and refinement.

Three themes were constructed. The first theme talks to the structural and systemic factors which impacted the implementation of RCP. The prevailing norm of valuing workflow and expediency over practicing RCP often compromised a clinician's sense of agency or control over one's actions. The second theme provides insight into the challenges of using RCP in everyday practice which commonly resulted in internal tension for clinicians. This manifested in three distinct ways. First, when clinicians took time to find out what was important to the patient and agree shared goals, clinicians were sometimes unable to meet these expectations due to factors outside of their control. Second, there could be a lack of alignment between the clinician's disciplinary and evidence-based knowledge and patient choice. Third, some clinicians perceived a tension between their discipline-specific norm of providing practical hands-on treatment

and the ethos of taking the time to engage with the patient. The final theme illustrates how positive experiences of using RCP strategies empowered and enabled clinicians to be confident and motivated to continue to use those strategies and embed RCP in a more fulsome way into their practice, particularly when using Te Ao Māori approaches.

The research identified three original contributions to advance practice knowledge. The first contribution provides insight into change programmes needing to take into account the divided sense of responsibility clinicians have to whaiora, the organisation, and their discipline-specific practice norms. This divided sense of responsibility impacts clinicians' ability to prioritise relational practices. The second contribution talks to the need for an overarching organisational change programme in Aotearoa New Zealand when introducing initiatives like RCP to ensure uptake and sustainability. It is imperative to partner with cultural experts and apply Indigenous change frameworks in the design, implementation and evaluation phases to honour our commitments to the articles of Te Tiriti o Waitangi in health delivery in Aotearoa New Zealand. Finally, the third contribution provides insight into the need for a transformational shift in the practice paradigm that some professionals appear to work from to embrace this relational way of working in their everyday practice. Unless some professions are challenged on how they define who they are, what they contribute, and what their role is at the most foundational level, then it will be difficult to sustain behavioural change. This issue needs to be addressed at a pre-qualifying training level and reinforced by the regulatory bodies and healthcare organisations into which these health professionals are socialised. RCP or PCC initiatives will not be successful until the long-standing beliefs that these clinicians hold of being 'the expert' and 'in control', and that their clinical knowledge and hands-on treatment is 'best', are addressed.

This study provides significant insights into how the RCP programme can be redeveloped at Te Matua Maui Hawkes Bay (formally HBDHB) to better embed its underpinning principles. A range of implications are discussed including identifying key changes in RCP programme design drawing from the findings, steps that can be taken at an organisational level to enable and embed RCP, and broader implications for allied health curricula and regulatory bodies. The original contributions to knowledge and practice developed through this doctoral research may have significance in influencing and

informing the design and implementation of other health delivery programmes underpinned by a similar philosophy in Aotearoa New Zealand and further afield.

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Kupu – Māori to English Translations

He tangata, he tangata, he tangata	The people, the people, the people
Hui process	A coming together or meeting of people for a specific purpose
Kaiāwhina	Health support worker
Kaimahi	Workers
Karakia	Prayer
Kaumatua	An older male that holds the respect and knowledge of tribal history, traditions, and practices
Kaupapa Māori	A Māori approach or agenda
Iwi	Several related Indigenous clans or descent groups within a tribe
Iwi katoa	The societal context of belief about behaviours and norms
Mana	Dignity and presence of a person
Mihimihi	The initial greeting
Ngāti Kahungunu iwi	The third largest grouping in Aotearoa New Zealand encompassing the tribes in the Hawkes Bay and Wairarapa regions
Poroporoaki	Concluding the encounter
Pouwhakaruruhau Matua	Senior cultural advisor
Rangatiratanga	The right to self-determination
Taha hinengaro	Mental health
Taha tinana	Physical health
Taha wairua	Spiritual health
Taha whānau	Family health

Taiao	Taking into account the physical environment that whaiora and whānau are living in
Tauiwi	Any person who is not Māori
Tikanga	Customs and traditional values of that tribal grouping
Te Tiriti of Waitangi	Founding document of Aotearoa New Zealand
Wānanga	Open discussion, gathering together to discuss differing thoughts, opinions, and experiences
Whaiora	A person seeking health
Whakapapa	Refers to one's identity, placing oneself in a wider context, and linking oneself to land and tribal groupings
Whakawhānaungatanga	Making a connection
Whānau	A sense of belonging and connectedness encompassing family, friends, and community
Whānau ora	A culturally-based, and whānau centred approach to well-being focused on the family group
Whenua	Land - where one comes from

Abbreviations

AHP	Allied Health Professional
AHPs	Allied Health Professionals
HBDHB	Hawkes Bay District Health Board
MDT	Multi-Disciplinary Team
PCC	Person-Centred Care
RCP	Relationship-Centred Practice

Transcription Guide

... Indicates words removed from the original transcript

[...] Indicates words added by the researcher to clarify the meaning of the quote

“ ” Indicates a direct quote from a participant or literature

‘ ’ Indicates a quotation within the participant’s direct quote

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tool or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor any material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Anne McLeod

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He Mihi
Kei a koutou e rau rangatira mā
Koutou e ngā hau e whā
E ngā kārangaranga maha
Koutou e hoa mā, whānau, hapū hoki
Tēnā koutou mo ōu mahi
E manaakitia ki ahau te whakamutua
Tōku mahi Pukenga momoho
No reira, e karanga atū nei ki a koutou
Tēnā koutou, tēnā koutou, tēnā rā tatou katoa
Mauri ora!

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to the many respected people,
from across the four winds,
to the many affiliations,
to friends, families, the sub-tribes also
Thank you for your support,
thank you for your help, time, patience in bringing this work to a close,
for the attainment of a higher reward,
therefore my call goes out to you all,
greetings once, greetings twice, greetings to us all.

Ehara taku toa I te toa takitahi, engari kē he toa takitini
Just as it takes a village to raise a child, it takes a community to enable success

Chapter One: Introduction

Tikanga Ako Hono-Tāngata is an approach to relationship-centred practice (RCP) developed at Hawkes Bay District Health Board (HBDHB). This programme was first taken out to staff in 2017, and over 800 staff have now been through the training modules. However, it appeared challenging for staff to implement in routine practice in a sustained way. As an allied health leader in the organisation, and someone involved in developing and delivering the programme, I wished to understand what the blocks were for clinicians trying to implement this way of working in their day-to-day practice, so that we could use this knowledge to inform future iterations of the RCP programme. As a result, I undertook this doctoral research to better understand what supports allied health professionals (AHPs) to change practice and embed relationship-centred care. While the primary aim of this doctoral research was to develop an understanding of what helped or hindered the implementation of the RCP programme at HBDHB, a secondary aim was to explore the role that practice context (e.g., acute care, community setting) has on meaningful implementation. The findings of this research offer insights into what supports are required to sustain practice change for clinicians working in acute and community healthcare settings. These findings may assist in informing future practice change programmes in Aotearoa New Zealand.

Background to the Research: Positioning the Researcher and the Research Context

The concept of health professionals engaging meaningfully in true partnership with their patients (also referred to as 'whaiora', a te reo Māori term meaning a person seeking health), has been an area of interest for me over the last 15 years. My interest stems from my social work background and my drive for social justice and equity in the health environment. This background, coupled with my passion for coaching, coaching facilitation, and making a real difference in the lives of the whaiora and whānau (a te reo Māori term used to describe a sense of belonging and connectedness encompassing family, friends, and community) that we serve, fuelled my interest in how clinicians can meaningfully engage in every healthcare interaction. Both social work and coaching have an ethos of working in partnership to assist people in making informed decisions about

their lives and it has shaped my drive for ensuring whaiora healthcare is culturally responsive, equitable, and effective.

In 2017 I was awarded a Winston Churchill Fellowship which enabled me to travel to the United Kingdom (UK) to research person-centred care (PCC) programmes. PCC is described as an approach to healthcare that puts people and their families at the centre of their healthcare and well-being through effective engagement and partnership (McCance et al., 2013; The Kings Fund, 2012). The study trip enabled me to critically reflect on what programmes were being implemented, the barriers and facilitators to implementation, and how services monitored and evaluated success of these programmes. It also gave me insight into the factors that contributed to the sustainability of such programmes and whether these organisations had been effective in embedding this way of working with their healthcare team. Visiting a variety of programmes and organisations in the UK assisted me to reflect, and gain greater clarity, on some strategies that might be useful in creating a programme based on the PCC model in Aotearoa New Zealand.

In the same year, I was fortunate to be part of a Kahungunu iwi-led delegation to look at Indigenous models in Alaska. Iwi is a te reo Māori term used to describe several related Indigenous clans or descent groups within a tribe. The Ngāti Kahungunu iwi is the third largest grouping in Aotearoa New Zealand encompassing the tribes in the Hawkes Bay and Wairarapa regions. Being part of the Ngāti Kahungunu iwi delegation was significant as we travelled with the mandate of the local tribal group and were led by respected Māori elders or kaumatua (a te reo Māori term used to describe an older male that holds the respect and knowledge of tribal history, traditions, and practices). Travelling as a mandated iwi group meant that we were more readily accepted and welcomed by the native Inuit Alaskan people as a fellow Indigenous group that had also been colonised.

During this trip, I was introduced to an Indigenous model of care known as the Southcentral Foundation's Nuka System of Care. This system of care is viewed as a world leader of healthcare redesign (Collins, 2015; Jones, 2017). It is a relationship-based model which has a 'customer-owner approach' to transforming healthcare, that seeks to put the whaiora at the centre of every decision on their healthcare journey (Gottlieb et

al., 2008). It incorporates Indigenous healthcare practices embracing physical, mental, emotional, and spiritual wellness; and is practiced in conjunction with traditional western medicine. The intent of this approach to care is that the whaiora is in control of, and central to, every healthcare decision (Gottlieb et al., 2008). This open sharing of knowledge of an effective Indigenous healthcare model furthered my thinking around what could be achieved in developing a model of practice that reflected the specific cultural and health needs of people in Aotearoa New Zealand. This experience, together with my interest in PCC, led me to wonder how we could better support and equip clinicians to work in partnership with whaiora and whānau to ensure meaningful engagement in our healthcare context.

At this early stage I had also done some background research trying to find information about PCC, but could not specifically find any literature about a Aotearoa New Zealand PCC model. I reflected on whether a care model could be co-designed with whaiora that reflected the uniqueness of Aotearoa New Zealand and embraced Te Ao Māori models of healthcare engagement. With this reflection forefront in my mind, I brought together clinicians from both secondary hospital and primary healthcare settings, Māori Health liaison staff, and whaiora representatives that had used the health service to discuss the concept and gauge whether there was an appetite to co-design an Aotearoa New Zealand model of care. The initial meeting showed that there was an appetite to co-design a programme to better equip health professionals to work in a relational way in partnership with whaiora. A working group, consisting of whaiora, Māori Health staff, organisation and development representatives, and healthcare clinicians from a variety of different disciplines encompassing nursing, medical, and allied, was then formed to work together to co-design a programme. The goal was to build clinicians' skills and provide strategies to meaningfully engage and work in partnership with the whaiora and whānau that they work with.

The co-design process is what gave rise to Tikanga Ako Hono-Tāngata – RCP. The specific content of that programme is discussed in more detail in Chapter Two. RCP was also informed by two key factors. First, HBDHB's values of tauwhiro (delivering high quality care to patients and consumers); taranga te tira (working together in partnership across

the community); he kauanuanu (showing respect for each other, staff, patients, and consumers); and ākina (continuously improving everything) (HBDHB Website, 2024). The second factor was a rising interest in PCC internationally as a way of engaging in a partnership model with patient, to ensure effective engagement and improve the quality of their care (McCance et al., 2013; McCormack et al., 2011b; Naldemirci et al., 2017; The Kings Fund, 2012). However, RCP extends beyond PCC to also consider equity and cultural responsiveness, as discussed later in this Chapter and in detail in Chapter Two.

The proposed programme was presented to the HBDHB Executive Leadership Team, HBDHB Māori Relationship Board, and Consumer Council. Further robust discussion resulted in changes being made to ensure it was in alignment with Kahungunu Iwi tikanga (a te reo Māori term used to describe the customs and traditional values of that tribal grouping), HBDHB values, and organisational goals.

In 2017 the Tikanga Ako Hono-Tāngata – RCP programme was piloted with staff and consumers with minor adjustments being made through a feedback and evaluation loop. The programme was initially rolled out to AHPs, before being made more widely available to other disciplines across the organisation.

HBDHB – Background and Context

HBDHB serves a population of 165,000 people and was established in Aotearoa New Zealand in 2001 by the New Zealand Public Health and Disability Act (Ministry of Health, 2001). HBDHB is responsible for ensuring effective and efficient care of people in need of health services or disability support within the region. The primary aims are to improve, promote, and protect the health, well-being, and independence of the population and address health inequities (HBDHB, 2024). HBDHB is situated on the east coast of the North Island of Aotearoa New Zealand and serves a vast area from Mahia Peninsula in the North to Porangahau in the South. The region is made up of 65% New Zealand European, 27% Māori, 5.6% Pasifika, 5% Asian, and 1.7% other (NZ Census, 2018). The percentage of Māori in Hawkes Bay is 39% higher than the national average of 16.5% (NZ Census, 2018). The main hospital is situated in Hastings with an outlying rural hospital in Wairoa to the North and a health centre in Waipukarau in the South.

Several areas are rural and isolated and some people live an hour and a half away from medical services.

The Hawkes Bay Health Equity Report highlighted that 35% of the total population (57% of Māori and 70% of Pasifika) live in the most deprived quintile areas compared to the Aotearoa New Zealand baseline of 20% (McElnay, 2014). The report highlighted higher health inequities compared to the Aotearoa New Zealand average, including that more people, on average, in Hawkes Bay have a poorer health self-rating, a diagnosis of one of the common mental health disorders, and die at a younger age (McElnay, 2014).

It was in this HBDHB context that my interest grew in how we, as healthcare professionals, could address these growing health inequities by more effectively engaging with whaiora and their whānau in a partnership model of care. I asked myself, what strategies or Māori ways of engaging could we use to more meaningfully connect with the people we serve? RCP appeared to be a way of working which could go some way towards addressing the issues of whaiora engagement and partnership, and be more effective in our work in addressing the health inequities.

Aotearoa New Zealand Health Care Context

In this section I reflect on key turning points in the Aotearoa New Zealand healthcare context over the last 20 years which have implications for my area of research. I provide an overview of policy direction and how it has impacted service delivery and PCC. Situating my research within the current social and political context of health practice in Aotearoa New Zealand helps to contextualise what underpins, influences, and shapes health professionals' behaviour and day-to-day practice.

Historically, Aotearoa New Zealand healthcare has followed a biomedical Western model (Neuwelt & Matheson, 2012). Over the last 20 years, there has been increasing attention to PCC, evidenced through the emergence of partnership models focusing on increased patient engagement and whaiora encouraged to take shared responsibility for their healthcare (Gauld, 2020; Neuwelt & Matheson, 2012; Santana et al., 2018). The New Zealand Public Health and Disability Act (Ministry of Health, 2001) had made District Health Boards at a local level responsible for improving, promoting, and

protecting the health and independence of their populations. Over time it became apparent that effective outcomes were just as, if not more important, than the throughput of patients being seen by healthcare providers.(Neuwelt & Matheson, 2012; Nicholls et al., 2020). This was crucial to paving the way for the development of models of care, such as PCC and RCP, that focused on improving health outcomes through effective engagement and partnership with patients (Neuwelt & Matheson, 2012; Santana et al., 2018).

The New Zealand Health and Disability Strategy (Ministry of Health, 2016) endeavoured to bring together all previous health strategies. This strategy reinforced that partnership was integral to all New Zealander's health and well-being. It promoted the concept of 'People Powered Health', putting emphasis on improving patient experiences, promoting active partnership, and collaboration in rehabilitation and health promotion. The intent and direction of this strategy (Ministry of Health, 2016) supported the development of implementation of models of practice such as PCC and RCP. The strategy overtly placed emphasis on health professionals trying to understand and meet the needs and goals of the whaiora and whānau that they were supporting, placing people at the centre of their healthcare (Ministry of Health, 2016).

As mentioned above, Hawkes Bay has a high proportion of Māori and under Te Tiriti o Waitangi, health providers are required to work in partnership to be culturally responsive and address health inequities. This practice has been reinforced through various health strategies such as He Korowai Oranga, (Ministry of Health, 2002) and Pae Ora (Ministry of Health, 2014) both of which place emphasis on partnership to ensure whaiora and whānau have more control over their own health and well-being. These strategies also emphasise the concepts of equity and whānau ora (a te reo Māori term used to describe a culturally-based, whānau centred approach to well-being focused on the family group). In each of these policy developments the importance of whaiora and whānau having rangatiratanga (a te reo Māori term used to describe the right to self-determination) was a strong premise. These policy reforms introduced an imperative for whaiora and whānau to have a 'voice' within their own healthcare (Neuwelt & Matheson, 2012).

However, the strategies did not appear have a significant impact on moving healthcare forward to improving access, equity, rangatiratanga, and shared decision-making (Came et al., 2020; Elers, 2014). Secondary healthcare still appeared to be being delivered in a paternalistic, biomedical, and western centric model, with healthcare focused only on an individual's illness and physical symptoms (Came et al., 2020; Elers, 2014). Came et al. (2020) argued that institutional racism prevailed. The Te Ao Māori perspective of health incorporating taha hinengaro (mental health), taha tinana (physical health), taha wairua (spiritual health), and taha whānau (family health) were not taken into account in most healthcare interactions (Barton & Wilson, 2008; Elers, 2014; Kidd et al., 2019).

The Waitangi Tribunal was set up by the Treaty of Waitangi Act in 1975 and created a commission of inquiry that makes recommendations on claims brought by Māori relating to breaches in the promises made in Te Tiriti o Waitangi (Stokes, 1992). Under the New Zealand Public Health and Disability Act (Ministry of Health, 2000) there was a commitment to meeting Te Tiriti o Waitangi principles of partnership, protection, and participation, as they were then specified. The Tribunal's Wai 2575 inquiry into healthcare breaches highlighted that the New Zealand Public Health and Disability Act (Ministry of Health, 2000) was not compliant with Te Tiriti and that health systems in Aotearoa New Zealand have failed to achieve equitable outcomes for Māori (Kidd et al., 2019). It exposed that a true partnership approach to working alongside Māori and a commitment to equity had not been achieved (Kidd et al., 2019). Kidd et al. (2019) argued that subsequent policy and strategies have been a reflection of the dominant culture and a political compromise among stakeholders. Came et al. (2020) suggested that where institutional racism is embedded, any sustained change requires a planned and multi-faceted approach where genuine Māori leadership is imperative. Embodying kaupapa Māori (a te reo Māori term used to describe a Māori approach or agenda) models of care and approaches in every aspect of the healthcare journey is critical to challenging western centric assumptions to eradicate racism and achieve health equity (Cameron, 2019). Thus, redesign and new ways of working in the healthcare sector are imperative to ensure that partnership and equity for Māori are being addressed at every level.

RCP was developed amidst this significantly changing health landscape; and since that time the need and mandate for co-designed approaches to partnership has become stronger. For instance, in 2019 a Health and Disability Review was undertaken to look at how effective the healthcare system was in achieving equitable outcomes for the people of Aotearoa New Zealand (Simpson, 2020). The report concluded that the Aotearoa New Zealand healthcare system required an overhaul and that there was a need to place consumers, whānau, and communities at the heart of the health system. It identified that healthcare needs to be driven more by what consumers value and need most, with more choice about how needs are met. In 2021, a restructure of healthcare in New Zealand saw the disestablishment of District Health Boards and healthcare nationalised under one entity, Te Whatu Ora Health New Zealand.

Te Whatu Ora has taken over the role of the Ministry of Health, with District Health Boards being restructured as localities to centralise health and be more responsive to the needs of all New Zealanders (Te Whatu Ora, 2022). The newly formed entity has released a health plan—Te Pae Tata (Te Whatu Ora, 2022)—which identifies that placing whānau at the heart of the health system is a top priority to improve equity and health outcomes. At the core of Te Pae Tata (Te Whatu Ora, 2022) is embedding Te Tiriti o Waitangi principles into healthcare with emphasis on the principles of equity and rangatiratanga. Te Whatu Ora Health New Zealand have committed to services being whānau centred and cohesive and that people and their whānau will be supported to take charge of their own health and well-being (Te Whatu Ora, 2022). This direction is strongly aligned with the central premise of PCC and RCP in terms of whaiora and whānau being central to their healthcare and being supported to make decisions about their own health and well-being journey.

Person-centred care

PCC is based on effective engagement through a partnership model with the patient, rather than an expert/telling biomedical model. Over the last 20 years, PCC has gained increased recognition with evidence emerging that it is a transformative approach to delivering healthcare for those with chronic conditions or long term disabilities (McCance et al., 2013; The Kings Fund, 2012). PCC is described as:

> An approach to practice established through the formation and fostering of

> therapeutic relationships between all care providers, people and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development. ((McCormack et al., 2011a, p. 13)

PCC places people at the centre of their healthcare and well-being (McCance et al., 2013; Naldemirci et al., 2017; Rockwell, 2012; The Kings Fund, 2012). The fundamental values underpinning PCC are respect for the individual and their family, and upholding people's rights to self-determination (McCormack et al., 2011b). While a range of concepts and terminology are used such as patient-centred care, PCC, person-centredness, or RCP, they share some core characteristics and values. For example, a key component is health professionals developing genuine partnerships with people and whānau (McCance & McCormack, 2017; Neuwelt & Matheson, 2012). This is achieved through strategies of finding out not 'what is the matter with them' but 'what matters to them', developing a shared agenda and working collaboratively towards the patient's and clinicians' agreed health goal. Another core shared characteristic is that this approach supports people to take a more active role in managing their health by building their confidence, knowledge, and skills to make shared decisions about their health (McCance et al., 2013; Naldemirci et al., 2017; The Kings Fund, 2012).

However, PCC is more than an engagement and activation model. In their thematic analysis of PCC models, Jesus et al. (2022) put forward a cross-disciplinary approach in the form of a person-centred rehabilitation model in adult physical rehabilitation settings. They suggested person-centred rehabilitation can be effective at many levels. From a *patient level* being reflexive and adaptive to the patient, empowering them toward a co-constructed rehabilitation programme; to a *multidisciplinary level* with the whole team emersed in the person-centred rehabilitation approach. At an *organisation level*, person-centred rehabilitation can be effective with whaiora and health professionals being involved in any service evaluation and improvement programmes (Jesus et al., 2022). The person-centred rehabilitation model illustrates that PCC can be multi-faceted and enabled across multiple levels.

Current Situation

While there have been many models of PCC developed internationally, the RCP model at HBDHB weaves together the general tenants of PCC with an Aotearoa New Zealand equity focus. As discussed earlier in this chapter, this co-designed programme was termed Tikanga Ako Hono-Tāngata or RCP. RCP (as conceptualised through this programme) enriched more general understandings of PCC through its explicit attention to embedding Māori models of health and ways of working. It is heavily underpinned by Te Whare Tapa Whā, the Meihana model, and the Hui Process (all Māori healthcare models that will be explained in Chapter Two) (Lacey et al., 2011; Pitama et al., 2014; Rochford, 2004). These models and approaches all prompt the exploration of patient and whānau situations to understand who they are, what is important to them, and, thereby, trying to understand their social circumstances. RCP seeks to give health professionals the skills to bring their clinical knowledge together in partnership with a patient and whānau's lived reality to understand what really matters to them, and then plan and provide healthcare that effectively meets whaiora needs. A detailed explanation of Tikanga Ako Hono-Tāngata or RCP is provided in Chapter Two.

Reasons Behind this Study

At the time of starting this doctoral work over 650 clinicians had gone through the RCP training. Since then, a further 150 health professionals have completed the training. The training facilitators were all skilled health professionals and educators, and evaluation of the training programme modules by participants was extremely positive. However, anecdotally, there was a sense that RCP was not easily sustained or embedded by some health professionals in their everyday practice. Furthermore, as a clinical leader in the organisation I was regularly involved with supporting health professionals and multi-disciplinary teams with the discharge plans of whaiora with complexity or higher social needs, back to community. The narrative I heard, and the sense that I got from both Clinical Nurse Managers and AHPs about health professionals' interactions with whaiora, was that RCP was difficult to consistently achieve. While these clinicians acknowledged RCP strategies were important, the demand to assess, treat, and rehabilitate whaiora quickly and expediently to ensure good patient flow sometimes took precedence. I was intrigued as to why RCP strategies could not be embedded within health professionals' practice and applied when they were actively working with a patient; and that RCP was

being viewed as an add-on, rather than integrated into their daily practice. Some clinicians suggested that they needed RCP refreshers but when these were provided, they had not been well attended, so had been discontinued. As previously discussed, my study trip to the UK and my Kahungunu iwi delegation experience in Alaska had also provided a firm basis for my interest in embedding practice change. This knowledge, coupled with the narrative from clinicians that RCP was difficult to embed, fuelled my curiosity as to why RCP was not sustainable in practice. I wanted to understand what were the blocks to successfully rolling out a programme like RCP and what would support the embedding of a partnership model of care in a healthcare organisation in Aotearoa New Zealand. As Director of Allied Health, I was particularly interested in considering the experiences of AHPs, knowing that I was in a role where I had potential to have influence to better support them to embed relationship-centred practice. While healthcare teams are multidisciplinary, and we have trained all disciplines including nurses and doctors, my own positioning meant this research focused on allied health experiences.

Research Aims

The overarching aim of my research was to gain an understanding of what helped or hindered the implementation of Tikanga Ako Hono-Tāngata – RCP by AHPs within HBDHB. The specific objectives were to:

1. Explore what helps or hinders the implementation of RCP by AHPs
2. Examine the role that context and practice setting has on implementation of RCP
3. Explore AHPs perspectives on what supports sustained practice change

My research topic has significance as any new understandings will guide future iterations and implementation approaches of RCP at Te Matua a Maui Hawkes Bay, and potentially inform future healthcare practice change programmes in this area in Aotearoa New Zealand.

RCP Versus PCC

I will be using the term PCC when discussing existing literature as it is the dominant term used in the international and Aotearoa New Zealand literature. However, when I move

to looking at my specific research within the context of HBDHB's RCP programme, I will be using the term RCP.

HBDHB and Te Matua Maui Hawkes Bay

As mentioned previously a restructure of healthcare in Aotearoa New Zealand in 2021 saw the disestablishment of District Health Boards and healthcare nationalised under one entity, Te Whatu Ora New Zealand. Consequently, HBDHB was renamed Te Matua Maui Hawkes Bay while this doctoral work was in process. Given this change, when I am referring to the context in which the RCP and this doctoral work was initiated, I refer to HBDHB. Whereas, in the recommendations and discussions (see Chapters Seven and Eight) I refer to Te Matua Maui Hawkes Bay, given this is the new context in which my findings would be implemented.

Structure of Thesis

Within this first chapter I have provided an overview of the research topic, my own positioning, and the healthcare context in which the research occurred. I have provided insights into the circumstances that led to the development of RCP and clarified how key terms will be used in this thesis, along with outlining the reasons why I was so interested in this research topic.

An overview of Tikanga Ako Hono-Tāngata, the RCP programme as conceptualised at HBDHB is provided in Chapter Two. An outline of the programme co-design, development and implementation processes is provided.

Chapter Three presents a review of the global literature to explore what is already known about factors that may enable or impede the implementation of PCC into routine healthcare practice. This chapter also looks at the literature pertaining to the barriers and enablers of implementing PCC initiatives specifically within the Aotearoa New Zealand healthcare context. The chapter helps to develop the theoretical scaffold for the study (Thorne, 2016) and provides insight into what supports implementation and sustainability of PCC.

In Chapter Four I introduce interpretive description, the study methodology. I outline its roots in naturalistic inquiry and social constructionism, and provide a rationale for using this approach. I also outline how it informed the design of my research study and the analytic methods utilised. An overview of the study's design and the key methods used are outlined in Chapter Five. It includes the procedure for sampling and recruitment, data collection processes, analysis, positionality, ethical and cultural considerations, and research rigour.

In Chapter Six the study findings are outlined, detailing the enablers and barriers that clinicians experienced when implementing RCP. Three predominant themes are identified and discussed. I weave together knowledge gained from my empirical study, and from the wider PCC literature in Chapter Seven to consider how this research can inform practice change to working in a relationship-centred way. I make recommendations particularly for future iterations of RCP at Te Matua a Maui Hawkes Bay and for other services seeking to embed relational approaches to working.

Chapter Eight proposes three novel contributions that this research makes to practice knowledge. I discuss how these contributions advance and challenge knowledge within the healthcare practice change arena in Aotearoa New Zealand. The chapter also outlines the key strengths and limitations of my research, and suggests future research opportunities that have been identified through this study.

Chapter Two: An Overview of the RCP Programme

In this chapter, I provide an overview of the RCP programme including its inception, development, and implementation. This information contextualises my research aim and purpose, and provides insight to my desire to inform practice change in this area.

Co-design Process

As described in Chapter One, in 2017 at HBDHB an idea was formed about co-designing an Aotearoa New Zealand person-centred implementation programme for health professionals from community, primary, and secondary services, together with whānau and iwi. There was already a network of health workers committed to patient engagement, partnership, and promoting equity, so an initial meeting was held. Whānau and consumer involvement was sought, as well as iwi representation, and a co-design group was formed to focus on bringing together a training programme. This co-design group met once a month for 7 months focusing on the overarching vision and purpose, the parameters of the concept, objectives, and an action plan to achieve the agreed objectives. The new programme was underpinned by a PCC model of care, and was termed Tikanga Ako Hono-Tāngata – RCP. A hui was held with the HBDHB Māori Relationship Board to ensure alignment to Ngāti Kahungunu, the local iwi, and tikanga (Māori concepts and ways of thinking), and to obtain guidance on embedding whānau voice in the programme. The concept plan was also presented to the HBDHB Board, Clinical Council, and Consumer Council for their input and support.

The co-design group then developed the training material for the Tikanga Ako Hono-Tāngata programme. Two pilot training programmes were run with health professionals and consumers, encouraging robust evaluation, whānau voice, and critique. The programme was refined further, finalised, and rolled out, initially to just AHPs and then health professionals across the organisation. The training programme was also run for the Executive Leadership Team and Senior Managers.

Values and Principles

When the group set out to co-design the programme, the value of putting people at the centre of their healthcare in a true partnership model was increasingly being recognised as an approach that can enhance patient engagement and outcomes (McCance et al., 2013; The Kings Fund, 2012). However, in Aotearoa New Zealand, health professionals are also heavily influenced by Te Ao Māori where the whole family or whānau is considered important for health and well-being. Consistent with this understanding, the concept of whānau ora, or empowering the whole whānau or family in their healthcare through partnership, emerged as a critical component of health interactions (He Korowai Oranga Māori Health Strategy 2002; NZ Public Health & Disability Act, 2000; Pae Ora, 2014). As such, the co-design group agreed that the foundational principle of RCP was placing whaiora and their whānau at the centre of their healthcare in a true partnership model.

Another foundational principle was ensuring equity and cultural responsiveness were addressed in healthcare engagements through the RCP programme. The co-design group agreed that the Aotearoa New Zealand healthcare system still operated in a predominantly biomedical model which focused on individuals and their physical health symptoms rather than drawing on the more holistic Te Ao Māori perspective of well-being, health, and healing (Barton & Wilson, 2008; Elers, 2014; Kidd et al., 2010). Whānau Ora, Te Whare Tapa Whā, the Hui Process, and the Meihana model were all formative to the co-design group's early thinking and will be discussed later in this chapter (Durie, 1994; Lacey et al., 2011; Ministry of Health, 2002, 2014; Pitama et al., 2007).

The group co-designed the programme guided by whānau voice with a focus on cultural centredness to inform programme content. Two Māori consumers were part of the co-design group and a hui was held with the Māori Relationship Board to gain the perspectives and voice of Ngāti Kahungunu representatives to shape the programme. Input from the HBDHB Consumer Council, a representative group of consumers with different disabilities and a diversity of ethnicities was also sought in designing the training.

Equity, alongside whaiora and whānau right to self-determination, was a central premise of the RCP programme. The co-design group felt that drawing on the principles of the Te Ao Māori models of care would create the context for health professionals to consider cultural, societal, and environmental factors in their interventions. The Tikanga Ako Hono-Tāngata co-design group believed this orientation would enhance cultural responsiveness and, in doing so, would support whaiora engagement. The group hoped that this would, in turn, translate into health professionals being more effective in contributing to equitable health outcomes. The main purpose of RCP was to give health professionals the tools to enable them to bring their clinical knowledge alongside patient and whānau knowledge, to partner with them, and more fully understand and be informed by their lived reality. It was intended that this programme would allow health professionals to support and work with that patient and whānau, acknowledging what really mattered to them.

Another foundational principle the co-design group supported was the wider relationships with colleagues, other agencies, and one's relationship with self. While the relationship with patients and whānau were considered central, other relationships were also viewed as important, particularly relationships with self. This includes developing an understanding of one's own beliefs and values, and any taken-for-granted assumptions that might impact day-to-day practice. Through this reflexive practice, issues around socialisation, practice norms, equity, and unconscious bias may become evident and be addressed (Nundy & Oswald, 2014; Pitama et al., 2014). Curtis et al. (2019) maintained that by ensuring appropriate and equitable care, addressing bias and institutional racism are all ways that can assist clinicians to move forward to assist with eliminating health inequities. Cultural safety and cultural responsiveness is important at an individual health professional level, as is addressing inequity at an organisational level (Curtis et al., 2019). Therefore, knowledge of self and critical reflexivity can be a catalyst to enabling health professionals to challenge their own internal belief system and biases, and assist them to focus on their cultural competency and responsiveness.

Whānau Ora and Te Ao Māori Models that Informed the RCP Programme

The concept of whānau ora was developed to empower families as a whole, rather than just focusing on an individual's healthcare. It was prompted by social and healthcare

policy changes over the last 2 decades which encouraged taking into consideration the wider family or whānau unit as important in improving healthcare outcomes (Ministry of Health, 2001, 2002, 2014). As mentioned in Chapter One, Pae Ora, the Māori Health Strategy (Ministry of Health, 2014), emphasised working collaboratively and holistically, attending to the interconnected elements of: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments to improve Māori health outcomes. The importance of whaiora and whānau having rangatiratanga (the right to self-determination) was central to their healthcare. Whaiora being empowered to make decisions about their own healthcare was embedded in these guiding healthcare policies (Neuwelt & Matheson, 2012). The support from, and the connection to, whānau was critical to a person's well-being and the building of resilience (Kidd et al., 2010; Smith et al., 2019). This was a shift away from a more conventional person-centred focus which has tended to be more individualised, to embracing the whole whānau and connecting to Māori tikanga (values and practices).

A key model and approach to care that had been influential in achieving whānau ora was Te Whare Tapa Whā (Durie, 1994). Durie (1994) put forward the notion that Aotearoa New Zealand's healthcare system focuses on the individual which is based on a western centric concept of society and social interaction. Te Whare Tapa Whā embraces the importance of four cornerstones of health and well-being: taha hinengaro (mental health), taha tinana (physical health), taha wairua (spiritual health), and taha whānau (family health). This Indigenous model of health embraces identifies that the four dimensions are inextricably linked and need to be addressed to ensure the well-being of the individual and their whānau are being addressed (Durie, 1994). Te Whare Tapa Whā has transformed clinical practice over the last 30 years, providing health care professionals with a richer and more holistic framework to better understand the interlocking elements that are at the core of Māori health and well-being (Durie, 1994, 2004; Pitama et al., 2007; Rochford, 2004).

The concept of Whānau Ora is based on the Te Whare Tapa Whā Model and embraces improving the cultural, social, and economic well-being of whānau to ensure better health outcomes for Māori (Ministry of Health, 2014). It was in this environment where Pae Ora, the Māori Health Strategy (Ministry of Health, 2014), was being rolled out and

the concept of Whānau Ora was adopted by non-government organisations that the concept of the RCP programme was conceptualised and co-designed. The programme was informed by Te Whare Tapa Whā, and Whānau Ora with families being central to the decisions and management of their own health (Kidd et al., 2010; Smith et al., 2019).

The Hui Process was developed as a tool to help promote engagement with whaiora and whānau was developed, nurtured, and maintained throughout the healthcare journey (Pitama et al., 2007). This key approach draws on the tikanga (values and practices) of the traditional hui process (a coming together or meeting of people for a specific purpose) and has four essential elements that aim to promote good communication and dialogue. The mihimihi (the initial greeting), whakawhanaungatanga (making a connection), kaupapa (attending to the business or central purpose of the meeting), and poroporoaki (the close and farewell to the session) are identified as four essential elements. This approach assists clinicians to progress through a healthcare interaction in a systematic way to enhance patient engagement and promote effective communication (Pitama et al., 2007). This model is based on the Māori ritual of coming together and has been developed for health professionals to be more culturally congruent in their practice. It is also aligned with the Calgary-Cambridge Framework of clinical interviewing for health professionals (Lacey et al., 2011). This Te Ao Māori model includes the clinician sharing something of themselves through the mihi (greeting) and whakawhanaungatanga (making a connection). However, the Hui Process is more than just building rapport. It is focused on making a deeper connection through a clinician's understanding of patient and whānau values and experiences. It is a mutual process, a two-way engagement and coming together to know more of each other. This connection may be in terms of the person's language, whānau involvement, or their whenua (or land/where they come from). Lacey et al. (2011) suggested that pursuing the clinical agenda or kaupapa will not be successful until a point of shared experience or connection is realised. The Hui Process is framed as a key strategy in the RCP programme as it provides clinicians with practical steps to connect and engage in a culturally appropriate way with whaiora and whānau. While the six dimensions of the Meihana model are implicit in the RCP training, ensuring health care professionals are confident in using the hui process to promote patient engagement was one of the essential strategies taught in the programme.

RCP was also informed by the Meihana model, as a practice focused model for health professionals to engage and connect with whaiora and whānau in a meaningful way (Pitama et al., 2014). The Meihana model builds on Te Whare Tapa Whā, adding additional elements—taiao (taking into account the physical environment that the whaiora and whānau are living in) and iwi katoa (the societal context of belief about behaviours and norms)—to form a clinical assessment framework that underpins intervention and practice in healthcare settings (Lacey et al., 2011; Pitama et al., 2017; Pitama et al., 2014). The Meihana model provides a platform to explore the beliefs, experiences, and current situation of whaiora and whānau within a Māori worldview and how this might impact on any clinical assessment and intervention (Pitama et al., 2014). The framework brings together clinical competencies, and cultural responsiveness and safety for health professionals to facilitate and enable a better understanding of the diverse and complex needs of whaiora (Pitama et al., 2017; Rochford, 2004).

Tikanga Ako Hono-Tāngata or RCP Programme Outline

The programme has two distinct parts; an online pre-requisite training module, available on the HBDHB's Ko Awatea learning platform, and face-to-face interactive workshops. The workshops are delivered in two distinct modules, both 4 hours in duration and scheduled 2 weeks apart. This allows participants to put into practice some of the tools following the first module before returning to the second module to build on their initial learning. The roll-out of RCP training at HBDHB has endeavoured to ensure that health professionals have the skills to work in an authentic partnership way in their daily interactions with consumers and whānau.

A summary of the key objectives of the Tikanga Ako Hono-Tāngata – RCP training programme is provided below. The programmes objectives are to enable health professionals to:

- Develop knowledge of the overarching RCP framework
- Enhance skills in a collaborative partnership model of whaiora and whānau interaction
- Develop skills in considering the wider cultural, societal, and environmental factors in working with whaiora and whānau

- Develop tools to be more culturally responsive and understand of equity
- Develop skills in the Hui Process—mihi, whanaungatanga, kaupapa, and poroporoaki—and an awareness of the Meihana model
- Develop and enhance skills in collaborative agenda setting with the whaiora and whānau
- Develop and enhance skills in action planning and goal setting
- Develop and enhance skills in exploring and addressing patient or whaiora ambivalence and confidence levels
- Develop and enhance coaching skills
- Gain more insight and understanding of the importance of health literacy

The training includes developing skills in key areas consistent with the values and intent of the programme. The key RCP strategies consist of discrete components: the Hui Process, shared decision-making, coaching skills, health literacy or making health easier to understand, the decisional balance matrix (DBM), and whaiora activation tools. All these RCP strategies are to assist the health professional to work collaboratively with the whaiora and whānau in a mana enhancing way. The toolkit of the RCP strategies that were co-designed and delivered in the programme is included in Appendix A. The training facilitators are all experienced health professionals who have worked in a relationship-centred way with backgrounds in tikanga Māori, nursing education, psychology, social work, and pharmacy. The RCP programme is continuing to be delivered to healthcare professionals across the newly formed organisation of Te Matua a Maui – Hawkes Bay.

Chapter Three: Literature Review

The main aim of this literature review was to ground my doctoral study with what is known about the implementation of person-centred ways of working. This is consistent with interpretative description, the methodology chosen for this doctoral study (see Chapter Four). Interpretive description requires the researcher to bring both their practice knowledge and knowledge gained from the literature to form a theoretical scaffold for the study (Thorne, 2016). There is a significant body of literature seeking to understand, develop, implement, and evaluate PCC approaches in healthcare (e.g. Hibbard & Gilbert, 2014; Levesque et al., 2013; Mathers & Paynton, 2016; McCance et al., 2013; Naldemirci et al., 2017; Phillips, 2015; Santana et al., 2018; Terry & Kayes, 2020). While my research has alignment with PCC, Tikanga Ako Hono-Tāngata is subtly different and is specifically tailored to the Aotearoa New Zealand cultural context. Regardless, the international literature examining implementation of PCC more broadly provides important insights which may be relevant to this doctoral research. As such, this chapter examines both the global and Aotearoa New Zealand specific literature to explore what is already known about factors that may enable or impede the implementation of PCC into routine practice. I present the methods for engaging with the global evidence and the synthesis of these findings, before going on to outline the rationale, methods, and findings of the review of Aotearoa New Zealand literature. Key insights gathered from both literature reviews are then discussed and the gaps identified. The direction and rationale for this doctoral study has been shaped by identifying these gaps in knowledge. More specifically to focus my research on what is required in the Aotearoa New Zealand context to ensure the successful implementation of PCC programmes that are informed by Te Ao Māori ways of working.

Review Approach

I used a narrative review approach to explore what is known about the factors that have helped or hindered the embedding of PCC into practice (Sukhera, 2022b). A narrative review is flexible and interpretive, and involves a comprehensive synthesis of existing literature to produce an overview and understanding of a topic (Gregory & Denniss, 2018; Sukhera, 2022a). I was guided by the narrative review process steps as outlined by

Sukhera (2022a) which requires identifying the rationale for a narrative review, clarifying the scope and boundaries of the review, justifying the inclusion and exclusion criteria, ensuring reflexivity and sufficiency, and, finally, analysis and interpretation.

A narrative review was appropriate as it assisted me to understand and summarise the current state of knowledge regarding the implementation and embedding of PCC. This approach also helped to inform my research question by assisting me to identify any gaps or inconsistencies in the existing PCC research (Greenhalgh et al., 2018; Sukhera, 2022b). This analysis helped to anchor the purpose of my research.

The narrative review approach is consistent with interpretive description methodology, requiring an interpretive engagement to the articles identified and production of an interpretive synthesis of what is known. This narrative review approach to analysing the literature prompted me to combine my practice knowledge with the existing knowledge and evidence, which aligns with interpretive description. Thorne (2016) suggested that conducting a literature review is an essential element in scaffolding an interpretive descriptive study in that it gives insight into what previous studies have uncovered about the subject, methods used, problems encountered, and conclusions reached. It allows the researcher to "come to know and draw conclusions about the state of the science in relation to the applied problem the researcher is focusing on" (Thorne, 2016, p. 60). This provides a platform of what is known and not known, prior to moving forward to develop deeper understanding and generate knowledge that can advance clinical practice (Thorne, 2016).

My review was carried out in two parts. Part A aimed to synthesise evidence on what helped or hindered uptake of a PCC approach generally within the international evidence. Part B aimed to synthesise evidence on implementing PCC in the Aotearoa New Zealand context, including embedding Te Ao Māori ways of working into practice.

Part A Global Literature Search

Aim and Purpose

The main purpose of this literature review was to identify and synthesise research which provided insight into what helps or hinders the implementation of PCC. In particular, I

wished to identify what supported clinicians to embed and sustain this way of working in their everyday practice.

Search Strategy

Initially I did an online search of databases that are known to index papers on health care, PCC, psychology, and practice change published in English. Specifically, these were EBSCO Health Databases (CINAHL, MEDLINE, and Psychology and Behavioural Sciences), and SCOPUS. Tuwhera Open Access Theses and Dissertations was also searched, along with the open access repositories at other New Zealand tertiary institutions, to ascertain whether other postgraduate study relevant to the topic had been undertaken. Google Scholar was also searched using the same search terms. The search was limited to publication types of academic journals, books, and reports.

Articles published in the English language in peer-reviewed journals between 2004 and 2021 were included. This time period was selected for two reasons. I sought research set in the context of a contemporary health environment and this appeared to be the time period where PCC gained traction and momentum in the healthcare environment, being recognised as an effective way of engaging with patients in a partnership model of care (Edgar et al., 2020; Manley et al., 2011; McCance & McCormack, 2017). The rationale behind only including articles published up to July 2021 was due to the review being undertaken to inform my research direction and as part of the theoretical scaffold for my interpretive descriptive study. More recent literature is incorporated into my analysis and discussion. Specifically, in Chapters Seven and Eight, I draw on this more recent evidence to show where my doctoral findings sit in the current context, extending and challenging that existing knowledge.

The search strategy is outlined in Table 1 below. The search strategy drew on search terms in three key domains including:

1. RCP or PCC
2. health professional or health context
3. barrier or enabler

Boolean operators were used to combine terms, with OR being used to combine terms within a domain, and AND used to combine terms across domains. The "*" truncation symbol was added to the end of root words to instruct the database to search for all variations of the word.

Table 1.

Databases Searched and Search Criteria Used

Databases searched	Search terms	Articles retrieved (N = 321)
EBSCO Health databases, (CINAHL, MEDLINE, and Psychology and Behavioural Sciences) and SCOPUS	1. "relationship Centred Care" OR "relationship centered care" OR "relationship-centred care" OR "relationship-centered care" OR "Person Centred Care" OR "Person Centred Practice" OR "PCC" OR "Person-centred practice" OR "person centered care" OR "person centered practice OR "person-centered care" OR "person-centered practice" OR "Person Centredness" OR "Person centeredness" AND 2. Health Professional" OR "Health Practitioner*" OR "healthcare professional" OR "clinician" AND 3. Barrier* OR Enabler OR Help OR Hinder*	N = 318
Google Scholar	Same search terms applied	N = 3

Papers were eligible for inclusion if they a) focused on the barriers and enablers of implementing PCC from health professional perspectives; and/or b) focused on experiences of developing, facilitating, implementing, and/or embedding PCC care programmes; and/or c) were literature reviews that provided a synthesis of qualitative studies on the implementation of PCC.

Articles were excluded if a) they only focused on the outcomes or evaluations of patient engagement in their healthcare through clinicians working in PCC way or b) full text was not available. If any articles on outcomes or evaluations of patient engagement included an evaluation of the perspective of the clinicians themselves, then they were included.

Abstracts were screened by applying the inclusion and exclusion criteria. From the original search a smaller number of studies were identified as possibly meeting the inclusion criteria. The full texts of these potentially relevant articles were obtained and read in entirety to identify whether they met the criteria. The reference lists of included articles were also checked to see if any additional papers could be identified. This yielded three additional relevant papers and the full texts were obtained. After reviewing the full text of all articles, I identified that 19 met the inclusion criteria. These articles were downloaded to EndNote. The articles that were included were read fully to gain an understanding of the purpose of the study, participants, methodology used, design, and key findings. This information was summarised in an Microsoft Excel Spreadsheet.

Quality Considerations

The intention of the literature search was not to be exhaustive and identify every paper published in the area but to gain an overarching understanding of what is already known in this field. In sampling papers, I was seeking sufficiency (breadth and depth) and saturation (consistency in knowledge being generated) (Sukhera, 2022a). As this doctoral study was to inform future practice change programmes in a healthcare setting, I wanted to interpret the review findings in the context of the credibility and rigour of included papers. To ensure the integrity of my research, I appraised articles with reference to a number of quality markers to ensure rigour. This included markers such as worthy topic, credibility, resonance, and contribution (Malterud et al., 2016; Sandelowski, 1995a; Thorne, 2000, 2016). These factors were taken into consideration when appraising the included articles (As outlined in Table 2 below).

The included studies were also evaluated against the Critical Appraisal Skills Programme (CASP) criteria using either the CASP Qualitative Studies Checklist for Qualitative Studies and the CASP Systematic Review Checklist for Literature Reviews (Public Health Resources Unit, 2018). The CASP framework provides a structured approach to evaluating the quality of qualitative research by offering specific criteria such as the clarity of research aims, appropriateness of methodology, rigour of data collection and analysis, reflexivity of the researcher, and relevance of findings to the research context (Long et al., 2020; Purssell, 2020). The CASP Systematic Review Checklist offers specific criteria for literature reviews such as whether the question focus was clearly addressed,

whether included studies were relevant, whether the quality of papers were assessed adequately, assessment of clarity and precision of results, and whether outcomes were appropriately considered. Using the CASP checklists ensured consistency and transparency in the appraisal of the articles selected. However, Besley et al. (2011) suggested that the results from applying the CASP tool need to be interpreted cautiously as the 10 appraisal criteria may not have equal value or importance.

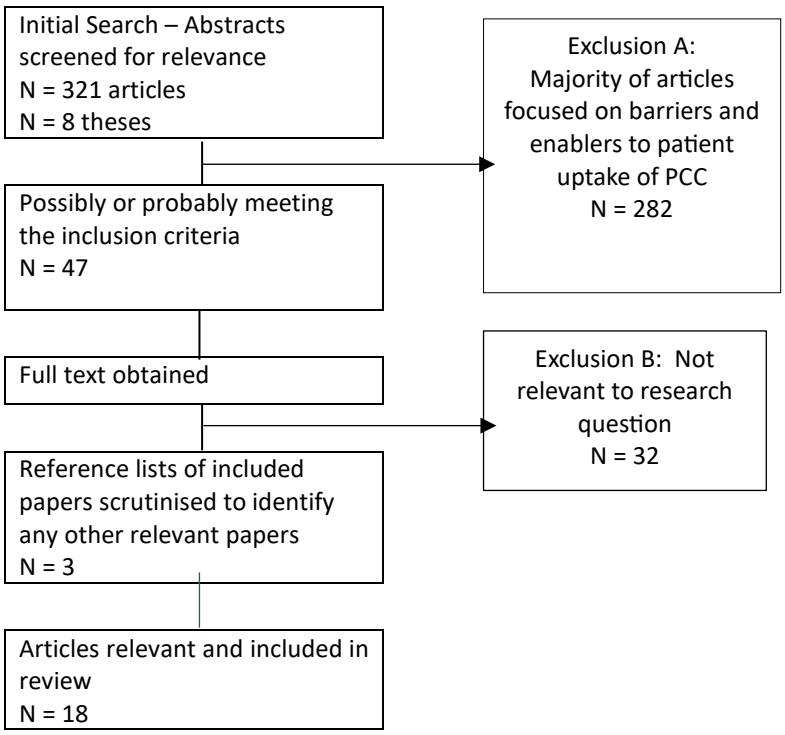
As a novice researcher, I used the CASP checklists as they centred me on what to be looking for in terms of credibility and rigour, and they offered me a starting point for evaluating the qualitative research papers. However, I was acutely aware that the dynamic, flexible, and context-sensitive nature of qualitative research often requires a more nuanced and adaptable approach, so it was important to balance the use of established criteria with the specific needs and goals of the included papers (Besley et al., 2011). In recognising these limitations I used the CASP checklist as a starting point only and then used a more adaptable approach in applying markers mentioned above such as worthy topic, credibility, resonance, rigour when assessing the contribution and intended goals of the included papers (Malterud et al., 2016; Sandelowski, 1995a; Thorne, 2000, 2016). The findings of the quality appraisals are discussed in more detail in the key quality appraisal findings section later in this chapter.

Overview of Search Results

The outcome of the search process outlined above is shown in Figure 1 below. A total of 321 articles were identified in the initial search. Duplicate results were removed and titles and abstracts of all papers were screened for inclusion. Eight theses were identified as of interest from the Tuwhera Open Access Theses and Dissertations search. Most articles and all the theses (N = 282) identified focused on evaluating the patient in terms of their own behavioural change and the patient then taking responsibility for their healthcare through PCC programmes, and so were excluded. From the original search, 47 papers were identified as being possibly relevant. The full text of these were retrieved and read in full to confirm inclusion or not. After reading and fully screening these articles only 18 were identified as meeting the inclusion criteria. As above, reference lists of included papers were scrutinised to identify any other potentially relevant papers.

Figure 1.

International Literature Search Process and Results



Of the 18 papers that were included in this narrative review:

- Seven papers explored health professionals' perspectives (Bradshaw et al., 2021; Dyb et al., 2021; Entwistle et al., 2018; Hebblethwaite, 2013; Hecht et al., 2021; McCance et al., 2013; McCormack et al., 2011b; Rockwell, 2012).
- One paper explored the perspectives of healthcare students and new graduates (Dickson et al., 2020)
- Five papers explored health professional and clinical researcher perspectives or just clinical researcher perspectives (Bright et al., 2012; Gibson et al., 2020; Moore et al., 2017; Mudge et al., 2014; Naldemirci et al., 2017). These papers provided extra depth delving into the nuances of PCC, exploring the subject with an added layer of a clinical researcher lens.
- One paper explored a PCC interest group's perspectives (Greene et al., 2012)
- One paper explored programme facilitator perspectives (Timlin et al., 2018)
- Three papers explored the relevant literature (Edgar et al., 2020; Manley et al., 2011; Phelan et al., 2020). These literature reviews all met the inclusion criteria

and provided useful insights into collective thinking central to changing culture and practice in order to successfully embed PCC.

Of the 18 articles that met the inclusion criteria, three papers were led or co-authored by New Zealand researchers and so are relevant to PCC in the Aotearoa New Zealand context (Bright et al., 2012; Gibson et al., 2020; Mudge et al., 2014). However, these papers have been included in Part A as they are centred on furthering understanding and knowledge around the concept of PCC more generally, rather than focusing on implementing PCC or Te Ao Māori models of care within the specific Aotearoa New Zealand context. Of the 16 papers included that focused on the perspectives of health professionals, clinical researchers, facilitators, or healthcare students, 14 were qualitative and one used a mixed method design. The studies used a mix of data collection methods including questionnaires, semi-structured interviews, field observations, discussions, and reflections. An overview of included papers is provided in Table 2, including details of research aims and purpose, methodology, design, participant perspective, rigour, credibility, and the quality appraisal score on the CASP checklist (Malterud et al., 2016; Public Health Resources Unit, 2018; Sandelowski, 1995b; Thorne, 2016; Tracy, 2010).

Table 2.

Summary of Included Global PCC Articles Included

Author and year	Aim/purpose	Study design	Methodology	Perspective	Participant characteristics	Study quality (CASP criteria) and other quality considerations
Bradshaw et al., 2021	Explored the casual mechanisms underpinning person-centred implementation and the 'how' and 'why' of implementation challenges and outcome measures	Exploratory qualitative study	Data collected using semi- structured interviews drawing on Normalisation Process Theory to understand processes and context	Clinicians using PCC perspectives	N=63 healthcare professionals across 11 specialist palliative care services	QCC* – 7/10 criteria met; 3/10 unclear. Strengths: Clear aim, data analysis detailed, worthy topic and contribution. Rigour identified and maintained. Findings extend insight into the challenges of implementing PCC in seven areas Limitations: Data collection processes unclear
Bright et al., 2012	Explored how client-centred practice (CCP) was operationalised and implemented during a clinical trial in a rehabilitation setting, using innovative goal-setting techniques	Co-autoethno-graphy	Data collected through group discussions and written reflections. Thematic analysis and coding used to identify themes	Clinical researchers' perspectives	N=3 clinical AHP researchers	QCC – 8/10 criteria met; 2/10 unclear. Strengths: Clear aims, design consistent with aim. Clear statement of findings. Provides insights into client-centred practice from a clinical researcher perspective, worthy topic, credibility shown
Dickson et al., 2020	Provided analysis of person centredness from a global and development perspective and identifies key principles to inform a curriculum framework for the education of PCC health professionals	Hermeneutic praxis methodology	Data collected using focus groups and qualitative questionnaires. Data analysed through multiple rounds thematic of analysis	Service users, undergraduate and postgraduate students, mentors, educationalists, service managers, professionals and leaders	N=391 health students and health professional graduates	QCC – 7/10 criteria met; 1/10 unmet; 3/10 unclear. Strengths: Clear aims and analysis. Diverse stakeholders across five countries. Worthy topic and contribution, rigour and credibility maintained Limitations: Not clear that the researchers' and participant relationship adequately considered
Dyb et al., 2021	Evaluated embedding of technology supported PCC programmes for people with long term care needs	Qualitative ethnographic study	Field observations of four innovation arenas of technology-supported PCC in Scandinavia	Healthcare professionals providing technology based PCC to people with long term	N=29 healthcare providers	QCC – 5/10 criteria met; 1/10 unmet; 4/10 unclear. Strengths: Clear aims, research design appropriate. Focused on evaluating PCC through a technology lens which provided

Author and year	Aim/purpose	Study design	Methodology	Perspective	Participant characteristics	Study quality (CASP criteria) and other quality considerations
				conditions perspectives		a different angle to other included studies, credibility Limitations: Unclear whether recruitment strategy and data collected appropriately. Worthy topic but resonance less aligned to my research study.
Edgar et al., 2020	Explored the current perspectives and interrelated concepts on embedding PCC	Literature review	Search of the grey literature and the Medline and CINAHL databases, as well as review of articles published in the *International Practice Development Journal*	Authors' perspective and discussion after thematic synthesis of the included articles	N=93 PCC articles	SCC** – 7/10 Criteria met; 1/10 not met; 2/10 unclear. Strengths: Clear aims and robust discussion from literature review with clear implications for practice, worthy topic, resonance and contribution Limitations: Literature review pragmatic rather than systematic
Entwistle et al., 2018	Identified and analysed tensions and uncertainties in person-centred approaches	Qualitative No defined methodology	Data collected using individual interviews. Analysis was informed by philosophical reasoning and discussion with stakeholders	Clinicians' perspectives on working with Parkinson's or diabetes clients/patients	N=26 healthcare clinicians	QCC – 7/10 criteria met; 3/10 unclear. Strengths: Clear aim. Data collection and analysis processes detailed. Several steps to promote rigour undertaken. Worthy topic and contribution. Reflexivity and credibility shown Limitations: Not underpinned by a defined methodology
Gibson et al., 2020	Focused on practice considerations of how rehabilitation practitioners reconcile the implementation of core PCC principles with competing practice demands	Post-qualitative methods	Data collected using diffractive analysis. An iterative process to analyse and discuss texts	Clinicians' perspectives to rehabilitation care events	Clinicians' experiences of N=9 care events	QCC – 8/10 criteria met; 2/10 unclear. Strengths: Clear aim. Robust analysis. Rigour applied, worthy contribution and contribution Limitations: Post-qualitative research that experiments with research approaches and writing conventions; however, research does provide valuable insights
Greene et al., 2012	Focused on a broader range of factors affect the patient centredness of health care experiences	Qualitative No defined methodology	Data collected through analysis of Literature review and Interest Group Discussion	PCC Interest Group of Health Professionals perspectives	N-2 Healthcare Professionals Discussion Group	QCC – 7/10 criteria met; 1/10 not met; 2/10 unclear. Strengths: Clear aim; clear statement of findings, worthy topic and contribution Limitations: No defined methodology

Author and year	Aim/purpose	Study design	Methodology	Perspective	Participant characteristics	Study quality (CASP criteria) and other quality considerations
						Does not show rigour
Hebblethwaite 2013	Explored tensions between the theory and practice of PCC and relationship-centred care	Qualitative interpretive framework	Data collected through participant interviews and thematic analysis	Therapeutic recreational specialists in a health and rehabilitation setting perspectives	N=11 therapeutic recreational specialists	QCC – 7/10 criteria met; 3/10 unclear. Strengths: Clear aims and well- designed research methodology. Robust data analysis. Clear statement of findings, credibility, resonance, and worthy topic. Limitations: Rigour not clear
McCance et al., 2012	Explored the impact of culture and context on implementing PCC in an acute care setting in a facilitated practice development programme	Qualitative Mixed methods with data analysis using a creative hermeneutic approach	Data collected through process evaluation, reflective accounts, and focus group interviews	Perspectives of nurses and midwives who had undertaken the PCC programme in the previous 2 years	N=10 nursing teams across 5 sites	QCC – 8/10 criteria met; 2/10 unclear. Strengths: Clear aims, data collection and analysis process detailed, worthy topic and contribution, resonance and credibility shown Limitations: Rigour not clear; organisation was going through significant change so not clear how this impacted on results
McCormack et al., 2011	Evaluated the Older Persons National Practice Development Programme against McCormack and McCance's contextual framework	Qualitative research Case study	Data collected through narrative and observational data	Residential care staff nurses' and care assistants' perspectives	Healthcare professionals 18 residential care units for older people	QCC – 8/10 criteria met; 2/10 unclear. Strengths: Clear aims. Design and analysis of data appropriate, worthy topic and contribution Limitations: Recruitment strategy not clear. Programme not adequately defined
Manley et al., 2011	A rigorous concept analysis that identified the attributes, enabling factors and consequences of an 'effective workplace culture'	Qualitative research Literature review	Data collected through rigorous analysis of PCC articles	Authors' perspective and discussion after thematic synthesis of the included articles	PCC articles N=97	SCC – 7/10 Criteria met; 1/10 unmet; 2/10 unclear. Strengths: Systematic literature review. Data collection and analysis process detailed. Clear statement of findings, worthy topic and contribution, credibility and resonance shown Limitations: Assumptions may not have been adequately addressed
Moore et al., 2016	Explored the barriers and facilitators of PCC focusing on delivery in different healthcare settings	Qualitative research Narrative and	Data collected through semi-structured interviews	Perspectives of researchers in the PCC field	N=18 researchers from 7 research studies across hospital, primary,	QCC – 8/10 criteria met; 2/10 unclear. Strength: Clear aim. design, data collection and analysis robust. Diversity of healthcare setting brings a broad range of perspectives on development of PCC

Author and year	Aim/purpose	Study design	Methodology	Perspective	Participant characteristics	Study quality (CASP criteria) and other quality considerations
		interpretive methodology			and community settings	programmes. Clear statement of findings, worthy topic and contribution Limitations: Unclear whether the researchers' and participant relationship adequately considered. Programmes included in study are at different stages of development and implementation
Mudge et al., 2014	To gain an understanding of the conflicting responses and discomfort of a physiotherapy rehabilitation culture	Co-auto-ethnography	Data collected through written reflections and joint discussions	Physiotherapists' personal and professional experiences of neurological rehabilitation	N=3 clinical physiotherapist researchers	QCC – 10/10 criteria met. Strengths: Clear aim, data collection and analysis process detailed. Findings clear and triangulated, credibility shown, worthy topic and contribution Limitations: Subjectivity of autoethnography methodology; however, the process, content, assumptions, and rigour are identified and challenged
Naldemirci et al., 2017	Focused on deliberate and emergent strategies to overcome implementation barriers to the normalisation of embedding PCC. A qualitative interview study with researchers, professionals, and patients	Qualitative No defined methodology	Data collected through semi-structured interviews using purposive sampling approach. Analysis using Normalisation Process Theory	Healthcare practitioners' and researchers' perspectives	N=18 researchers N=17 practitioners	QCC – 7/10 criteria met; 1/10 not met; 2/10 unclear. Strengths: Clear aim, methodology appropriate, robust data analysis, worthy topic and resonance Limitations: Not clear whether data collection appropriate. Not clear whether the researchers and participant relationship adequately considered. Not exhaustive in systematically exploring all difficulties in embedding PCC
Phelan et el., 2020	Review of global developments at a national level of PCC building on previous reviews by Harding et al., 2015 and McCormick et al., 2015	Qualitative research Literature review	Data collected through rigorous analysis of PCC articles	Authors perspective and discussion after thematic synthesis of the included articles	N=14 included articles	SCC – 7/10 Criteria met; 1/10 not met; 2/10 unclear. Strengths: Clear aim. Robust analysis. The findings extend current knowledge around health professionals and educators being entrepreneurial and challenging practice, worthy topic, contribution and resonance. Systematic literature review

Author and year	Aim/purpose	Study design	Methodology	Perspective	Participant characteristics	Study quality (CASP criteria) and other quality considerations
						Limitations: Unclear whether it was reasonable to combine the results of the review
Rockwell., 2011	Focused on a long-term care facility for older people highlighting barriers between the medical model, organisational structures, and being relational in approach	Qualitative descriptive methodology	Semi structured interviews	Doctors' and social worker's perspectives	N=5 healthcare professionals	QCC – 5/10 criteria met; 2/10 not met; 3/10 unclear. Strengths: Clear aims, robust data analysis, clear but brief statement of findings, worthy topic, credibility and resonance Limitations: Not clear on whether recruitment strategy and the researchers and participant relationship adequately considered
Timlin et al., 2018	Focused on the shared reflections of PCC Facilitators a year on from rolling out a PCC programme	Qualitative research	Methodology not specified. Written reflections and focus discussion groups	PCC facilitators' perspectives	N=12 Facilitators of hospital PCC programme	QCC – 6/10 criteria met; 1/10 not met; 3/10 not clear. Strengths: Clear aim, systematic literature review, robust analysis, peer reviewed, worthy topic, contribution, resonance and credibility Limitations: Methodology not specified. Views of facilitators not health professionals but still valuable study

*QCC denotes the qualitative CASP checklist

**SCC denotes the systematic CASP checklist (Public Health Resources Unit, 2018). See Appendix B for full checklist.

Overview of Quality Appraisal Findings

The methodological quality of articles included in this study varied widely when appraised against the markers of quality including rigour, credibility, resonance, reflexivity, contribution, and relevance (Malterud et al., 2016; Sandelowski, 1995b; Thorne, 2016; Tracy, 2010). The articles were also appraised using the CASP checklist tool (Public Health Resources Unit, 2018). A summary of the CASP results is provided in Appendix B. All included articles had a well-defined aim and purpose, a clear statement of findings, showed credibility, and had varying levels of rigour. A wide range of different methodologies were utilised, with all designs appearing to be consistent with the intended aim of the study. The common short coming of the included studies was the extent to which the researcher had adequately described their relationship with the participants. There was a lack of transparency about the researchers' positionality and relationships, and limited detail of other reflexive processes, making it difficult to interpret the role that they played in the selection process, data collection, and the subsequent analysis of findings (Bradshaw et al., 2021; Dickson et al., 2020; Dyb et al., 2021; Entwistle et al., 2018; Greene et al., 2012; Hebblethwaite, 2013; Hecht et al., 2021; Moore et al., 2017; Rockwell, 2012; Timlin et al., 2018). When applying the CASP criteria, it is important to note that qualitative research often requires a more nuanced and adaptable approach; thus, the CASP framework, while a useful tool, should be interpreted with caution (Beasley et al., 2011).

The literature reviews included in this narrative review also showed clear aims, relevance to the topic, credibility, and rigour; and provided contribution clearly addressed the topic question around implementing or evaluating PCC programmes. These literature reviews searched and included appropriate papers with outcomes being considered. However, it was difficult to assess the clarity and preciseness of results and whether it had been reasonable to combine results of some of the included studies because of lack of detail in all of the review papers.

Part A – Synthesis of Global Literature

Thematic synthesis of the included papers from the global review identified several factors that were perceived to either help or hinder the successful implementation of PCC. These were: the implementation environment; a supportive culture; leadership and

role modelling; skills to navigate practice level tensions; effective relationships and clear communication and robust evaluation methods. These themes are described in more detail below.

Implementation Environment

The majority of the literature that focused on the implementation of PCC detailed the complexities of implementation in an environment of increasing demand, limited resources, and reduced spend (Edgar et al., 2020; Gibson et al., 2020; Greene et al., 2012; Manley et al., 2011; McCance et al., 2013; Moore et al., 2017; Phelan et al., 2020). The rising demand for healthcare, together with traditional bio-medical practices and structures, was considered to undermine effective PCC implementation. Moore et al. (2017) argued that the existing overt and covert power relationships, based on the influence of the medical profession, can be barriers to health professionals working in a relationship-centred way, particularly in the context of high demand and limited resources. These power relationships, combined with demand and constrained resources, can result in a default to, and maintenance of, the transactional biomedical model. This was demonstrated in Moore et al. (2017)study, which showed that in times of high workload pressure, there was an orientation back to using traditional bio-medical approaches in clinicians' everyday practices. However, given some ward sites were still in the process of implementation during the study, this may have influenced this study's findings.

Similarly McCance et al. (2013) also highlighted the difficulty of being person-centred in a high pressured, demand-driven healthcare environment. In their empirical study of nursing and midwifery staff across five hospital sites in Scotland, they highlighted the tension that clinicians experienced between being person-centred in approach and meeting rising work demands. In times of heavy workload, nurses and midwives appeared to default to a more biomedical orientation. Large patient volumes needing to be seen in an environment of limited resources and the impact on healthcare professionals' ability to embed PCC into their practice was also evidenced in other papers (Entwistle et al., 2018; Gibson et al., 2020; Hebblethwaite, 2013; Timlin et al., 2018). A British study found that nursing staff experienced tension when managing high volumes of Parkinson's and diabetes patients with high complexity, often feeling they had to

compromise PCC values to ensure patients were at least being seen (Entwistle et al., 2018). Provision of any care had to be prioritised over the provision of high-quality PCC. Similarly, an American study of therapeutic rehabilitation specialists highlighted the tension of service demand together with pressure from colleagues to move on and see the next patient which limited the attempts for these health professionals to work in a PCC way (Hebblethwaite, 2013). In that study, however, it was not only the biomedical culture dominating that impeded health professionals using a PCC approach but also the added perceived pressure that they felt from the culture of the team focusing on expediency of work practices (Hebblethwaite, 2013). While some of these studies are focused on smaller distinct sample groups and others are larger studies across multiple sites, together they point towards a strong orientation back to a biomedical way of working in times of high workload pressure.

This pull back to a biomedical way of working highlights that having good intentions is not sufficient enough to ensure the embedding of PCC. In their New Zealand autoethnography of clinical researchers' experiences of enacting PCC in rehabilitation, Bright et al. (2012) reflected the dominance of the biomedical model was a barrier to successful implementation. The intent of health professionals was to be relationship-driven in their assessment or rehabilitation; however, the pressures of the system and the overt and covert rules of the rehabilitation service meant that this was often not the reality for these health professionals (Bright et al., 2012). This study aligns with the findings outlined above which highlight a disconnect between health professionals' intention and their actual practice (Entwistle et al., 2018; Hebblethwaite, 2013; McCance et al., 2013; Naldemirci et al., 2017). Hebblethwaite (2013) study discussed above, reported similar experiences to Bright et al., evidencing that although the health professionals studied intended to deliver PCC in their practice, they perceived they were constrained by the realities of routine practice and organisational processes. Bright et al. (2012)and Hebblethwaite (2013)both highlighted that being prepared and having good intent is not enough to sustain PCC practice. Bright et al. also highlighted the detrimental effect of what high patient demand and a focus on expediency can result in at a practice level for healthcare professionals. In contrast to the previous studies, Bright et al. expanded on this concept, arguing that key information that was meaningful and important to the patient can easily be missed in a culture of prioritise quickly, treat, and

move on to the next patient. They maintained that this can sometimes lead to dissatisfied patients and/or a lack of job satisfaction for health professionals.

It is clear from the literature that the focus on patient flow and production-line efficiency in healthcare over the last 2 decades detract from a PCC way of working (Edgar et al., 2020; Manley et al., 2011). Having good intentions to embed PCC is not sufficient to ensure sustainability. For PCC to work effectively it needs to be supported by an implementation environment that enables a PCC way of working (McCance et al., 2013).

Ensuring a Supportive Culture

The culture of an organisation is formed by the set of shared values, attitudes, and rules that shape people's behaviour, with culture also being influenced by broader environment factors (McCormack et al., 2011a; Nightingale, 2018). While the implementation environment of PCC is impacted by broader systematic, political, and economic elements that determine such things as health spend and resourcing, culture refers to the guiding framework that shapes the internal norms of a team or an organisation (Nightingale, 2018). McCormack et al. (2011a) argued that the "challenge is moving from person-centred moments to a person-centred culture" (p. 13) because of the complex contextual issues and the commitment and energy required to facilitate sustained culture change. Maintaining a person-centred culture is said to be a continuous process which requires buy-in at all levels of an organisation, from health professionals at the clinical interface to healthcare leaders to policy makers and funders, and appears to be a critical factor in the success of embedding PCC (Bradshaw et al., 2021; Dickson et al., 2020; Edgar et al., 2020; Moore et al., 2017). The literature suggests that to ensure the right workplace environment to effectively embed PCC, it is imperative to have a supportive and nurturing culture that aligns with this relational approach (Dickson et al., 2020; McCance et al., 2013; McCormack et al., 2011a; Moore et al., 2017). To move from person-centred care moments to an enabling culture, the literature suggests three essential key intertwining elements are required: 1) PCC facilitating processes, 2) the care environment, and 3) learning and development (Bradshaw et al., 2021; Edgar et al., 2020; McCance et al., 2013; McCormack et al., 2011b).

Developing PCC facilitating processes, such as a set of core values, assessments, and reporting mechanisms that support clinicians to work in this way, all appear to be important to develop a supportive culture (Bradshaw et al., 2021). These could include electronically changing assessment, reporting, and outcome measures to reflect a PCC approach to be transparent in driving this practice at whaiora, team, and service levels. These facilitating processes can assist clinicians to be more engaged in the implementation process, facilitate shared responsibility, and be a motivator to embed PCC into practice (Hebblethwaite, 2013; McCance et al., 2013).

As already identified, promoting and modelling relational practices in the care environment is an essential element to embedding PCC into clinicians' practice. McCance et al. (2013) qualitative study showed that having values that respected patients' perspectives and beliefs, promoted dignity, and having a common PCC language were all ways that a positive care environment could be enacted and reinforced at a patient interface level. These results are similar to those reported by Bradshaw and colleagues (2021), who identified that having a common language was a catalyst in reinforcing clinician behaviours, uniting the team, and creating a care environment that supported PCC. Creating shared meaning, a common purpose, and ensuring greater understanding amongst the palliative care teams was achieved by promoting a consistent and shared terminology of words between patient and their health professionals (Bradshaw et al., 2021). This is a demonstration of how the care environment can support a person-centred culture and way of working.

Another way of ensuring a positive culture that supports PCC implementation appears to be having a learning culture. It includes developing reflective learning and coaching strategies that assist clinicians to maintain this way of working in times of pressure. In their empirical study of aged care workers across 18 sites, McCormack et al. (2011a) identified that having all staff trained in the programme, and promoting and encouraging a learning culture, maintained and sustained a PCC way of working. This was achieved through providing workplace champions and mentoring sessions. Similarly, in their exploration of nurses engagement in a facilitated practice PCC programme, McCance et al. (2013) identified that developing a learning culture was imperative to sustaining a relational way of working within the acute ward setting. Both McCance et al. (2013)and

McCormack et al. (2011a)share a number of findings. Both studies argue that building a learning culture that supports, educates, encourages, and reinforces uptake of PCC at the patient interface is critical in moving from moments of PCC to a person-centred workplace culture. Furthermore, both argue that a pivotal factor is providing and facilitating ongoing opportunities for reflective work such as coaching and mentoring for individuals and workplace teams to ensure learning and development is supported (McCance et al., 2013; McCormack et al., 2011a). Having a learning culture in place that helps facilitate PCC, encourages a supportive care environment, and promotes a learning environment are all fundamental elements to support a PCC culture to flourish.

However, strong leadership is required to sustain a PCC culture, as continually promoting shared values, modelling a relational way of working, and fostering a learning culture, as discussed above, can be difficult (Bradshaw et al., 2021; Edgar et al., 2020; McCance et al., 2013; McCormack et al., 2011b). The role leadership plays in supporting and reinforcing a PCC culture will now be considered.

Leadership and Role Modelling

Strong leadership is a critical element that can support the implementation and uptake of PCC. The literature suggests that training clinical leaders in PCC can support buy-in from clinicians, and help ensure strategies are in place to support and reinforce a relational way of working (Bradshaw et al., 2021; Manley et al., 2011; Moore et al., 2017; Timlin et al., 2018). In their study examining the adoption of PCC for palliative care health professionals, Bradshaw et al. (2021) argued that strong leadership is the catalyst required to create a nurturing environment to support healthcare workers with practice change. Furthermore, without leadership championing this approach, Manley et al. (2011) put forward the notion that PCC can flounder and be eroded. This is exemplified in the work undertaken by Timlin et al. (2018) in their evaluation of a PCC programme a year after it was introduced in an acute Scottish medical hospital. They identified that in workplace areas without firm buy-in from clinical leads, the implementation of PCC appeared to flounder. In contrast, within wards and teams where there was commitment from clinical leads, the adoption of PCC appeared to flourish. While solid leadership appears to be pivotal to the successful and sustained implementation of PCC, Manley et al. (2011)maintained that leadership is more than just supporting the roll-out of a PCC

programme. They argued that to ensure sustainable change, leaders need to proactively identify and mitigate any internal and external barriers to PCC. Furthermore, they contended that leaders need to actively engage in structured reflection with clinicians and multidisciplinary teams (MDTs) to support practice change and address any stumbling blocks at a service level (Manley et al., 2011). This aligns with developing a reflective learning workplace, a dimension of culture that has been previously discussed (Bradshaw et al., 2021; Edgar et al., 2020; McCance et al., 2013; McCormack et al., 2011b).

Another element of effective leadership is a leader's ability to role-model PCC behaviours (Manley et al., 2011). In a systematic review of PCC literature, Edgar et al. (2020) argued that when leaders are seen to be embracing PCC, it creates an environment and a learning culture where health professionals will want to emulate this way of working. Moore et al. (2017) took this premise further, suggesting that the style of leadership can have a direct bearing on the uptake of this relational way of working. They contended that specific leadership characteristics, such as adaptability and being able to set a clear vision, are essential. It is these characteristics that assist leaders to build trust, promote change, and that helps to encourage and espouse PCC practice values that promote a relational multidisciplinary way of working. They suggested that these leadership qualities are all required to inspire and sustain practice change in clinicians. It is leaders with these characteristics that Moore et al. argued serve as role models and forerunners to embedding PCC programmes. In summary, it is evident from the literature that strong clinical leadership and specific leadership characteristics can be a catalyst for sustaining a relational PCC approach in healthcare teams.

Navigating Practice Level Tensions

Some studies provided deeper insight and a more nuanced understanding of the factors that caused tension for clinicians when trying to implement PCC at a patient and clinical interface level. One example of this tension is when there is a disconnect between patient preferences and the health professional's treatment plan, reflecting that clinicians can default to their professional training norms and what is perceived as best practice standards in their patient interaction (Entwistle et al., 2018). Health professionals bring their clinical knowledge and expertise to every patient encounter,

whether it be assessment, treatment, or rehabilitation (Bright et al., 2012; Gibson et al., 2020; McCormack et al., 2011a). However, several studies have demonstrated how this professional and clinical assessment can be at odds with patient or whānau preference, motivation, or factors existing in their home or social situation (Gibson et al., 2020; McCance et al., 2013). For instance, Entwistle et al. (2018) highlighted these tensions in their study of health professionals trying to implement PCC with diabetes patients in the UK. One example they provided cites a diabetes educator trying to motivate a patient to lower their blood glucose levels to reduce the risk of hypoglycaemic episodes. However, this was at odds with the patient's willingness and motivation to make the necessary lifestyle modifications to effect this change. Rather than privileging clinical assessment and knowledge, PCC is said to involve a more considered process taking into account both the patient's goals and the health professional's clinical goals, which need to be integrated to reach agreement through a process of shared decision-making (Entwistle et al., 2018).

A further tension that can arise at the patient and clinical interface level is the perception a health professional might have of what a patient's life might be, versus the actual reality of that patient's situation or life (Entwistle et al. 2018). Health professionals bring preconceived ideas shaped by their socialisation to any given situation, and can make assumptions about the patient's reality from their own worldview (Entwistle et al., 2018; Gibson et al., 2020). Without taking time to fully understand a patient's reality, factors such as home and work commitments, material hardship, safety, and poverty can be overlooked. When a health professional aims to empower a patient to pursue certain actions or goals, but has made assumptions without fully understanding the patient's reality and their reasoning for their chosen preferences, a misunderstanding can sometimes occur. For instance, Entwistle et al. (2018) contended that there is a relationship between the amount of active listening Parkinson's specialist clinicians undertook to understand their patients' lived reality in the initial patient encounter and the high rates of future engagement and clinic attendance of these patients. When interviewed, Parkinson's patients who had been actively listened too, articulated that they felt heard, understood, and, subsequently, appeared more engaged in taking responsibility for their own healthcare (Entwistle et al., 2018). Gibson et al. (2020) reiterated this view, arguing that when a health professional tries to listen to understand

a patient's reality, it can be a catalyst in assisting a patient to be able to realise self-determination and take ownership over their healthcare.

It has been noted that some professions have a strongly defined paradigm or practice model shaped by discipline-specific norms. These clinicians sometimes find it difficult to compromise these standards to co-produce a plan with a patient who may have differing goals, as these clinicians appear to want to adhere to what they perceive as their discipline-specific practice standards (Entwistle et al., 2018; Gibson et al., 2020; Moore et al., 2017). For instance, in a study of neurological rehabilitation physiotherapists, clinicians saw themselves as the experts and viewed the patient in terms of their "body being a machine" (Mudge et al., 2014, p. 450). The physiotherapists' discipline-specific training had positioned them as the primary authority on the patient's condition in a way that has the potential to discount the views and preferences of the patient and limit their ability to embrace a PCC approach (Mudge et al., 2014). Similarly, in another study around the barriers and facilitators of implementing PCC, ranging from acute coronary care to osteopathic fracture programmes, the authors contended that strong disciplinary paradigms were a deterrent to adopting this way of working (Moore et al., 2017). Strong adherence to a professional paradigm can also lead to what Gibson et al. (2020) termed benevolent manipulation with health professionals unintentionally trying to persuade a patient to accept their disciplinary expertise. Mudge et al. (2015) provided added insight into this physiotherapy discipline-specific paradigm. They maintained that the profession is underpinned by a biomedical discourse that separates the mind from the body which can cause tension when adopting a relational and person-centred approach. It is this paradigm that limits physiotherapists' ability to embrace aspects of PCC such as building positive relationships, valuing patient preferences, and managing expectations (Mudge et al., 2015). Together, the studies by Moore et al. (2017) and Mudge et al. (2015) provide a deeper elucidation of the strong disciplinary paradigms that these clinicians work within.

Another tension at the patient and clinical interface appears to be the deficit approach that results from the focus on expediency and patient flow (Bright et al., 2012; Hebblethwaite, 2013). This is in direct contrast to the strengths based approach of PCC (McCance et al., 2013; McCormack et al., 2011b). Bright et al. (2012) study of the

personal experiences of clinical researchers revealed that the pressures to be expedient with workflow in past clinical roles meant that "length of stay, safety and discharge took priority" over PCC (p. 8). In order to establish a safe discharge plan, the dominant practice approach was assessment based and deficit driven focusing on what a patient was unable to do (Bright et al., 2012). Similarly, Hebblethwaite (2013) substantiated Bright et al. (2012) argument of a deficit approach to rehabilitation. These authors suggested that the biggest barrier to therapeutic recreational specialists implementing PCC was the norm of focusing on impairment, loss, and disability. Both these studies suggested that a deficit approach appeared to be central to the clinician patient relationship and interaction. This is in direct contrast to the PCC approach of finding out 'what matters' to the patient, and the clinician and patient working on their health goals in partnership (McCance et al., 2013; McCormack et al., 2011b). These two studies highlight that at times there may be a need to navigate the barrier of a deficit approach when implementing PCC at a practice level (Bright et al., 2012; Hebblethwaite, 2013).

Another tension or disconnect at the patient and clinical interface is that some patients have been socialised to be passive recipients in their healthcare. Patients may be not prepared or not able to be an active participant in their healthcare due to their beliefs, cognitive, emotional, or social factors. Making decisions in collaboration about their healthcare with their clinician may be uncomfortable and a challenge (Moore et al., 2017). The prevailing paternalistic medical and expert telling model prompts patients to be a passenger in their healthcare, rather than sharing the decision-making with their health professional (Moore et al., 2017). Entwistle et al. (2018) reinforced this assertion in their qualitative study of health professionals working with Parkinson's patients. These authors suggested clinicians struggled to engage patients and work in a PCC way because "they [the patients] had become almost paralysed not wanting to do anything because they have to refer back to the doctor" (p. 3). Some authors contend that patient education programmes are needed to support patients and whānau to engage with PCC processes to be more active partners in their own healthcare (Moore et al., 2017; Naldemirci et al., 2017). This was evident in Naldemirci et al. (2017) study where PCC was introduced into acute medical wards and a learning culture was normalised, making patient education a priority at every interaction. This resulted in a greater uptake of patients actively wanting to be involved in the decision-making about their own care

(Naldemirci et al., 2017). However, it is not clear that education alone would address the issue of clinicians defaulting to the medical expert telling model of patient interaction (Entwistle et al., 2018; Moore et al., 2017; Naldemirci et al., 2017). In this example, Naldemirci et al. (2017)argued that instilling a learning culture from the patient right through to the clinician, educating and coaching the patient group, was more successful, with patients becoming more active partners in their healthcare.

All these tensions point to the need to put strategies in place to navigate workplace and practice level tensions to support a PCC approach within the pressures of the current healthcare environment.

Effective Relationships and Clear Communication

Effective relationships between clinicians and their clinical leaders appear to be necessary in the successful implementation of PCC at the patient interface level; although this is not universally agreed upon within the literature. Two PCC evaluation studies, one in a palliative care service and another in a Swedish medical ward using normalisation process theory, showed that relationships were important to effective and sustainable implementation (Bradshaw et al., 2021; Naldemirci et al., 2017). Both studies evidenced the importance of having effective communication, good working relationships within the MDT and a learning culture to drive integration into everyday practice. In contrast, Phelan et al. (2020) literature review of global developments in the PCC field and Timlin et al. (2018) evaluation of PCC programmes in seven medical hospitals, did not highlight relationships and communication as critical elements to embedding a PCC approach. However, these two elements may have been implicit within having a good workplace culture and strong leaders (Phelan et al., 2020; Timlin et al., 2018).

Maintaining effective relationships appears to be dependent on clear communication, which is argued to be critical in successfully embedding PCC. Naldemirci et al. (2017) noted the importance of continuous communication and the frequent and open sharing of information between all staff. These findings are comparable to Bradshaw et al. (2021) who purport that "buy-in to implementation of PCC requires the involvement and good communication of all team members in the implementation process" (p. 2). PCC

strategies were talked about in team meetings, at patient hand-over, and in MDT meetings to embed this approach into everyday practice (Bradshaw et al. 2021). Naldermici et al.'s and Bradshaw et al.'s (2021) findings resonate with the global literature, noting that relationships and effective communication are key at every level of PCC implementation. It is evident from the literature that clear and open communication and good collegial team relationships are important to successfully embedding a PCC approach into practice.

Integrated Evaluation Methods

Another critical element in successfully embedding a PCC culture appeared to be having an evaluation and audit process to evidence outcomes. Having evaluation systems in place can assist to sustain a programme. Substantiating the outcomes of a programme can support engagement from sceptical clinicians and managers, and/or funders seeking evidence of effective and equitable outcomes (McCance et al., 2013; Moore et al., 2017). Although numerous studies have examined the importance of evaluation for continued resourcing of PCC programmes, few appear to have examined the impact that positive outcome measures have on clinician engagement and the bearing that this has on clinicians' motivation to embed PCC into their everyday practice. Bradshaw et al. (2021) demonstrated that receiving feedback about the impacts of PCC in palliative care "motivated continued involvement" (p. 8). In particular, receiving feedback relating to the impacts of practice on patient experience and wider lives, appeared powerful to motivating and engaging clinicians. Evidencing patient engagement, patient satisfaction, and improved health outcomes can create clinician commitment, increase management support, and extend or attract funding. The downstream positive effect of this evaluation can lead to PCC being viewed as an effective healthcare outcome strategy (Bradshaw et al., 2021; Dyb et al., 2021; Greene et al., 2012; Phelan et al., 2020).

In summary, a synthesis of global evidence from the literature identified six themes which appear critical to successful implementation of PCC:

1. having the right implementation environment
2. ensuring a supportive culture
3. strategies to navigate practice level tensions
4. strong leadership and role-modelling

5. ensuring effective relationships and clear communication and
6. ensuring robust evaluation methods are in place to evidence outcomes

These six areas appear to be inextricably intertwined in creating a sustainable PCC environment.

These themes have all been identified from the global evidence, but there are several key aspects that are missing when looking at PCC in the Aotearoa New Zealand context. The majority of the studies from the global evidence were undertaken in western countries with little or no consideration of Indigenous populations. To address this gap, I further expanded my literature review to look more explicitly at PCC within the Aotearoa New Zealand context, including looking at Te Ao Māori models of healthcare that focused on a relational way of working.

Part B – Aotearoa New Zealand Literature Review

Aim and Purpose

In this search, I sought to identify papers focusing on what helps or hinders the implementation of PCC in Aotearoa New Zealand context. The secondary purpose of this literature review was to search for papers to assist my understanding around the processes of embedding Te Ao Māori concepts in healthcare practice, given that this was a critical component of RCP as developed and implemented by HBDHB.

Search Strategy

My search terms in Part B mirrored those of Part A, with the exception of a) including terms specific to Aotearoa New Zealand, and Te Ao Māori models and ways of working; and b) extending the search beyond peer-reviewed journals to include grey literature given the likelihood that unpublished works may have important insights to offer. Articles published in English language, between 2004 and 2021, were included. Similar to Part A, this time period was selected as I sought research set in the context of a contemporary health environment, given it informed my research direction.

Papers were eligible for inclusion if they a) focused on the barriers and enablers of implementing PCC or Te Ao Māori models of health in the Aotearoa New Zealand context from a health professionals perspective; and/or b) focused on clinicians' experiences

with developing, facilitating, implementing, and/or embedding PCC or Te Ao Māori models of health; and/or c) were relevant literature reviews that provided a synthesis of qualitative studies on implementation of PCC or Te Ao Māori models of health. Due to there being a paucity of relevant articles identified in the initial literature searches undertaken in Part B, I later expanded the search to also identify articles that focused on Māori consumer perspectives of the Aotearoa New Zealand healthcare system to augment my broader understanding of culturally responsive practice in Aotearoa New Zealand.

I used three strategies. First, I rescreened all of the papers from my first literature search in Part A, with the expanded Aotearoa New Zealand inclusion criteria in mind, to identify any papers that met this new question and inclusion criteria. The terms specific to Aotearoa New Zealand and Te Ao Māori models that were used included “Whānau Centred” OR “Whānau Ora” OR “Māori” OR “Māori Concepts” OR Māori Healthcare Models” OR “Te Ao Māori” AND “Aotearoa” OR “New Zealand”. This search resulted in only seven potentially relevant articles.

I then did a further literature search applying the Aotearoa New Zealand specific search terms only as detailed in strategy one above, to see if this would identify any extra papers that met the inclusion criteria. This search resulted in a further 28 papers being found that were potentially relevant to my research topic in the Aotearoa New Zealand context. From the combined searches of strategies one and two, outlined above, 35 articles were identified as possibly meeting the inclusion criteria based on the research question. After screening the abstracts only seven were probably relevant to my study topic. Three from search strategy one and four articles from search strategy two. The full text of these seven articles was obtained and read to identify whether they met the criteria. The reference lists of included articles were also checked to see if any additional papers could be identified. From this search and screening only four articles were identified as meeting the Part B search criteria. It was at this stage that I discussed the paucity of articles that focused on PCC or whānau centred care (a te reo term for family centred care) in the Aotearoa New Zealand healthcare context with my supervisors. From this discussion a decision was made to expand my inclusion criteria to focus on Māori consumer perspectives of the Aotearoa New Zealand healthcare system.

As the Tikanga Ako Hono-Tāngata programme at HBDHB included a strong focus on cultural responsiveness, whaiora (patient) engagement, and equity, expansion of the inclusion criteria aligned with the RCP programme and the intent of my study. I expanded the search terms to include "Māori Consumer Perspectives" OR "Experiences". I again screened the articles from the Aotearoa New Zealand strategy step two search with the expanded search criteria to capture any articles that focused on Māori consumer perspectives and experiences of the Aotearoa New Zealand healthcare system. This search identified a further five papers as potentially relevant. The full text of these articles was obtained and read to decide whether or not they met the criteria. Only two articles met strategy three's expanded inclusion criteria and were relevant to being included in this study.

Quality Considerations

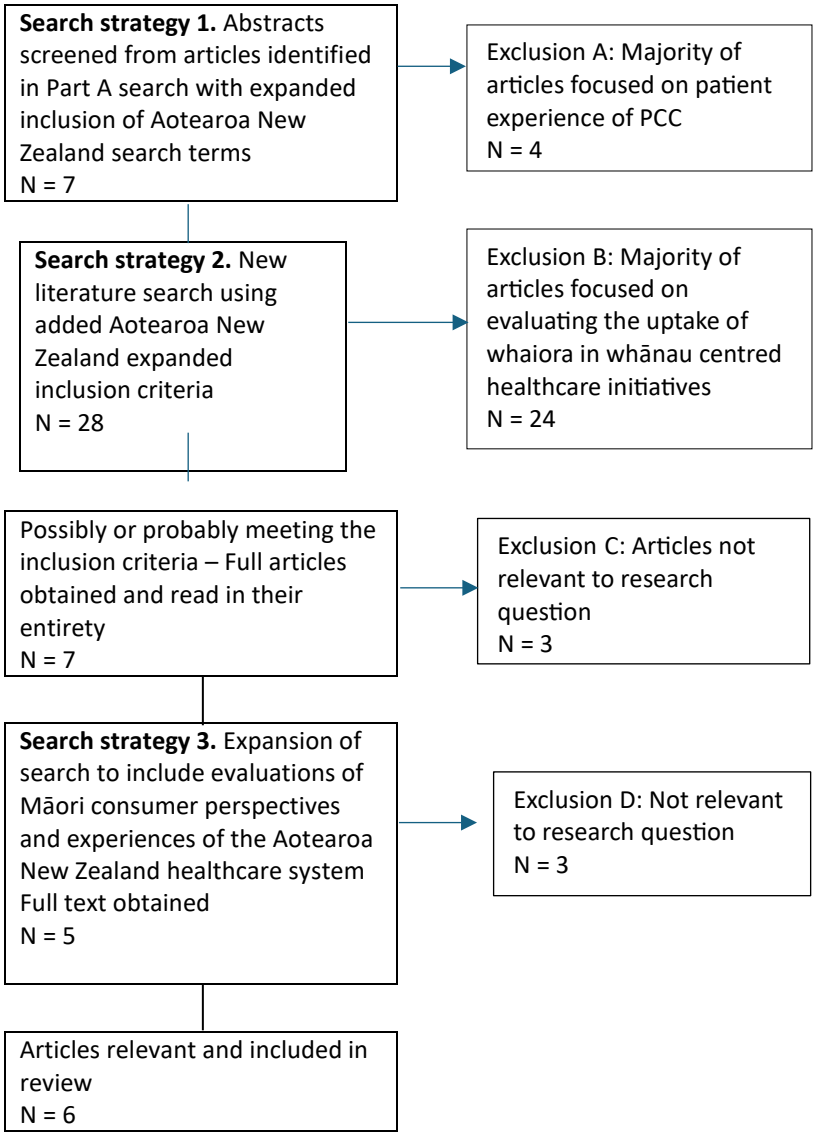
Similar to Part A, articles were appraised on quality aspects that are consistent with research focused on applied clinical implications. In assessing the studies, I again focused on quality markers such as rigour, sincerity, credibility, and resonance that contributed toward the focus of my research topic (Malterud et al., 2016; Sandelowski, 1995a; Thorne, 2000). The articles were also assessed using the CASP criteria to ensure consistency with the global literature review quality appraisal (Public Health Resources Unit, 2018). However, the CASP criteria was again applied with caution, and I utilised this approach as a starting point only as I was aware that the flexible and context-sensitive nature of qualitative research often requires a more nuanced and adaptable approach, as discussed in Part A above. (Besley et al., 2011). It was important to balance the use of established criteria with the specific needs and goals of the included papers, so I again used a more adaptable approach in applying markers mentioned above such as worthy topic, credibility, resonance, and rigour when assessing the contribution and intended goals of the included papers (Malterud et al., 2016; Sandelowski, 1995a; Thorne, 2000, 2016). It is also acknowledged that these appraisal techniques are Westernised tools and may not be appropriate to be utilised when assessing Indigenous studies.

Overview of Research Results

The search results are shown in Figure 2. Similar to Part A, most literature focused on evaluating the patient in terms of their own behavioural change and the patient then taking responsibility for their healthcare through PCC programmes. In the Aotearoa New Zealand literature search, Part B, the global literature was scanned with the expanded search terms as outlined in strategy one above, and only seven articles were identified as possibly being relevant. These articles focused on PCC or whānau centred healthcare programmes and met the Aotearoa New Zealand literature research criteria.

Figure 2.

Aotearoa New Zealand Literature Search Process and Results



I then undertook a separate literature search applying the added search terms that were specific to Aotearoa New Zealand and Te Ao Māori models and ways of working, as outlined above in strategy two. This search identified 28 articles that possibly met the Part B Aotearoa New Zealand inclusion criteria. The abstracts of these articles were screened; however, the majority of articles focused on evaluating whaiora uptake of healthcare initiatives. Only four articles were identified that probably met the inclusion criteria.

The full text of the seven potentially relevant articles from search strategies one and two was obtained and screened for relevance. From the combined searches only three articles were relevant to my research question, one from strategy one and two from strategy two. As outlined above, I then changed my eligibility criteria and identified more papers within the existing search and identified articles that focused on Māori consumer perspectives of the Aotearoa New Zealand healthcare system. Expansion of the inclusion criteria elicited five further articles that were possibly or probably relevant to my study. Only two of these articles were applicable to my research question and were included to strengthen knowledge around my topic of Māori experiences of the Aotearoa New Zealand healthcare context in terms of whaiora engagement, cultural responsiveness, and a focus on equity of service provision (Graham & Masters-Awatere, 2020; Palmer et al., 2019). From these three distinct search strategies in Part B of engaging with the Aotearoa New Zealand literature (as outlined in the search strategy section above), only six articles were identified as being applicable, meeting the inclusion criteria, and relevant to be included in my literature review as shown in Figure 2 above.

Of the six papers included in this narrative review:

- Two studies were from a health professional's perspective, focusing on factors that may enable or impede the implementation of PCC or whānau centred care into routine practice (Ormrod, 2016; Sheridan & Kenealy, 2016).
- One study was a discussion paper focused on transforming a kaupapa Māori health and social service non-government agency into a whānau centred organisation (Fanselow & Hughes, 2019).
- Three literature reviews were included; one that looked at models that informed a PCC or Māori-centred relational care approach and two that researched the

experiences of Māori within the Aotearoa New Zealand healthcare system (Graham & Masters-Awatere, 2020; Palmer et al., 2019; Wilson et al., 2021). These two literature reviews focusing on the healthcare experiences of Māori gave background to PCC or whānau centred care and were included to strengthen the discourse around this topic in the Aotearoa New Zealand context.

Two of the studies used a qualitative research methodology (Ormrod, 2016; Sheridan & Kenealy, 2016), three used a systematic literature search methodology (Graham & Masters-Awatere, 2020; Palmer et al., 2019; Wilson et al., 2021), and one study was a discussion paper with no defined methodology (Fanselow & Hughes, 2019).

Data collection in the included articles ranged from semi-structured interviews to patient surveys to wānanga (a te reo Māori term used to describe open discussion, gathering together to discuss differing thoughts, opinions, and experiences).

Table 3.

Summary of Aotearoa New Zealand Included Articles

Author and year	Aim/purpose	Study design	Methodology	Perspective	Participant characteristics	Study quality (CASP criteria) and other quality considerations
Fanselow & Hughes., 2019	An Indigenous view of organisational transformation to embed whānau centred practice that incorporates health outcomes into a holistic, Indigenous and people-centred view of well-being in Aotearoa New Zealand	Discussion Paper	No defined methodology	Researcher's perspective critiquing the embedding of a whānau centred care model into clinicians' practice	Managers and health care workers at Te Whānau o Waipareira, an Indigenous Māori provider	N/A Strengths: Clear aim and purpose. Provides insights into an Aotearoa New Zealand PCC initiative, worthy topic, resonance and contribution Limitations: Discussion paper. No defined methodology. No rigour or comprehensive evaluation of outcomes
Graham & Masters-Awatere., 2020	Māori experiences of Aotearoa New Zealand's public health system: A systematic review of 2 decades of published qualitative research	Literature review	A systematic search using PRISMA protocols and reflexive typology organised around categories of Māori, public healthcare, and qualitative research. A qualitative meta synthesis	Authors' perspective and discussion after thematic synthesis of the included articles	N=14 relevant articles	SCC* – 10/10 criteria met. Strengths: Clear aim, systematic literature review, robust analysis, rigour applied. Findings clear, worthy topic, resonance, credibility and contribution Limitations: Much of Māori practitioners' work is not published in academic sources and as this study was a systematic review, these studies are not included
Ormrod 2016	Evaluation of a general practice's led primary care PCC model which supports and empowers patients with long term conditions	Qualitative research	No defined methodology Patient experience surveys, patient narrative, and staff interviews	MDT & patient perspective	N=2 general practitioner practices	QCC** – 4/10 criteria met; 1/10 not met; 5/10 criteria unclear. Strengths: Clear aims and purpose. Robust discussion and analysis of the impact of PCC in two general practitioner practices, worthy topic and resonance Limitations: No defined methodology. Not clear whether relationship between researcher and participant adequately considered. Descriptive of a project. No robust evaluation
Palmer et al., 2019	Explores Māori consumer experiences of health systems and programmes	Literature review	Qualitative literature review	Authors' perspective and discussion after thematic	N=54 included articles	SCC – 7/10 criteria met; 3/10 criteria unclear. Strengths: Clear aims, systematic literature review. Robust analysis. Provides insights around the necessity of being relational to address inequities,

Author and year	Aim/purpose	Study design	Methodology	Perspective	Participant characteristics	Study quality (CASP criteria) and other quality considerations
				synthesis of the included articles		clear findings, worthy topic, resonance, credible and contribution Limitations: Not a comprehensive search and may not have identified all the relevant studies
Sheridan & Kenealy, 2016	Explores the benefits of a community based Whānau Ora healthcare approach—Kia A Ra Ngatiwai—that integrated health and social services	Qualitative Kaupapa Māori case study	Interviews and wānanga. Data analysed inductively	Kaumātua with chronic health conditions perspective	N=15 kaumātua experiencing the Kia A Ra Ngatiwai Whānau Ora approach	QCC – 6/10 criteria met; 4/10 criteria unclear. However, applying CASP criteria is probably not appropriate in this Indigenous study Strengths: Clear aims, robust design and analysis, methodology aligns with evaluating a Te Ao Māori approach, worthy topic, resonance, and contribution Limitations: Case study. Not clear whether relationship between researcher and participants adequately considered
Wilson et al., 2020	Identifies the key concepts and values embedded within Māori models of health and well-being and determines how these could inform development of a Māori-centred relational care model	Qualitative Literature review	Literature review of relevant articles	Authors' perspective and discussion after thematic synthesis of the included articles	N=9 of included articles	SCC – 6/10 criteria met; 2/10 not met; 2/10 unclear. Strengths: Clear aim and purpose, robust analysis, rigour evidenced with extensive cultural review process undertaken. Worthy topic, resonance, credibility and contribution Limitations: Papers analysed were descriptions of Māori models of care rather than robust evaluations

*SCC denotes the Systematic CASP checklist (Public Health Resources Unit, 2018) and
** QCC denotes the Qualitative CASP checklist and. See Appendix C for full checklist.

Overview of Key Appraisal Findings

The methodological quality of articles included in this Aotearoa New Zealand review varied widely when appraised against the quality markers (Malterud et al., 2016; Sandelowski, 1995a; Thorne, 2000; Tracy, 2010). A summary of the appraisal of rigour and the results of applying the CASP checklist tool are included in Table 3 (See Appendix C for summary). The two qualitative studies focusing on PCC or whānau centred care identified clear purpose, the methodology was appropriate, and the findings well outlined (Ormrod, 2016; Sheridan & Kenealy, 2016). There was a lack of detail regarding recruitment strategies making it difficult to assess their appropriateness. Similarly, there was no evidence that the relationship between the researcher and participants had been adequately considered. There was limited transparency relating to researcher positionality and how this may have influenced data collection and interpretation of the findings in these two studies. There also appeared to be minimal justification as to whether the research design was appropriate in these two qualitative studies (Ormrod, 2016; Sheridan & Kenealy, 2016).

The appraisal of the literature reviews highlighted that all three adequately addressed the research question, appeared to search for appropriate papers, and included relevant studies; but, may have not been exhaustive in their search (Graham & Masters-Awatere, 2020; Palmer et al., 2019; Wilson et al., 2021). Quality of papers were assessed and important outcomes considered. However, it was unclear from these literature reviews how precise the results were as it was not detailed in the studies, making this CASP element difficult to assess. The discussion paper was a Kaupapa Māori study (Fanselow & Hughes, 2019). This study was valuable because it provided useful practice insights into an Indigenous organisation that had embraced a PCC or whānau centred way of being in Aotearoa New Zealand. Again, it is acknowledged that these appraisal techniques are Westernised tools and may not be appropriate to be utilised when assessing Indigenous studies.

Part B – Synthesis of Aotearoa New Zealand Literature

The Aotearoa New Zealand healthcare context was outlined in Chapter One. The narrative review in Part A of this current chapter reiterates that healthcare in Aotearoa New Zealand mirrors the pressures other healthcare systems are facing internationally

(Gibson et al., 2020; Mudge et al., 2014). The limited evidence specifically exploring the implementation of PCC in the Aotearoa New Zealand context appears to be still evolving. While there are a few studies that highlight the barriers and enablers to health professionals working in a PCC way, overall, my literature search revealed a lack of studies in this area. There also appeared to be a paucity of research examining the uptake and use of Te Ao Māori models of health in practice in Aotearoa New Zealand; however, this does not necessary mean that it is not happening. Kaupapa Māori programmes may not be being researched and/or published as this is a western centric concept (Bishop, 2011). Further, it is important to note that my search may not have been exhaustive or tailored to understanding the extent to which Te Ao Māori models of health have been used. However, the articles selected in this literature search highlighted several factors that are perceived to hinder or help the implementation of PCC and Te Ao Māori models of care in Aotearoa New Zealand. These factors included the current healthcare funding model; the lack of cultural responsiveness and equity; the need for an organisational wide approach; and strong and adaptive leadership. These factors will now be looked at in more depth.

It is important to note that there is an inconsistency in language used by authors regarding the constructs of cultural safety, cultural competency and cultural responsiveness. In this chapter, I use the language of the authors when discussing their work, and when I am discussing and interpreting their findings and perspectives. However, when reflecting on these concepts myself in other parts of the thesis (such as in the Discussion Chapter), I have sought consistency in my own language, primarily using the concept of ‘cultural safety’ as defined by Curtis et al. (2019). Cultural safety in healthcare, extends beyond cultural awareness and sensitivity. It involves creating an environment in which patients' cultural identities and experiences are recognized, and healthcare practices are adjusted to be responsive to those identities. It requires a proactive approach by health professionals, acknowledging and addressing the social determinants of health and structural inequalities that contribute to disparities in health outcomes for Māori It particularly focuses on ensuring that patients are not marginalized or made to feel inferior due to their cultural backgrounds. Cultural safety emphasizes that it is not the patient's responsibility to adapt to the healthcare system but for the system and its providers to be adaptive to the cultural needs of the patient.

The focus is on preventing harm caused by power imbalances, stereotypes, or ignorance of cultural needs and practices (Curtis et al. 2019).

Current Healthcare Funding Models

The current funding and resourcing models in Aotearoa New Zealand do not appear to be in alignment with a PCC approach. This is evidenced by Ormrod's (2016) research centred on evaluating the introduction of PCC into two general practices which operate under a business model focused on fee for service, 15-minute appointments, expediency, and efficiency. Ormrod's study highlighted that support was required to embed the change to a PCC approach including MDT involvement, clear and effective internal communication, health coaches to support the role out of PCC practices for more complex situations, on-going training for all roles, a shared technology platform, and the need for flexible funding for individualised interventions (Ormrod, 2016). However, the change management processes required to sustain this way of working within a medical practice and to ensure that the team remained committed as a whole was found to be challenging because of staff resourcing, large patient numbers, and the business model of fee for service and short patient appointments (Ormrod, 2016). This study provides insight into the difficulties in sustaining PCC practices when the wider funding model is not aligned with this way of working. This primary care example is also congruent with the research findings about secondary care services in Aotearoa New Zealand that evidence expediency and efficiency as the main focus because of the high demand and a lack of resources (Wilson et al., 2021). This study also aligns with the global research which highlighted that if organisational structures and funding streams are not in line with a PCC way of working then it is more challenging to sustain these work programmes (Edgar et al., 2020; Phelan et al., 2020).

Cultural Responsiveness and Equity

Another barrier to implementing PCC in the Aotearoa New Zealand context is the lack of focus on equity and cultural responsiveness by health professionals. This is evidenced by Palmer et al. (2019) whose systematic review of Māori consumer experiences highlighted that inequity in service provision was a barrier to these consumers engaging in a partnership way with health professionals. The authors suggested that clinicians need to be more responsive to the determinants of health for Māori consumers such as

health beliefs, cultural connectedness, costs of clinical care, and internalised blame (Palmer et al., 2019). This elucidates the culture and environment of care, with the authors arguing that equity and racism can be a barrier to implementing PCC. This claim is collaborated by Graham and Masters-Awatere (2020) findings from their systematic literature search. They contended that racist healthcare policies, discrimination, and reduced access for Māori all result in inequitable healthcare outcomes which detract from the concept of person-centred or whānau centred care.

Furthermore, health professionals need to be cognisant that consumers' previous experience may impact on their desire and ability to engage in healthcare services. As such, Palmer et al. (2019) suggested that health professionals need to take time to engage and understand whaiora and whānau situations to navigate any beliefs from past negative health experiences. This concept adds to the thinking about PCC in that it reiterates the importance of taking time to find out what is important to the whaiora and understanding their experiences, which may include a lack of trust in the health system and healthcare professionals (Palmer et al., 2019).

To embed PCC or whānau centred care in the Aotearoa New Zealand context, equity and cultural responsiveness need to be addressed at every level. Palmer et al. (2019) recommended that health professionals must be mindful to acknowledge and focus on what matters to Māori consumers and their whānau in every healthcare interaction. This study aligns with the global PCC literature about putting patients at the centre of their healthcare experience and decision-making (Edgar et al., 2020; Manley et al., 2011; McCance et al., 2013; Phelan et al., 2020). However Palmer et al. (2019) findings facilitate a more nuanced understanding into implementing PCC in an Indigenous culture, asserting that health professionals need to be culturally safe in their practice, aware of health literacy, and including tikanga (cultural norms) in their everyday practice. This notion is reiterated by Graham and Masters-Awatere (2020) who argued that health professionals need to examine themselves and the potential impact of their own culture, biases, assumptions, and the power imbalance between them and their patient in order to be culturally safe. They maintained that providing a workforce that is culturally safe, alongside sustained and consistent efforts to address some of the racist processes and structures embedded within Aotearoa New Zealand's healthcare system, is a crucial pre-

requisite to embedding whānau centred care. These cultural barriers were mainly attributed to the negative impacts of a colonial and alienating health system (Graham & Masters-Awatere, 2020). Graham and Masters-Awatere (2020) also highlighted that, at times, staff interactions could be rushed with ineffective communication, a lack of engagement, and less relational rapport being apparent, which is in direct contrast to a relational-centred way of working.

Although these studies have identified the need to address cultural competencies in Aotearoa New Zealand healthcare programmes, it appears that limited attention has been given to this aspect in some of the general PCC programmes that have been rolled out. The evaluation of the PCC programme in the two medical practices in Ormrod (2016) study, appeared to not take into account equity and/or being culturally safe as an outcome measure. Similarly, cultural safety was not focused on as a critical element of PCC in the three general Aotearoa New Zealand articles included in Part A of this literature review (Bright et al., 2012; Gibson et al., 2020; Mudge et al., 2014).

Using Te Ao Māori approaches to augment the embedding of a whānau centred care or PCC way of working is imperative to improve equity and health outcomes. This was the focus of Wilson et al. (2021) literature review. The authors identified that culturally relevant and meaningful approaches to engage with Indigenous people and their whānau was critical to improve health outcomes. Using Te Ao Māori relational approaches in healthcare delivery in mainstream as well as Indigenous organisations is argued to be a critical element to improve equity for Māori and other ethnic groups (Wilson et al., 2021). Wilson et al.'s (2021) argument is corroborated by two programmes, one in Northland and one in Tāmaki Makaurau (Auckland City), that both evidence that a relational approach is at the core of patient engagement and addressing equity (Faneslow & Hughes, 2019; Sheridan & Kenealy, 2016). The positive engagement and resulting improvement of health outcomes for kaumātua with chronic health conditions is evidenced in the Kaupapa Māori (Māori led programme) initiative in Northland. This programme was a Whānau Ora initiative (an Indigenous Aotearoa Māori model that supports whānau with their right to rangatiratanga, the right to self-determination) called Kia Ora Ngataiwai and had Te Ao Māori relational approaches at its core (Kara et al., 2011; Sheridan & Kenealy, 2016). Similarly, the success of culturally

relevant and meaningful approaches was evidenced by the positive health outcomes achieved at a Māori health and social service organisation in Tāmaki Makaurau called Te Whānau o Waipareira. This Indigenous Māori provider also used Te Ao Māori models of care to engage successfully with whaiora, and took an organisation wide approach to be whānau centred and ensure that processes and structures were culturally responsive (Fanselow & Hughes, 2019). To successfully implement PCC or whānau centred practices in Aotearoa New Zealand, health professionals need to be culturally safe and have a focus on equity to ensure they are taking into consideration and addressing the social determinants of health in every interaction.

Organisation Wide Approach

Consistent with the global evidence, the Aotearoa New Zealand literature highlighted that having an organisational wide approach can promote a culture of PCC. As already outlined, some of the Aotearoa New Zealand studies focused on organisations where equity and cultural responsiveness were at the very core of a relational-centred approach (Faneslow & Hughes, 2019; Sheridan & Kenealy, 2016). However, these programmes were in Indigenous Māori providers and not located in mainstream or secondary care settings. For example, Te Whānau o Waipareira, an Indigenous Māori provider, demonstrated that creating a transformational culture at every level of the organisation was successful to embedding whānau centred care (Fanselow & Hughes, 2019). Te Whānau o Waipareira developed a holistic, Indigenous culture that ensured whaiora and whānau were placed at the centre of all care decisions to achieve whānau centred care outcomes (Fanselow & Hughes, 2019). There are a number of similarities between Te Whānau o Waipareira and the Kia Ora Ngataiwai kaumātua programmes. Relationships and whakawhanaunatanga (connections) were central at every level with a common language to assist in uniting the kaimahi (a te reo Māori term for workers) and whaiora together. Equity, tikanga, and cultural responsiveness were at the core of these Te Ao Māori whānau centred care initiatives; with positive health and well-being outcomes evidenced. This mirrors Bradshaw et al.'s (2021) findings in Part A above, where a common language underpinned health professional and patient relationships and was a cohesive factor in the PCC approach in a palliative care service. A culture of adaptability, responsiveness, and transparency was encouraged at all levels at Te Whānau o Waipareira and also in the Kia Ora Ngataiwai programme (Fanselow & Hughes,

2019; Sheridan & Kenealy, 2016). However, like the Omrod (2016) study of PCC in two medical practices, Te Whānau o Waipareira also had to juggle the challenge of managing an innovative programme and high demand while maintaining business as usual. Their leaders and managers needed to be agile and adaptive to be able to navigate this tension (Fanselow & Hughes, 2019).

The Te Whānau o Waipareira and the Kia Ora Ngataiwai studies give insight into how a transformational organisation and/or programme wide approach can assist in socialising, embedding, and sustaining a relational practice change programme of whānau centred care (Fanselow & Hughes, 2019; Sheridan & Kenealy, 2016). This aligns with the global PCC literature in that those programmes that created a PCC culture at every level of the organisation from induction to training, leadership to the patient interface level, processes to supporting structures were shown to be the more sustainable and successful programmes (Edgar et al., 2020; Manley et al., 2011; Moore et al., 2017). These Aotearoa New Zealand studies provide additional insight into the importance of ensuring that equity and cultural responsiveness are built into the relational whānau centred or PCC approach at every level.

Required Characteristics of Leadership

The importance of flexible and adaptive leadership supporting health professionals to make strong connections with whaiora were found to be essential elements in embedding whānau centred care (Sheridan & Kenealy, 2016). A particular characteristic valued was leadership adaptability to quickly address and overcome obstacles. Leaders' role modelling and reinforcing the need for health professionals to build strong relationships with whānau to ensure they are at the centre of their healthcare was also pivotal. Similarly, leadership championing a clear vision for a programme or an organisation was also shown to be a catalyst to the success of the culture and commitment to a whānau ora approach at Te Whānau o Waipareira (Fanslow & Hughes). Both these studies' findings appear to be congruent with Manley et al. (2011) and Moore et al. (2017), from the global literature, in that there was a need for leaders to be proactive and adaptable to address any barriers for clinicians working in a PCC way. Leadership characteristics of being agile, adaptable, and setting a clear vision appear to

be pivotal in supporting healthcare professionals to sustain a PCC or whānau centred way of working.

Similar to the evidence from the global studies, the Aotearoa New Zealand literature highlighted that addressing the current healthcare funding model the need for an organisational wide approach, and strong and adaptive leadership were all important factors in implementing a PCC way of working. The Aotearoa New Zealand literature search differed from the global literature in highlighting that a lack of focus on cultural responsiveness and equity appeared to be a reason for health professionals to not be able to authentically work in a person-centred or whānau centred way.

Key Insights from this Literature Review

The literature review highlights that contextual, social, and cultural influences appear to impact on the ability to embed and sustain practice change in healthcare. The combined global and Aotearoa New Zealand evidence suggests that an organisation's culture, transformational leadership, support, flexibility, and adaptability to be able to meet and address any issues at the practice level are all important enablers to embed a sustainable person-centred approach. The Aotearoa New Zealand literature provides additional insight into the need for a culturally responsive workforce to ensure a relational way of working and support whaiora and whānau engagement. The Aotearoa New Zealand evidence also highlights the need to address the structural barriers that support inequities and racism to ensure person-centred or whānau centred care can be embedded and sustained in everyday health care practice.

Gaps in Evidence

The literature review highlights some gaps in knowledge. For instance, although some literature exists about what helps or hinders the implementation of PCC in the Aotearoa New Zealand setting, the extent to which the context (e.g., workload, culture) and setting (e.g., acute versus community, primary versus secondary) play a role in the likelihood of meaningful implementation of this way of working is not known. It may be that there is more of an opportunity to take up a PCC approach in slower paced community settings or within Indigenous community organisations where processes and structures are not as rigid as in hospital settings.

Overall, there was limited evidence evaluating factors relevant to the implementation of PCC in Aotearoa New Zealand. The only three Aotearoa New Zealand studies that discussed and/or evaluated PCC programmes were based in primary health settings. The three Aotearoa New Zealand articles included in Part A of the literature review focused on individual clinicians' experiences of embedding PCC into their own work with patients rather than embedding a PCC programme or way of working into a specific service (Bright et al., 2012; Gibson et al., 2020; Mudge et al., 2014). There appeared to be scant attention paid to evaluating the barriers and enablers of PCC programmes in secondary care hospitals in Aotearoa New Zealand which highlights a gap in the literature in this area. Critically, there is also an absence of evidence in the Aotearoa New Zealand literature exploring approaches underpinned by Te Ao Māori models of healthcare and limited research explicitly seeking to explore PCC or whānau centred care for Māori.

Gaps in Knowledge this Study is Intending to Address

It is evident from the literature review that little is known about the sustainability of embedding an Aotearoa New Zealand PCC model in a secondary healthcare setting. I anticipate that my research, which focuses on what helps or hinders the implementation of Tikanga Ako Hono-Tāngata, a relational PCC programme based in a hospital setting in Aotearoa New Zealand, will help address this gap in knowledge. This study will also provide an understanding of what helps or hinders health professionals endeavouring to incorporate Te Ao Māori Models into their practice. It will also explore the role of the context, community versus acute workplace settings, and the impact that this has on health professionals trying to work in a relationship-centred way. My research is timely, as Te Pae Tata, the New Zealand Health Plan (as discussed in Chapter One), identifies the importance of embedding Te Tiriti o Waitangi principles into healthcare with emphasis on the principles of equity and rangatiratanga (Te Whatu Ora, 2022). Similarly, it specifies that it is critical that whaiora and whānau are at the centre of their care and that cultural responsiveness and equity are at the forefront of all healthcare service delivery so as to improve health outcomes (Te Whatu Ora, 2022). My findings may shed light on some of the factors that influence or impact the implementation of successful change programmes in the field of PCC or RCP in this current healthcare environment in Aotearoa New Zealand.

Chapter Four – Methodology

This chapter provides an overview of my methodology, interpretive description. I first detail how I came to choose this methodology given the many different qualitative research approaches available. I then outline the background to interpretive description methodology, providing transparency about the underpinning epistemological assumptions. Next, I describe how my background and worldview aligns with interpretive description methodology. Finally, I provide a deeper and more nuanced discussion as to why interpretive description is congruent with my doctoral study.

Methodology Considerations

As the core aim of this study was to explore the subjective experience of AHPs to inform future implementation of RCP, I chose a qualitative methodology (Smythe & Giddings, 2007). I examined several qualitative methodologies to determine which was most aligned in assisting me to answer my research question and produce findings that could be used to inform my ongoing work. The candidate methodologies I considered were phenomenology, hermeneutic phenomenology, and appreciative inquiry (see Appendix D for my critique of the benefits and drawbacks of each). Through this process I was drawn to interpretive description as a methodology that would congruent with my research aims and purpose. I did have some initial concerns about using interpretive description. My initial understanding of the approach led me to believe it was used to look at patient-focused rather than practice-oriented research questions. I also initially questioned whether this approach might lead me to jumping to conclusions too early, as noted in a memo I wrote:

> Is this approach too clinically focused in its methodological design for looking at behavioural change inhibitors and enablers? My preconceived view could lead to jumping to conclusions too early in the data analysis – although on the other hand this approach does allow for continually questioning the meaning throughout the data analysis process so this could counter this and allow for deeper understanding and meaning to grow. *(Comparison Methodology Notes, March 2021)*

Through further reading I was able to understand that interpretive description is a methodology that supports exploring both practice- as well as patient-related questions to extend knowledge (Thorne, 2016). On further reflection, and in discussion with my

supervisors, I came to the conclusion that interpretive description would allow my research to explore the multiple realities that impact health professionals trying to change their way of working in a complex health system (Thorne, 2016). Furthermore, I felt that drawing upon interpretive description methodology would assist me to challenge any pre-conceived ideas that I might have developed and become entrenched in by working in this field as a health professional and training facilitator over the last 20 years (Thompson Burdine et al., 2021; Thorne, 2000). Thorne (2016) maintained that we often operate with "established truths that are held unquestionably until they are effectively challenged" (p. 259). Interpretive description methodology would enable me to unpack these established truths and existing assumptions to provide the transparency required to underpin this doctoral study.

Interpretive description also takes into account the social, cultural, and political factors that can interact and influence a situation, which would prompt me to attend to the context and complexities of the environment in which healthcare professionals work (Thorne, 2000, 2008), something integral to answering my research question. Taking into account these social, cultural, and political influences closely aligns with my social work background, where my ethos is to look at the wider context of impacting factors, and may well have influenced my orientation towards interpretive description. The benefits of using interpretive description as a methodology to examine healthcare professional experiences of embedding RCP into practice became overwhelmingly evident. I will discuss interpretive description in more depth and provide further justification for its use in the below sections.

Interpretive Description

Interpretive description is grounded in social constructionism (Aburn et al., 2020) and naturalistic inquiry (Thorne, 2016). It seeks to make sense of human interactions within their social context (Thorne, 2016). Through various data collection methods researchers gain knowledge about participants' perspectives, the underlying social constructs impacting on their situation, and the associated behavioural patterns. Interpretive description methodology prompts a researcher to focus on understanding the perceptions and experiences of participants in their natural environment to provide new plausible interpretive understandings of social phenomena (Thorne et al., 1997). To gain

a better understanding of interpretive description, I will now focus on the methodology's underlying roots of social constructionism and naturalistic inquiry.

Social Constructionism

The underlying premise of social constructionism is that individual experiences, and meanings of these experiences, are constructed through social processes. That is, knowledge and understanding are generated from the meaning that we attribute to our experiences or a given situation, influenced by our relationships and the social processes of which we are part. Those meanings are socially constructed through the interactions of groups of people in their day-to-day encounters, and the interactions between people and the wider social and environmental context. Therefore, those meanings can be everchanging, fluid, and dynamic (Camargo-Borges & Rasera, 2013). As such, attending to the wider meanings the participants had constructed through their relationships and experiences when trying to implement RCP in the workplace will be important, not simply examining individual perspectives and experiences in isolation.

Social constructionism is, therefore, aligned with my research focus. The way I viewed RCP were my considerations based on my experiences as a health professional and facilitator. The reality of RCP in practice is likely to vary by person depending on what has shaped their practice to that point and the varied contexts in which they are working. Practicing RCP may well have been influenced by the day-to-day interactions of other health professionals in the work environment and have become socially constructed and shaped by those encounters. Constructionism also holds that non-human aspects are part of social processes; hence, documentation, guidelines and policies, the unspoken rules of 'how we do things' will also have shaped how RCP was practiced (Camargo-Borges and Rasera (2013). Aburn et al. (2020) suggested that the cultural, social, and historical contexts can all impact on and attribute meaning to any given situation. This is consistent with the literature review finding (see Chapter Three) that PCC or RCP implementation can be influenced and swayed by the social and cultural context of the particular healthcare environment in which the health professional works (Hebblethwaite, 2013; Moore et al., 2017).

Naturalistic Inquiry

By engaging with participants in a meaningful way through naturalistic inquiry and a process of critical interpretation, research can shine light on a situation to gain a better understanding of these social constructs and behaviours. Guba and Lincoln (1982, p. 16) put forward the notion of naturalistic inquiry in contrast to rationalistic inquiry which begins with a theory and uses plurality of methods to test relationships between variables to explain a phenomenon. Guba and Lincoln (1982)maintained that as there are so many intertwined and multiple complexities that diverge and impact each other, a person's lived reality cannot be studied in isolation. It is not only the actual behaviours that shape our understanding in the naturalistic human sciences, but also the meaning and interpretation attributed to those behaviours (Guba & Lincoln, 1982). Filstead (1979, as cited in Guba & Lincoln 1982, p. 369) suggested that, "there are multiple realities [...] individuals are conceptualized as active agents in constructing and making sense of the realities they encounter". As the inquiry progresses, it raises more questions as to 'why', 'how', and 'what else' could this possibly mean (Guba & Lincoln, 1982). Further, in naturalistic inquiry, it is acknowledged that the researcher and the researched influence each other. The researcher cannot remain completely objective, value-free, and independent from the subject phenomenon in the naturalistic human behaviour realm. Research is influenced by the researcher's values, assumptions, and background in their choice and framing of the research question, the paradigm they choose to use, the data methodology selected, and in the analysis and interpretation of the findings (Guba & Lincoln, 1982). That is, the researcher takes an active role in the construction of knowledge.

Not everything is explained by a simple linear cause and effect situation in naturalistic inquiry; rather, one needs to take into account an implosion of multiple interacting factors that affect human behaviour (Guba & Lincoln, 1982). As such, one can only establish plausible themes and patterns to try to understand the commonalities or differences. (Guba & Lincoln, 1982).

Drawing together core constructs from social constructionism and naturalistic inquiry, and referring to Thorne's writing on interpretive description, the core epistemological foundations of this methodology can be identified as:

1. there are multiple constructed realities that only can be studied holistically;
2. no prior reasoning or theory could encompass the multiple realities and thus findings must emerge from the data;
3. the researcher and participant influence each other (Thorne, 2004).

Background to Interpretive Description

The last 2 to 3 decades has seen a proliferation of nursing research using approaches such as ethnography, phenomenology, and grounded theory to answer practice-based questions (Thorne et al., 2004). However, Thorne et al. (2004) argued that researchers have often felt hindered by the boundaries and prescriptiveness of these qualitative methodologies or have misrepresented their research by claiming to use a methodology that was inconsistent with what they actually did. To answer these qualitative research shortfalls, Thorne et al. (2004)contended that an approach that used analysis, interpretation, and explanation to answer the complex experiential and practice-based questions was required. Interpretive description evolved in response to this need to generate grounded knowledge pertaining explicitly to clinical nursing contexts (Thorne et al., 2004). The purpose was to be more responsive to practice based questions which could, in turn, inform future practice, and also fitted with the naturalistic and social constructionism schools of thought (Thorne, 2016). Interpretive description facilitates understanding of the perceptions and experiences of individuals to then inform practice and advance evidence-based knowledge. According to Thompson Burdine et al. (2021), interpretive description provides a "credible process through which to develop deep understanding and to generate knowledge that can advance clinical practice" (p .3). It assists the researcher to develop a deeper, richer, more intimate knowledge of the phenomenon of interest. It then prompts the researcher to take a step back to critically examine the data for any emerging patterns, themes, or incongruencies, so that new understandings can then be applied to inform future practice in the clinical setting.

A key aspect of Thorne's (2004) methodology is the theoretical scaffold. Interpretive description methodology prompts the researcher to bring the knowledge gained from exploring the existing literature together with their own practice knowledge to form a theoretical scaffold to frame the study. This theoretical scaffolding firstly prompts the researcher to contextualise what is already known about the topic from reviewing

existing literature and theories. The second element of the theoretical scaffold guides the researcher to understand their own thinking as a researcher and what has brought them to study this topic. The assumptions behind my initial thinking and the rationale for focusing on this research topic were, therefore, explicitly outlined in Chapter One, and form part of the theoretical scaffold that frames this study. This part of the theoretical scaffold sets the context to promote reflexivity of the researcher and to continually reflect on how their perspectives and assumptions influence their interpretation and understanding of the topic (Thompson Burdine et al., 2021). Providing a theoretical scaffold foregrounds the study with scholarly research and discipline, and/or personal perspectives, and helps ensure the research remains theoretically informed and positionality is transparent (Teodoro et al., 2018; Thorne, 2016). Ensuring that the two elements of a theoretical scaffold in a interpretive descriptive study are responded to may help ensure that the research has a strong platform that frames the study from the outset.

The development of interpretive description as a qualitative methodology has advanced the potential of qualitative research to inform practice based change in the applied health arena (Teodoro et al., 2018). Interpretive description provides a platform to explore patterns to then generate deeper meaning from health professionals' narratives that, in turn, can inform new directions for clinical practice. Thompson Burdine et al. (2021) suggested that interpretive description can advance knowledge in the practice area without sacrificing the methodological integrity of qualitative research approaches. Rather than adhering to the strict constraints associated with some qualitative research methodologies, interpretive description purports a more flexible approach to research design and conduct. It prompts freedom to explore inductive designs within a wide range of research methods while still maintaining epistemological integrity and coherence within its design and conduct so "that the results can be effectively applied and realistically synthesized into the evolving disciplinary knowledge" (Thorne et al., 2004, p. 3). Allowing a plurality of approaches enables the researcher to draw on the methods that best suit the aim and purpose of the research rather than being constrained and having to adhere to particular methods (Thorne, 2016).

Over time interpretive description has gained popularity with other health disciplines as a way of understanding a clinical practice question with multiple complexities and realities; and, at the same time, ensuring theoretical integrity within the healthcare environment (Thompson Burdine et al., 2021; Thorne, 2000). Research using interpretive description seeks to acknowledge and build on existing disciplinary knowledge and experience rather than being forced to put that knowledge to the side. This is a critical element of the theoretical scaffold, where the researcher gains knowledge and an understanding of what is already known about the applied problem being researched (Thorne, 2016). Interpretive description prompts a researcher to acknowledge and make transparent the differences in disciplinary perspectives of health professionals, recognising the role that this disciplinary knowledge has in informing research and practice.

> The enthusiasm for a topic derives directly from disciplinary interest, the way a research question is framed reveals the nature of the problem that that discipline would recognise as important …and the study design will be explicitly informed by how your discipline thinks about the population or problem. (Thorne, 2016, p. 73)

One's discipline and the knowledge acquired working at the practice level, therefore, informs and influences the theoretical basis of the research, shaping the research question, what observations are made, and the interpretations and meaning placed upon these findings as the research progresses.

Alignment of Interpretive Description to My Background and Worldview

As a social worker, by background, I felt that the philosophical ideology that underpinned the social work profession aligned with interpretive description methodology. With interpretive description foundations being based on social constructionism and naturalistic inquiry, it was a compelling approach for researching a healthcare issue as it neatly aligned with my social work background and ideology. Social constructionism acknowledges the socially constructed nature of reality, emphasising the importance of understanding the subjective meanings and perspectives that individuals attribute to their experiences, including those within healthcare contexts. This aligns with social work as the evolution of the profession has been deeply intertwined with shifts in

ethical, political, and social landscapes, profoundly shaping its epistemology (Fook, 2022). Social work has progressed from early notions of charity towards principles of social justice and empowerment. The profession's focus has expanded to include broader systemic factors influencing well-being such as poverty, marginalised communities, discrimination, and structural inequality (Carey & Foster, 2013; Flexner, 2001). This evolution reflects a deeper understanding of the interconnectedness between personal issues and societal context, enriching the epistemological foundations of social work with perspectives that prioritise collective welfare, equity, and social transformation (Carey & Foster, 2013; Flexner, 2001; Fook, 2022). For social workers who are trained to approach issues from a holistic and person-centred perspective, interpretive description offers a methodology that allows for the exploration of the complex interplay between social, cultural, and individual factors influencing practice and people's health and well-being.

Interpretive description's naturalistic inquiry roots means that researchers can immerse themselves in the natural settings and contexts where healthcare issues unfold, enabling them to capture the nuances and intricacies of real-life experiences. This approach resonated with me as my social work worldview placed emphasis on the importance of context and the need to consider broader systemic factors when addressing healthcare challenges. Furthermore, as a coach and a coach facilitator, I am trained to ask open questions, look for nuances behind the answers, and dig deeper to gain greater insights and meaning. This background meant naturalistic inquiry resonated with me as it was aligned with exploring individual experiences and perspectives in a person's natural environment to facilitate deeper understanding and gain greater meaning about situations.

Interpretive description's emphasis on reflexivity is also congruent with social work and coaching philosophies which encourage one to continuously examine their own assumptions and subjectivities, fostering greater transparency and understanding of self. Interpretive description methodology clearly aligns with my social work and coaching background, and provides a systematic approach that will guide me to gather and analyse data to assist me to understand what helps or hinders the implementation of RCP by AHPs at HBDHB.

Congruence of Interpretive Description to My Research Topic

Interpretive description is an appropriate methodology given it enables exploration of the complex intertwined social processes that have impacted on RCP implementation at HBDHB (Thompson Burdine et al., 2021). Interpretive description recognises that realities can be contextual, constructed, and, ultimately, subjective, which fits with the complexity of the healthcare environment. Interpretive description sets the context for me to unpack the research question through the rigorous analysis of participant interviews to construct, deconstruct, and reconstruct again the behaviours, social complexities, and themes that emerge regarding the implementation of RCP (Alburn et al., 2020; Thorne, 2016). This methodology provides a platform from which to focus on the AHPs' subjective perceived viewpoints of the barriers and enablers to the implementation of RCP in their everyday practice.

The methodology will prompt me to follow the participants' narratives to enable a more nuanced understanding of the individual participants' perceptions of what helped or hindered the implementation of RCP. Consistent with interpretive description, I will explore the contextual differences, such as participant workplace settings and different discipline orientations, to develop a more comprehensive understanding of the factors that impede or enhance these clinicians' ability to implement this way of working. The participants' insights may open up new lines of enquiry or, in some cases, limit lines of enquiry. Drawing on interpretive description methodology, alongside my skills as a coach, will hopefully provide the agility and flexibility required to follow the participants' articulation of their insights and actual experiences. It will guide me to drill down into how the clinician has experienced the task of implementing RCP by asking questions like 'what else could this mean' or 'what could the alternative understandings of this be'?

In an interpretive descriptive study the researcher is encouraged to embrace their positioning while remaining critically reflexive about how it has shaped their study design and their conduct. The researcher is an active player in the construction of data and findings and one's subjectivities are a strength rather than something to be mitigated (Thorne, 2016). Interpretive description methodology, coupled with my coaching and social work background, will prompt me to question the emergent thematic patterns to seek new meaning to go beyond the obvious and more fully explore

and explain the phenomena (Thorne, 2016). This approach will allow for inductive reasoning to occur and provide the adaptability to change direction as new interpretations, understandings, and themes emerge.

Summary

This chapter has outlined my initial methodological decision-making to determine which qualitative research methodology might be the 'best fit' to assist in addressing my aims and purpose. My analysis, reflections, and reasoning in selecting interpretive description as a methodology to guide me in this study is summarised. I also discussed interpretive description's philosophical alignment with my worldview, as a social worker and a coach. This chapter has also outlined the evolution of interpretive description along with the underlying roots of naturalistic enquiry and constructionism, as well as being transparent about the epistemological assumptions underpinning this methodology. Finally, I provided a deeper discussion as to why interpretive description is congruent with my doctoral research.

Chapter Five: Design and Methods

Interpretive description offers a methodological framework grounded in qualitative inquiry principles which guides researchers through a systematic, yet flexible, process to explore complex phenomena within specific contexts (Thorne, 2000, 2016). Interpretive description does not prescribe an exact way of undertaking research; rather, puts forward a coherent and organising framework from which multiple data construction and analysis techniques can be used. However, it is essential that logical integrity is maintained, ensuring the direction of study is both consistent and credible with positionality being transparent throughout (Thorne, 2016). This chapter describes how interpretive description methodology guided the design of this doctoral study and shows the methods I utilised for sampling, recruitment, data collection and analysis. The latter part of this chapter focuses on rigour, including my positionality, and the ethical and moral considerations that I took into account. I also focus on cultural aspects of the research which are particular to conducting research in Aotearoa New Zealand. This is particularly important because the RCP programme was co-designed with Ngati Kahungunu, the local iwi, and it is essential to meet Te Tiriti o Waitangi obligations.

Drawing on My Theoretical Scaffold to Design My Research

Providing a theoretical scaffold foregrounded this study. It guided me to focus on the Aotearoa New Zealand healthcare context, what is already known about the topic in the form of the two literature reviews, and my positionality in setting up and designing this study (as discussed in Chapters One and Three). Drawing on those sources, and combining an evidence base together with transparency of my personal and discipline-specific perspectives and assumptions, set the context for the methods used in my study.

By aligning the design of the study with a theoretical scaffold, researchers can ensure coherence, rigour, and depth in their analysis (Hunt, 2011; Thorne, 2016). My theoretical scaffold aligned with the methodology of interpretive descriptive with two critical elements as outlined in Chapter Four. First, understanding what is already known about the subject or, as Thorne (2016) suggested, “the state of science in relation to the applied problem the researcher is concerned with” (p. 60). The healthcare context of Aotearoa New Zealand (outlined in Chapter One), the history and background of RCP as it came to

be at HBDHB (Chapter Two), and the literature review (Chapter Three) all provided the foundation for this element of the theoretical scaffold. The second critical element of the theoretical scaffold is the researcher's positionality, including what has brought the researcher to this study, their disciplinary orientation, any preconceived ideas, assumptions, and/or values (Thorne, 2004). My positioning (provided in Chapter One) made clear my disciplinary orientation and values, and the positionality interview I undertook (discussed in the rigour section of this chapter) assisted me to make overt my initial thinking and assumptions about my research topic.

The theoretical scaffolding assisted me to set up the foundations of the study, including understanding what was already known about the topic and being transparent about my positioning (Thorne, 2016). The narrative review in Chapter Three provided an understanding of how other researchers have studied the topic, the problems and challenges they encountered, and their conclusions about the barriers and enablers of implementing RCP (Thorne, 2016). This element of my theoretical scaffolding influenced and informed my data construction techniques and data analysis. Reference to how the theoretical scaffold guided me through each of the design stages will be discussed in the following sections. The theoretical scaffolding which set up the foundations for me to be transparent about my positioning informed parts of my analysis and guided me to overtly question some of my initial assumptions when constructing the data, as outlined in the findings chapter.

Sample Characteristics and Size

There is no pre-determined sample size required in interpretive description studies (Thorne, 2016). However, Thorne (2016) suggested that the most appropriate way to determine sample size is to generate a rationale that is consistent with the research question being studied. To guide the sample size in my study, I used Malterud et al. (2016) notion of 120, which contends that the more information the sample holds relevant to the study aims, fewer participants are required. They suggest that the defined specificity of a study topic and sample, along with the quality and depth of dialogue with participants, is important in providing rich information. When combined with a clear theoretical underpinning and robust analysis, the information power that is generated

can be strong (Malterud et al., 2016). In considering the information power required for my study, I attended to:

- Study aim and sample specificity: My topic of what hinders or helps AHPs implement RCP in different service delivery settings in one specific organisation reflects a focused and defined research aim. Further, specificity of the experiences of the participants is high, given all have direct experience of the phenomenon of interest.
- Quality and richness of dialogue: My ability as an experienced coach to deepen understanding by asking open questions, fostering elaboration and clarification so participants can explain their experience as fully as possible within the frame of reference, I believed would ensure that a richness of dialogue would be captured (Thorne, 2016).
- Theoretical basis of the study: The extent to which the study builds on existing evidence and theory. My study is grounded in what is already known about the implementation of PCC and this knowledge underpins my doctoral study. On the basis that I am building from that knowledge base, I believe the information power that I will be able to generate from a smaller sample size will be sufficient (Malterud et al., 2016).

Thorne (2016) suggested that it is important to generate a reasoning that is consistent with the research question to justify sample size in interpretive description. If the existing literature shows that an existing phenomenon occurs regularly, and what is needed is a more in-depth exploration of the underlying subjective nature of the experience, then Thorne argued that a smaller sample size "can produce something worth documenting" (p. 103). Studying a small sample who have experienced a similar phenomenon can provide a depth and richness to explanations, along with insight and an understanding of the participants' lived experience (Malterud et al., 2016; Nicholls, 2009b; Thorne, 2016). As the purpose of the research was to undertake an in-depth exploration of a defined topic—the enablers and barriers to the implementation of RCP—a smaller sample size is justified. In discussions with my supervisors, who are experienced qualitative researchers, we considered that there was a defined purpose to my research and that sufficient information power would be provided in recruiting a smaller number

of 4-6 AHPs in each setting. However, the extent to which information power was being achieved was monitored throughout data gathering and analysis.

Sampling

My study was concerned with understanding what had hindered or helped AHPs to implement and embed RCP into their everyday clinical work at HBDHB.

Inclusion and Exclusion Criteria

All AHPs who had taken part in RCP face-to-face training in the period from 2017 to 2021, and were working directly with patients, were eligible to take part in this research. The 5-year time period was selected to ensure that the training, RCP approach, and strategies learned were still reasonably recent for the AHPs to reflect on.

Any AHP that was part of the initial RCP programmes, facilitated in the first 2 years of the programme inception, from 2015 to 2016, were excluded, as I was one of the programme facilitators at that time. This was to ensure that there was no conflict of interest and to establish rigour, as I had a concern that these AHPs might believe that I would expect they had embedded RCP into their practice.

Purposeful Sampling

Purposeful sampling aligns with interpretive descriptive research and is an important way to achieve depth, richness, and contextual relevance in a study's findings (Campbell et al., 2013; Thorne, 2016). Purposeful sampling can better match the sample to the study question and, as Campbell et al. (2013) argued, improve "the rigour of the study and the trustworthiness of the results" (p. 654).

Furthermore, ensuring that the sample represented the diversity of experiences relevant to the phenomenon under study was important (Patton, 2002). I purposefully sampled from those AHPs that met the inclusion criteria to ensure that the study included a diversity of allied health professions, work settings, and ethnicity to further support data credibility (Thorne, 2016). I also wanted to ensure that AHPs from different disciplinary background and work place settings, either acute ward or community, were included in the sample selection to further support transferability and data credibility (Thorne, 2016). This was because part of the research question I wanted to answer was focused

on whether context, acute versus community, influenced the uptake of embedding PCC into practice. Therefore, AHPs that met the inclusion criteria were chosen equally to represent the two workplace settings.

As highlighted in Chapter One, Māori comprise 27% of the population in Hawkes Bay. To ensure that the study was reflective of the population demographics and ethnicity, I wanted to use purposive sampling so that my participant group reflected this demographic to further support data credibility and transferability (Thorne, 2016). Another reason for focusing on ethnicity was that the theoretical scaffold of the Aotearoa New Zealand literature review, as outlined in Chapter Three, evidenced that cultural safety and equity were barriers to effectively implementing relational ways of working. By ensuring that the sample reflected the ethnicity demographics of the Indigenous Māori population, I felt the findings might be more robust and support data credibility in this area. The purposeful sampling approach is well-suited for interpretive descriptive studies as it allows researchers to focus on exploring the intricacies and nuances of participants' lived experiences within a specific context (Campbell et al., 2013).

Participant Recruitment

Bradshaw et al. (2017) outlined that all research participants have the right to be autonomous agents and should have the ability to accept or decline to participate in a study. In following this guidance, I sought to remove perceived coercion and persuasion from recruitment and to reduce any perceived power differential. A general poster was sent out to invite AHPs to participate in the research (see Appendix E) using the Allied Health, Scientific and Technical generic email distribution list in the District Health Board. People were invited to contact me if they were interested in participating. When people responded, I sent them a 'Participant Information Sheet' (see Appendix F) which also provided an opportunity for people to ask questions about the research. Once sampling criteria had been applied (see sampling section above) consent forms were shared with potential participants to be signed, scanned, and returned by email prior to commencing in person or Zoom-based interviews.

Data Construction

Data construction in interpretive description methodology is the process involved in collecting, organising, and making sense of data, and acknowledges that the researcher's choices and perspectives actively shape the data (Hunt, 2011). The term data construction reflects the recognition that data is not simply found or collected but is actively constructed through the research process. Data construction is an iterative rather than a linear process. Data are continuously revisited and reconstructed throughout the research process (Hunt, 2011; Thorne, 2016; Thorne et al., 1997).

Data were gathered via semi-structured interviews, as aligns with interpretive description, and was informed by the study's theoretical scaffold (Agee, 2009; DiCicco-Bloom & Crabtree, 2006). The interview format was informed by one of the central tenets of RCP, in that it followed the Hui Process framework (discussed in Chapter Two) of mihimihi, the initial greeting; whakawhanaungatanga, making a connection; kaupapa, attending to the main purpose of the interview; and poroporoaki, concluding the encounter (Pitama et al., 2014) (see Appendix G for the full interview guide). The interview questions were open questions that sought to establish what parts of RCP model the participants valued in their practice, which RCP strategies were easier to embed, what had helped or hindered them in implementing and sustaining RCP, and their overall experiences of putting RCP into practice. DiCicco-Bloom and Crabtree (2006) suggested that the iterative nature of interpretive research, as an inductive research process, means that it is fundamental for data collection and analysis to inform each other. As such, there was an opportunity to develop and refine the questions to develop more comprehensive understandings as the research progressed. After reviewing the first interview transcript with my supervisors, I expanded my questions to further develop my interview approach with subsequent participant interviews. Supplementary field notes were maintained using a reflective journal to capture my initial understanding following each of the interviews.

Member Focus Groups

Focus groups are a good mechanism to utilise group processes to generate collective "social knowledge, such as shared beliefs and attitudes that may underlie behaviour patterns" (Thorne, 2016, p. 141). Interviews provide distinct and unique individual

stories but the social dynamic that occurs in bringing participants together can generate different knowledge and reflections through participants hearing and responding to other perspectives and experiences. With this in mind I decided to set up a member focus group to enable group 'member reflections'. The notion of member reflections is embedded within interpretive description as a mechanism for checking the researcher's understanding of participants' contributions, explore if preliminary findings resonated for them, and to test assumptions that may be inherent in early interpretations (Thorne, 2016). The member focus group also provided an opportunity to further develop new meaning of the participants' collective experiences of what helped or hindered them in their implementation of RCP. For example, the discussion about the different workplace contexts, from the acute wards to working in a community setting, provided collective and rich dialogue about the shift in dynamic in working in these two areas. There was general agreement that participants felt less in control in whaiora home settings, as they, as health professionals, were in unfamiliar territory. This is discussed further in the findings chapter.

Following preliminary data analysis, I invited all participants by individual email to attend one member focus group lunch time session with pizza provided. All participants of the member focus group signed a further consent form prior to taking part in the group discussion. I discuss the process utilised to engage with the member focus group in the thematic analysis section later in this chapter.

Data Analysis

There is no prescribed method for carrying out analysis in interpretive description. Thorne (2016) suggested that "the researcher in interpretive description has to build a solid line of inductive reasoning through ideas that may be complex and contradictory and make defensible arguments as to the directional choices made" (p. 155). In this section I will provide a detailed account of my analysis process. Data were analysed using reflexive thematic analysis (Braun and Clarke, 2020). This is a method for constructing themes drawing from qualitative data and is congruent with inductive reasoning and interpretive description methodology (Braun & Clarke, 2020). Terry and Hayfield (2021) argued that "thematic analysis is a flexible analytical method that enables the researcher to construct themes - meaning-based patterns - to report their interpretation of a

qualitative dataset" (p. 3). Thematic analysis provides a systematic, yet flexible, approach to analysing qualitative data which complements interpretive description's emphasis on capturing the complexity of lived experiences and phenomena. Together, they offer researchers a robust toolkit for conducting rigorous qualitative inquiry.

There are multiple ways in which interpretive description and reflexive thematic analysis align. In reflexive thematic analysis the researcher is seen as central to the construction and interpretation of data with their reflexive engagement in the analysis process being important. There is a commitment to reflexivity and acknowledging the subjective influence of the researcher on the research process and findings (Terry & Hayfield, 2021). This reflexivity aligns with interpretive description's focus on generating interpretive explanations that are sensitive to context and researcher perspectives (Thorne, 2016). Reflexive thematic analysis advocates for a fluid, iterative, and recursive process to thematic development. Thorne et al. (2004) maintained that in interpretive descriptive research, processes, data collection, and analysis inform one another iteratively, and thus the shape and direction of the inquiry as new possibilities arise and are considered. Therefore, the iterative process in reflexive thematic analysis, where themes are continually refined and new possibilities are considered (Braun & Clarke, 2020; Terry et al., 2017), fits well with interpretive description methodology as it prompts the researcher to continually interpret and refine findings to ensure they are applicable and provide deeper meaning to the topic under study. Finally, there is an alignment between the underlying premise of interpretive description methodology in guiding a researcher to produce findings that can inform practice, and reflexive thematic analysis which places importance on constructing themes and generating insights from the lived experiences of participants that are meaningful for future practice application and change (Terry & Hayfield, 2021; Thorne, 2016). The elements outlined above evidence the congruency between interpretive description methodology and the choice of reflexive thematic analysis as a qualitative research method in this study.

Key Informant Group

To assist in reflecting on aspects of the study to develop deeper insights and ensure that my interpretations were trustworthy, four RCP facilitators, including two from the original RCP co-design group, agreed to come together at intervals to act as a key

informant group. This group acted to fulfil what Thorne (2016) termed 'thoughtful practitioners', in that their expertise as clinical practitioners and cultural advisors assisted me to build a credible, defensible, and logical line of reasoning and ensure interpretative authority. Te Ao Māori aspects and equity elements were also considered throughout my research, as the Pouwhakaruruhau Matua (the Senior Māori Health Advisor for the HBDHB) was part of my key informant group. Other members included a clinical psychologist, nurse educator, and a pharmacist. I engaged with this group at key turning points to present emerging or developing concepts or themes, and the richness of the discussion that ensued assisted me to see new patterns and develop other meaningful constructs. The touchpoints of when I engaged with this group are woven through the data construction and analysis sections of this chapter.

Reflexive Thematic Analysis

The six phases in reflexive thematic analysis provided me with a process to immerse myself in the data by reading and re-reading transcripts to familiarise myself with the material. Initial codes were then generated to label relevant features. These codes were grouped into patterns and refined by continuing to query them, searching for other meanings or alternate pattern formulations. Patterns were then grouped into potential themes which were queried and reviewed to ensure they adequately represented the data. Theme definitions were then developed to capture the core premise of the theme, and themes were then named. Finally, the analysis was written up linking the themes identified back to my research question. Examples of the data analysis strategies that I used at each of the six stages are outlined in Table Four below.

Table 4.

Six Phases of Data Analysis

Phases of thematic analysis (Braun & Clarke, 2020)	Data analysis strategies utilised in this study
1. Familiarisation with data	• Writing field notes after each interview • Reading interview transcripts • Engaging with interview transcripts again to gain early insights • Discussion of thoughts and early reflections with Supervisors
2. Generating codes	• Initial notes on concepts made in transcript margins • Creating meaningful labels from the data • Continual questioning of these initial labels
3. Constructing themes	• Collating data relevant to each of the codes and labels generated in step 2 • Extracting common patterns • Active process of pattern formulation and identification of concepts on large newsprint posters • Re-reading interview transcripts to look for more nuanced ideas not yet captured in the analysis • Member focus group session to develop new meaning of the participants collective experiences • Review member focus group data to look for additional patterns • Interpretive analysis of data
4. Reviewing potential themes	• Reviewing early patterns to ensure they capture the meaning of the collated data • Looking for variations between patterns • Merging experiences that are aligned or share a pattern • Checking for meaning against any new data • Revising, reviewing, and re-constructing any new ideas or patterns • Interpretive analysis of data • Presentation to key informant group (thoughtful practitioners) to check for resonance with provisional themes • Themes definitions are written
5. Defining and naming themes	• Themes are pulled together, further constructed, and refined • Themes are defined • Themes are named
6. Producing the report	• Moving forward to encapsulate these themes in findings, provide implications and recommendations for clinical practice • Provide discussion anchoring findings back to relevant literature about what is already known in the field and what new information this research puts forward

1. Familiarisation with Data

After each interview I wrote field notes and reflections on some of my early thoughts, capturing aspects that the participants had highlighted regarding the enablers and barriers to implementing RCP. After reading the transcripts, I listened to the interview recordings again. Thorne (2016) argued that listening intentionally for inflections, pauses, and emotion behind the words can enable threads and layers of meaning to be identified which may be hidden when engaging with transcripts alone. Immersing myself in the interview transcripts assisted me to absorb the essence of what was being said to more fully understand the participants' experiences and guided me to listen for meaning beyond the words. For instance, on relistening to an interview transcript where a community occupational therapist articulated that she found it easier to take a social worker with her on some home visits, her hesitance and inflection around this point made me listen for deeper meaning. The pause and emotion behind the words appeared to indicate that this occupational therapist felt less confident and/or comfortable on home visits. I made a note to explore this further in the member focus group, which was the catalyst for a discussion about the dynamics of different contexts and the subsequent impact on implementing RCP. Thorne (2004) suggested that in interpretive description methodology the researcher needs to "find the knowable, moving beyond the self-evident to illuminate the phenomenon under investigation, in a new and meaningful manner" (p. 4).

2. Generating Codes

In this stage of the analysis process I started to work with the data more systematically to begin generating broad codes. In reflexive thematic analysis coding is a fundamental step to add meaning to chunks of text and to start to identify patterns across data; but this process has the potential for the researcher to overlook the richness and variability of participants' experiences (Terry & Hayfield, 2021; Thorne, 2016). Interpretive description methodology places importance on preserving the contextual meaning and depth of participants' lived experience (Thorne; 2004). To reconcile this tension, I approached coding as a flexible, iterative process allowing codes to be generated and changed as new insights emerged during the analysis process. In my initial coding I was particularly attuned to factors that assisted or limited the embedding of RCP into practice to assist me in coding the data.

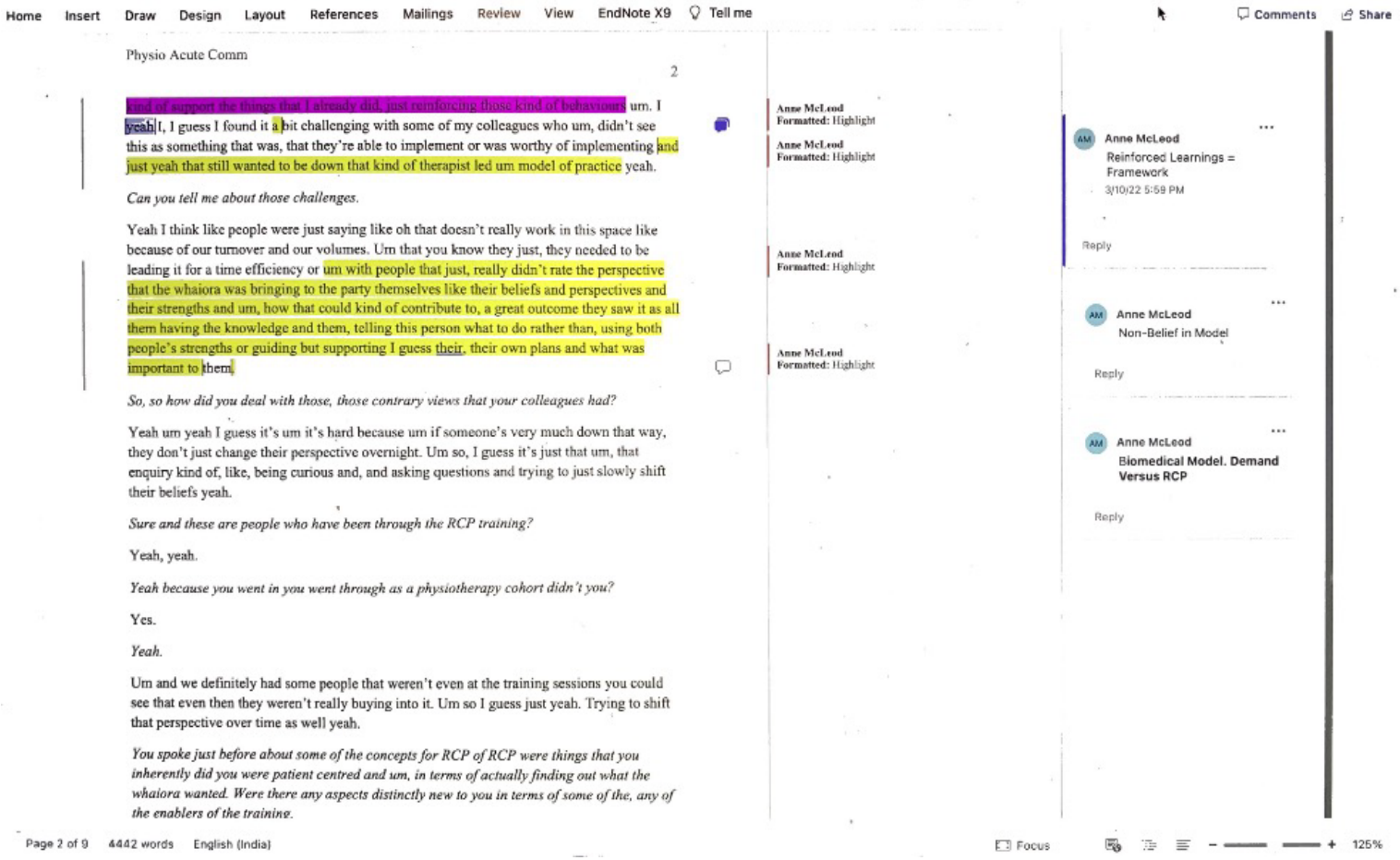
In reflexive thematic analysis capturing an idea and looking at what links or unites this idea to make sense of the data in a meaningful way is important (Braun & Clarke, 2023). In the transcript margins I wrote notes to capture early ideas and thoughts as shown in the transcript snip in Figure 3. There were some initial meaning-based concepts that started to become apparent as coding progressed. I began to colour code the individual interview excerpts on the transcripts (see below example) according to the different ideas or meaning-based concepts that I had noted in the transcript margins. This colour coding was for ease of referring to the interview notes later when I came to the stage of constructing potential themes.

This coding process resulted in between eight and 13 different data concepts being highlighted and generated from each interview transcript. Coding data in this way meant that I could use the codes to connect data across interviews and topics into very loose clusters of concepts. Braun and Clarke (2023) suggested that drawing together data that is connected to even seemingly unrelated topics, can be useful if the core idea or meaning is evident.

The depth of engagement in the data, and using an organic and iterative process to parse out and link the data pieces, is vital in this early stage of reflexive thematic analysis in order to generate codes (Braun & Clarke, 2023). Braun and Clarke (2023) suggested this process assists the researcher to move past the superficial and obvious about what is already known to create more meaningful linkages and deeper interpretations. With this in mind, I generated meaning-based linkages and coding labels on A3 sheets of paper (see Figure 4) from the data segments written in the transcript margins. Examples of the meaning-based coding labels included “Best Evidence Practice versus Patient Choice” which grouped together data pieces where patient choice about their health care differed from the health professionals’ disciplinary practice knowledge which appeared to be a barrier to implementing RCP. Another example of a coding label was “Biomedical Model Ruling” which included data segments like “medical power imbalance”, “not supporting whaiora choice”,and “telling the patient what to do from an expert lens” (highlighted in yellow in Figure 3).

Figure 3.

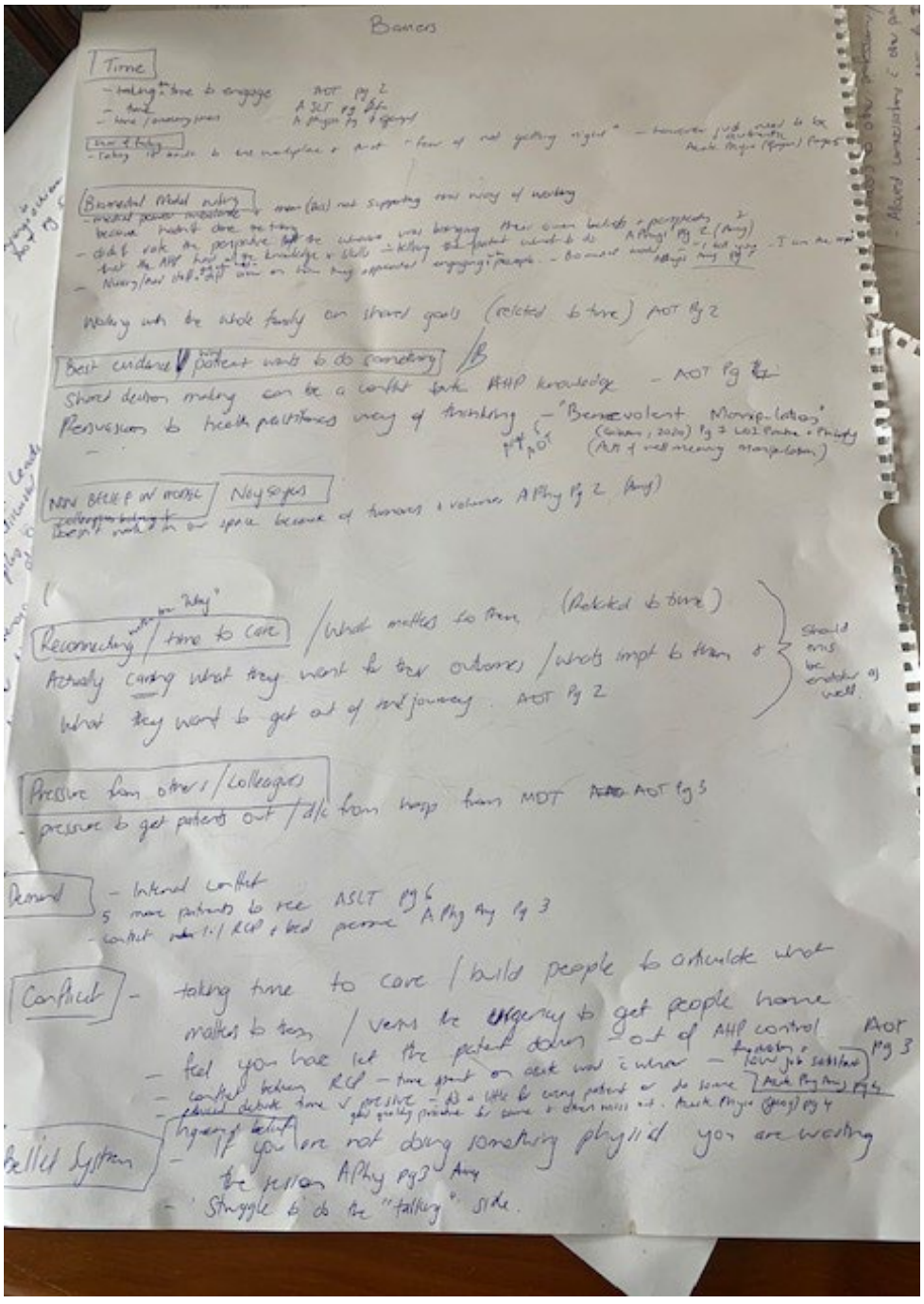
Example of Margin Notes of Early Ideas from A Transcript



These statements highlighted a perceived barrier to successfully embedding RCP into practice by a participant. On the A3 Coding and Labelling sheet, I also referenced statements with participant number and transcript page number so the statements could be tracked back to the full transcript (see example in Figure 4). Some of the data concepts were disregarded later if they had no relation to other data segments or appeared to be one-off ideas.

Figure 4.

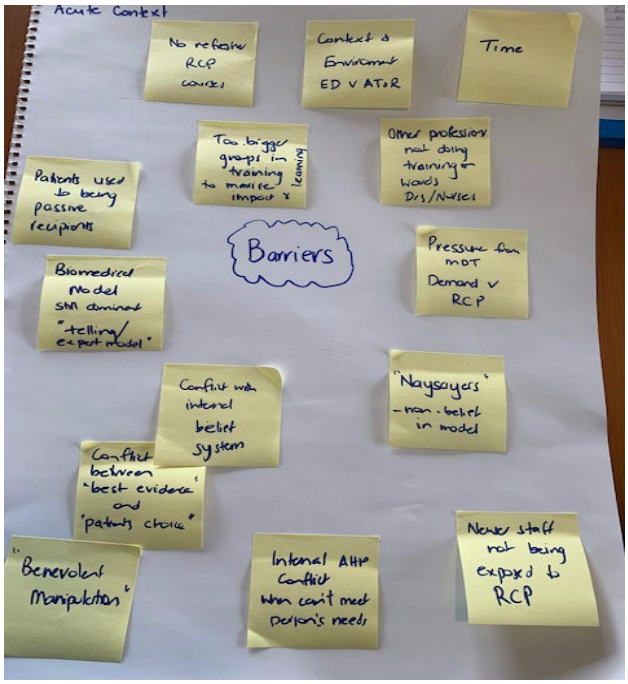
Example of my Initial Broad Coding and Development of Meaning-Based Labels



I then returned to the individual transcripts and my field notes to look for nuances within what participants were saying that I may have missed the first time around. This led to the generation of one additional coding label and linkage of two more data segments that I had initially missed. The label was “Context and Power Dynamics” signalling the difference between working in community and acute environments. This came from data segments highlighting the subtle change in power dynamics that appeared to occur in the community context between AHPs and whaiora, with the whaiora perceived to have more control in the home environment. I made a field note to further check this coding label with participants in the member focus group session. I used sticky notes to put these codes on A3 pages, separating them into what I perceived as barriers or enablers in implementing RCP (see Figure 5). By separating codes into barriers and enablers I was using what Braun and Clarke (2020) termed ‘bucket’ analysis; that is, grouping similar codes or data segments into broader categories or buckets. This process is a critical step in analysis, as it helps researchers move from raw data to more abstract themes. I also divided these initial codes into acute and community barriers and enablers, as one of my research questions focused on whether context had any bearing on the implementation of RCP (see Figure 5).

Figure 5.

Example of Coding



3. Constructing Themes

At this stage I moved forward to start capturing the patterns across the meaning-based coding labels previously constructed. A pitfall for many researchers drawing on interpretive descriptive methodology is making assumptions about patterns or reaching themes too early. Rigorous analysis means taking things apart, putting them back together, and searching for other meanings beyond what is obvious, deconstructing and looking for other meaningful interpretations (Thompson-Burdine, 2021; Thorne et al., 2004; Thorne, 2016). I was mindful not to solidify themes too early in my process. I was also aware that Thorne (2016) cautioned to initially utilise "broad based coding schemes until the researcher has moved a reasonable way into the analysis, so as to be able to take a higher helicopter viewpoint of what she terms "the evolving whole" (p. 161). To that end, in the early phases of analysis I referred to 'concepts' (rather than themes) when trying to group codes together and develop my thinking about higher levels ideas so as to avoid prematurely consolidating themes. I considered 'concepts' to be broader based ideas which held the codes together, with clear boundaries around each. Meaningful concepts needed to be constructed that were anchored and grounded in the data using the interview extracts to give them credibility (Terry & Hayfield, 2021). During this process, I came to realise that my meaning-based coding labels could reflect an enabler as well as a barrier. For example, RCP assisted some of the research participants to focus on finding out 'what matters' to the whaiora and was perceived as an enabler for reconnecting AHPs with their 'why', their purpose as clinicians taking the time to care.

> *RCP training was a huge reminder of asking our patients what they actually want, what's important to them and really reminding us to advocate for them. They are the reason we are here. It reconnected me to why I do what I do.* (Speech Language Therapist – Acute Tauiwi)

However, it also appeared to become a barrier to implementing RCP, as the time taken to connect with whaiora became difficult to navigate in the context of high caseloads and competing demands.

> *It was hard to be relationship centred when there was pressure from the MDT to get people out and discharge this person from hospital. I sometimes felt guilty but had to remind myself as to whose priorities were the most important.* (Occupational Therapist – Acute Tauiwi)

This insight informed my analysis as I realised that simply classifying something as an enabler or a barrier limited my ability to get nuanced insights. It prompted me to look at what it was about the context that made something a barrier or an enabler.

Once I had categorised these initial broad concepts, I sent a sample transcript, the A3 sheet of initial meaning-based label headings, and my initial broad concepts to my supervisors by email on 3 October 2022 for their perusal and feedback. Being mindful of not constructing themes too early, I left my analysis for several weeks. The guidance I had from my supervisors was to come back to the initial broad concepts and lay them out on the floor and stand on a chair to look down on them to see what else I could see. By viewing the initial broad concepts from another angle and considering what factors were related I was able to illuminate some new linking concepts. Grouping these under barriers and enablers was a starting point and enabled early bucket analysis. However, as analysis developed, I began to see that some of these initial concepts associated with barriers and enablers were out of the AHPs' control, while other elements were within their control. This led me to ask questions to assist in sorting concepts into clusters when constructing theme clusters such as what barriers and enablers were in, and out of, the AHPs' control.

At this stage, in November 2022, I decided to develop a PowerPoint presentation to bring together my emergent candidate concepts, the early concepts that had been constructed thus far in the reflexive thematic analysis process, to present to my supervisors and share with my key informant group and test out my thinking with them. Two of the slides are shown below (Figures 6 and 7; see Appendix H for full PowerPoint presentation). As I am an auditory processor of information, presenting and talking about the initial candidate concepts assisted me in organising my thoughts to develop new insights and make deeper connections that had not been apparent to me prior. Figure 6 shows external enablers for both community and acute research participants

Figure 6.

Example of an Initial Emergent Candidate Concepts Around RCP Enablers

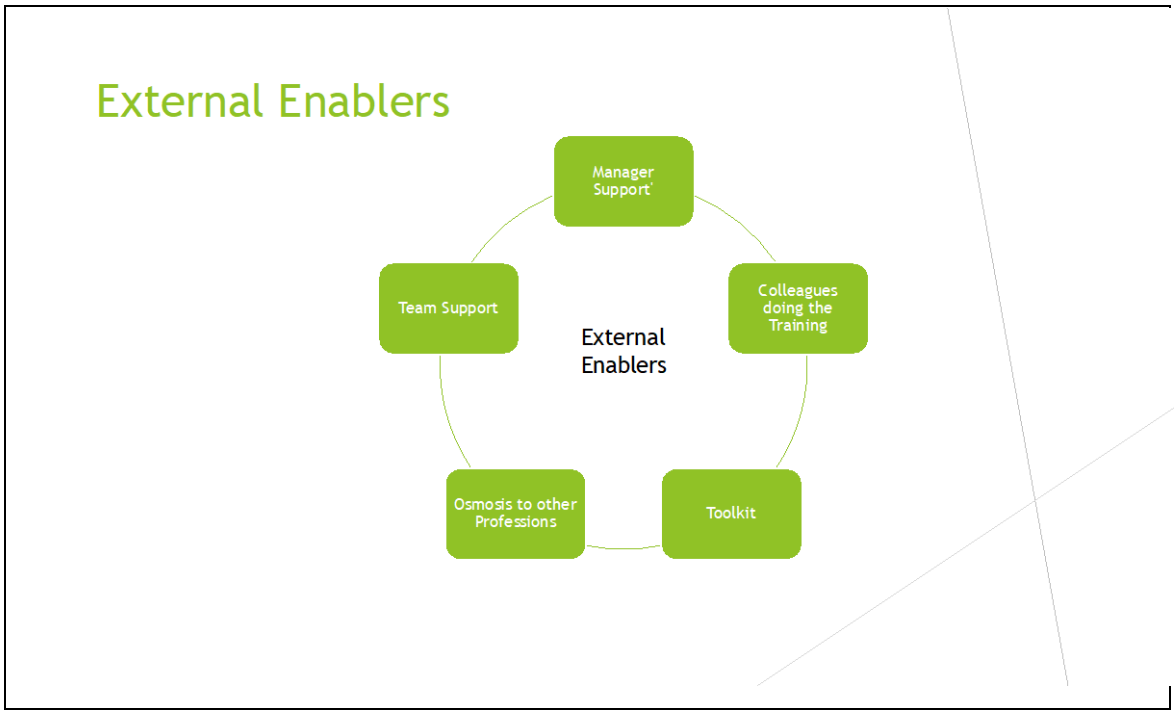
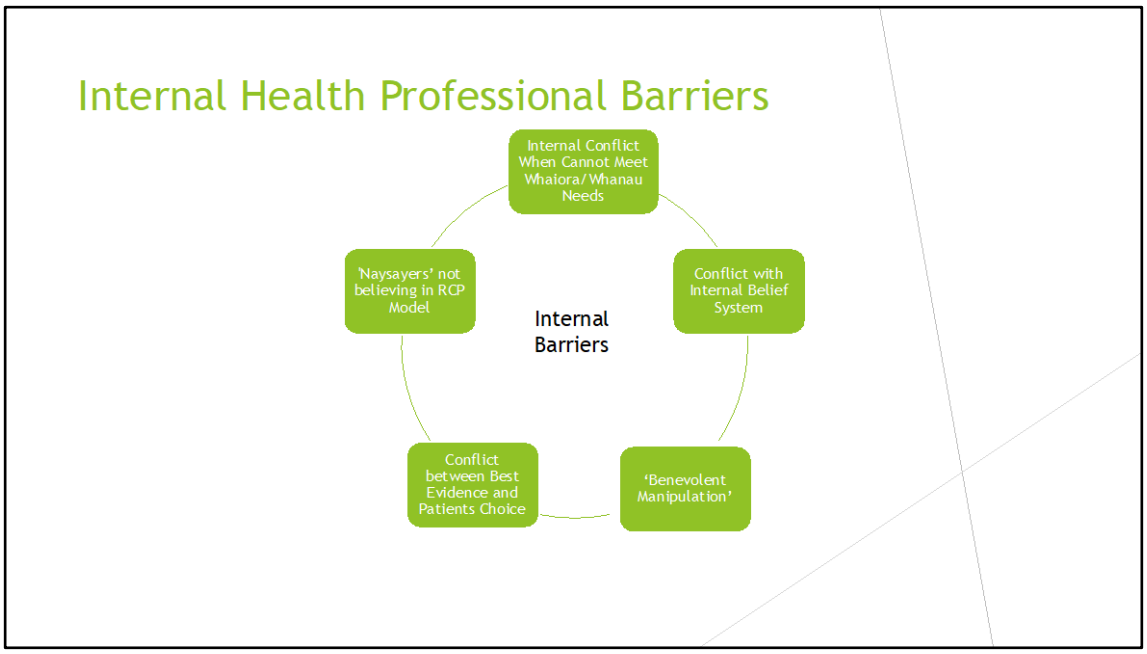


Figure 7 depicts initial candidate concepts around internal barriers that AHPs had articulated which they perceived had detracted them from embedding RCP into practice.

Figure 7.

Example of Initial Candidate Concepts Around Internal Barriers to Embedding RCP



The discussion with my supervisors and the key informant group around the constructed candidate concepts, presented in the PowerPoint, assisted with deconstructing and challenging some of my initial assumptions outlined in my positionality interview, to look beyond the obvious for "what else this could mean?". This was in line with deconstructing and looking for other meaningful interpretations, a core feature of interpretive description methodology (Thompson Burdine et al., 2021; Thorne, 2016; Thorne et al., 2004). Discussing the initial candidate concepts with my key informant group also enabled me to check out the cultural considerations and any nuances that I had made in my initial interpretations, with the Pouwhakaruruhau Matua (senior cultural advisor). Several meaningful interpretations emerged from these discussions. First, it reaffirmed that some of the barriers and enablers that the research participants had identified in embedding RCP into practice appeared to either increase or decrease depending on if they were working in an acute or community setting. Second, the discussion reaffirmed that some of the enablers and barriers appeared to be internal subconscious choices within a AHP's control; while others were external, related to organisational process and culture and outside their immediate control. This assisted me to move my thinking from 'barriers and enablers' to develop a more nuanced understanding on what was impacting RCP implementation.

As outlined earlier in this chapter, member focus groups can provide a platform for participants to co-create new meanings of their experiences and trigger richer dialogue (Thorne 2016). Nicholls (2009b) suggested that focus groups provide a robust forum to gather group experience around their shared meaning of social and cultural assumptions around a particular phenomenon. In early December 2022, I brought together participants who were able to attend into a member focus group and presented the PowerPoint of my initial candidate concepts (see Appendix H). There was general consensus that the candidate concepts were representative of participant experiences of embedding RCP. There was rich dialogue and general agreement around some of the internal conflicts, tensions, and barriers they faced in embedding RCP. For instance, the conflict for them as health professionals setting up expectations with the whaiora around what matters to them and then being pressured by the clinical team to discharge expediently without being able to meet whaiora expectations, provided strong discussion and consensus. It also became apparent that there was an inability for AHPs

to separate out embedding RCP in a community versus an acute setting as at least half the research participants had worked in both settings over the last 5 years. Interesting new insights into the power dynamics between working in the acute wards to AHPs working in whaiora home setting emerged in the member focus group. This reaffirmed my developing analysis and supported movement from the initial candidate concepts to the development of initial candidate themes.

Table 5 illustrates the progression from generating broad based codes through constructing concepts to further constructing candidate themes to finally defining and naming themes in the reflexive thematic analysis process phases 2-5.

4. Reviewing Potential Themes

My initial themes were challenged and reconstructed numerous times with new patterns developing, which led me to code the themes in different ways. This process reflects the iterative and recursive nature of reflexive thematic analysis. I was constantly exploring the range of possibilities of concepts, relationships, and linkages between patterns before drawing any interpretive conclusions (Thorne et al., 2004). Table 5 shows the development of themes from initially coding data segments (phase 2), to constructing initial candidate concepts and thematic development (phase 3) before reviewing (phase 4) and defining and naming themes (phase 5).

Using Terry and Hayfield (2021) process of writing theme definitions, I wrote narratives that articulated the potential themes with no data. In doing so, I was mindful that the themes needed to be clear and cohesive and adhere to a central overarching theme, but be distinct in their own right (Terry & Hayfield, 2021). I brought these narratives together and presented it to my supervisors in late January 2023. An example is shown both in PowerPoint summary form (see Figure 8) and in narrative form (see Figure 9).

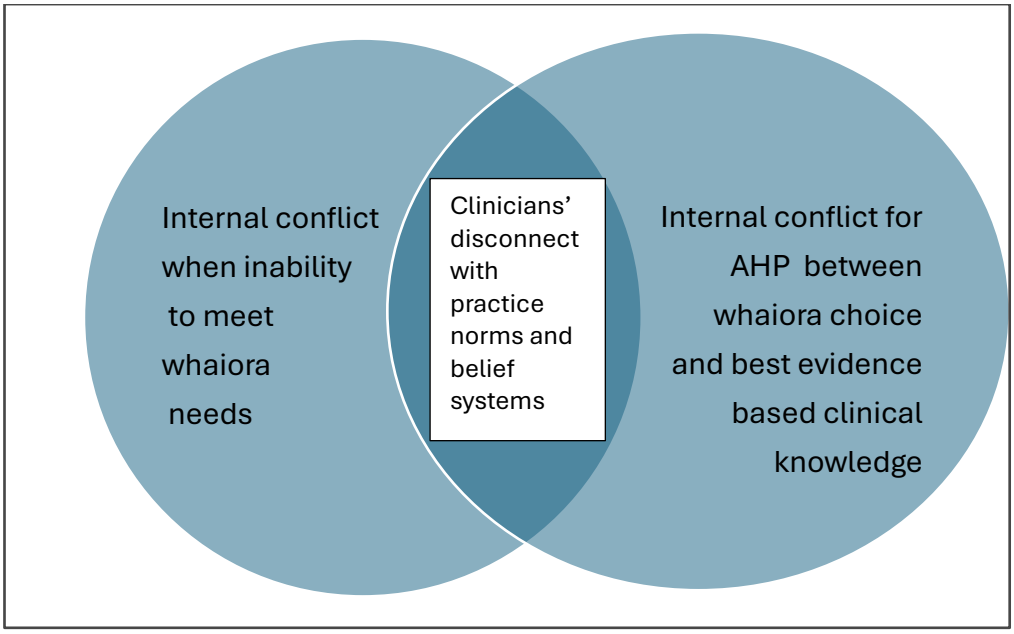
Table 5.

Example of How Themes Were Constructed and Refined Through the Process of Reflexive Thematic Analysis

Phase 2 Generating codes Initial broad codes from data segments	Phase 3 Constructing doncepts Broader based concepts	Phase 4 Candidate themes Theme definitions	Phase 5 Defining and naming themes Final findings
biomedical model dominating	biomedical model disconnect with RCP	biomedical model fallback position in times of high demand and work pressure	clinician's sense of agency restricted due to pressure to prioritise patient flow
tension when inability to meet whaiora need	the practice and value tensions clinicians experiencing	AHPs' internal conflict when inability to meet whaiora need	the internal tension experienced by clinicians
conflict between evidence-based practice and whaiora choice	the practice and value tensions clinicians experiencing	internal tension and cognitive dissonance when disconnect between practice norms and RCP	the internal tension experienced by clinicians
reconnecting with the 'why'	RCP strategies that assist to move through practice tensions	RCP strategies that motivate clinicians	experiencing RCP in action boosted ongoing confidence and motivation
perceived time required	perceptions and influences of spheres of control	what was in clinician's control and what was not	clinician's sense of agency restricted due to pressure to prioritise patient flow

Figure 8.

Example of Theme Definition in PowerPoint Format



5. Defining and Naming Themes

My supervisors challenged me again to look at synthesising these themes even further – 'what was the overarching theme' – and then to look at 'tightening up my sub themes'. I took a step back and was then able to see a bigger theme of 'practice and value tensions' for AHPs. I then used the Circle of Control and Influence Model (Covey, 2020) that often assists me in putting things into perspective to look at what was in the AHPs span of control and what was not; and what, if anything, they could influence (see Figure 10).

Overlaying the Circle of Control and Influence Model (Covey, 2020) across this theme assisted me to view it from a different angle. The barriers appeared to be all around practice and value tensions, and the enablers were the strategies that assisted AHPs to navigate and move through these practice and value tensions. This process enabled me to more clearly define and name the theme (Terry & Hayfield, 2021).

Figure 9.

Example of Theme Definition in Narrative Format

Narrative of Theme One

Internal Conflict When Inability to Meet Whaiora Need (Acute)

The internal conflict that an AHP has when practicing in a RCP way to achieve the whaiora and whānau's articulated need, requests, or goal of what is important to them, and this shared decision-making being hampered or blocked because of patient flow and pressure to discharge and the scarcity or unavailability of resources
(Note - these inhibiting factors are inextricably linked to Cluster One Themes of the prevailing Biomedical model.)

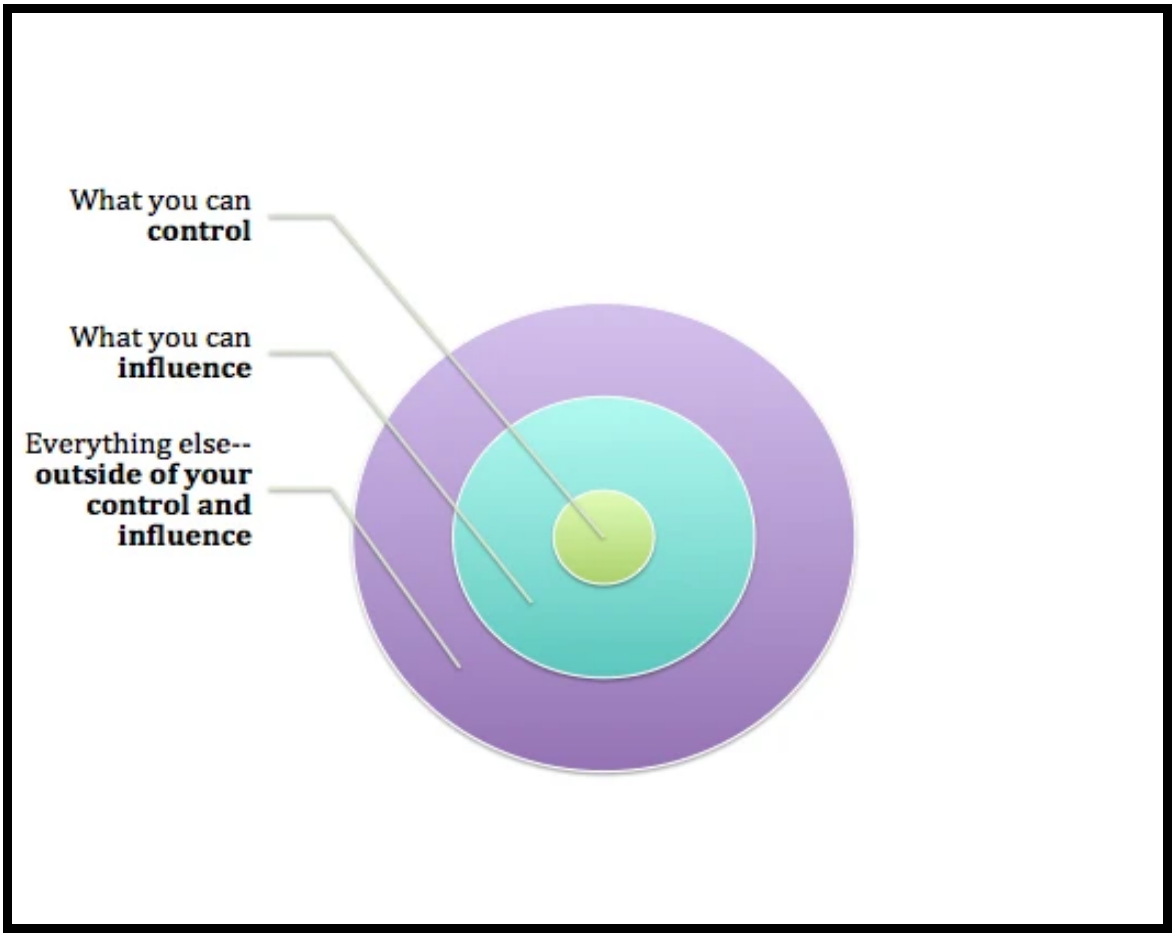
By finding out what is important to the patient through the enabler of the Hui Process and shared decision making in the RCP framework, the AHP has created expectations that these needs/requests or goals are important and that the AHP has acknowledged which of these that they will work towards to try and meet these together with the whaiora and the MDT.

The RCP framework promotes shared decision making between health professional and whaiora/whānau to reach or negotiate an agreement between the patient's articulated needs and the health professionals' practice knowledge. However, when these requests cannot be met the AHPs felt that they had not fulfilled or met the whaiora/whānau needs, leaving the AHP with a sense that they have failed to meet the expectations of the patient and their whānau. AHPs articulated that this left them feeling their sense of worth as a health professional trying to make a difference in the lives of the people they serve had been eroded and undermined which, in turn, impacted on their job satisfaction in that they did not feel fulfilled.

This occurring on more than one occasion has left AHPs hesitant about using aspects of the RCP model to find out 'what is really important' to the whaiora/whānau as the AHP is left feeling disillusioned and unfulfilled for failing to meet the patient's identified needs.

Figure 10.

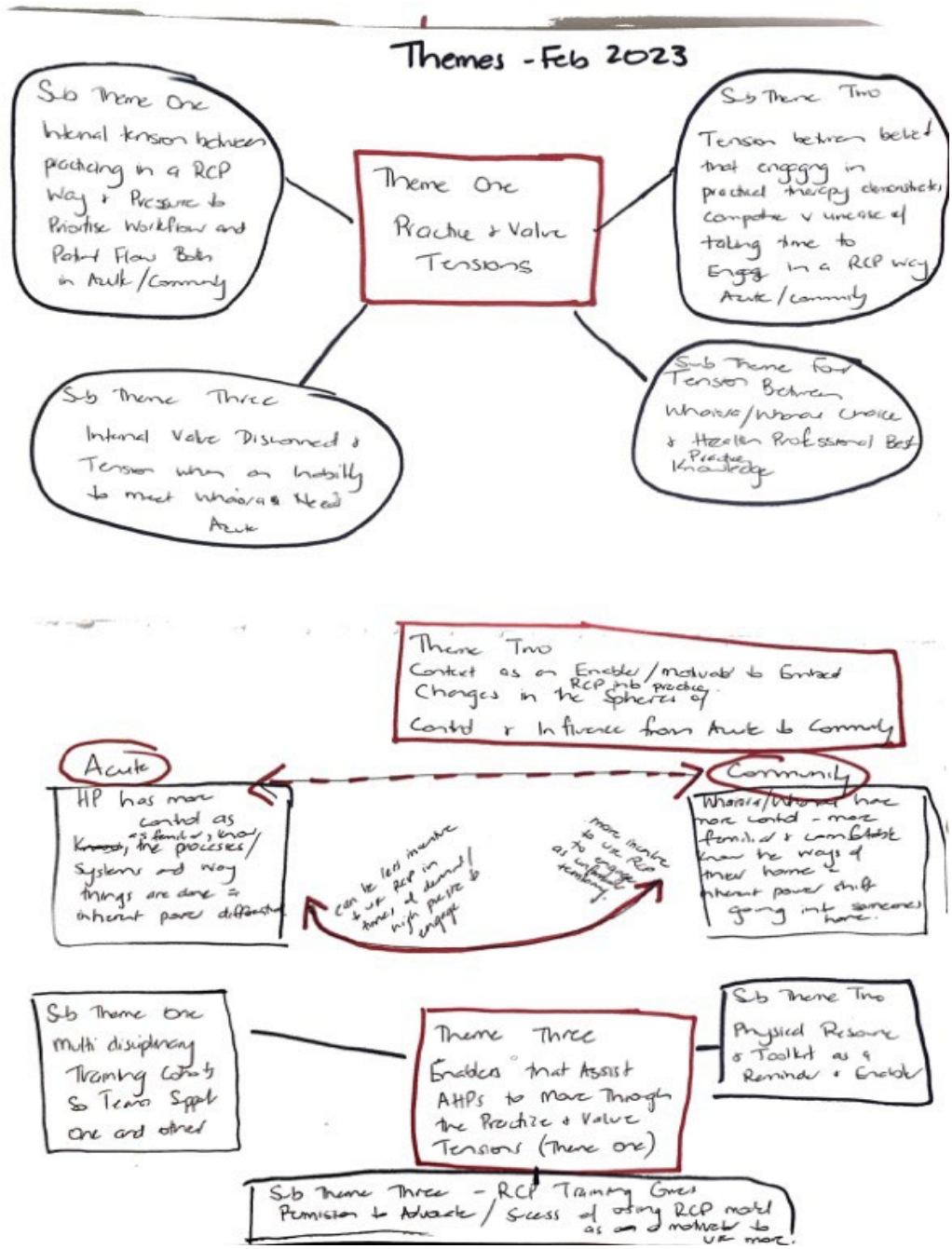
Circle of Control and Influence



(Covey, 2020)

A secondary theme around context was also reconstructed by looking at the original themes in a different way. There appeared to be a subtle change in the spheres of influence and related power dynamics for the AHP and the whaiora between practicing in the acute setting versus practicing in the community setting (see Theme Two in Figure 11).

Figure 11. *Theme and Subtheme Identification*



At this stage I was concerned that there was a more nuanced understanding that I was missing. I felt there was more behind the subtheme of the internal tension clinicians experienced in trying to use RCP when there was pressure to prioritise patient flow. I talked this over in supervision and kept coming back to what health professionals could control and what was out of their control. I then realised that the theme I was missing was that health professionals' 'sense of agency' on being able to implement RCP was

being compromised by the push to address patient demand and ensure expediency of flow. This realisation helped me to reconstruct the theme to 'clinicians' sense of agency being compromised'. I was then able to separate out the practice tensions as this was something health professionals could have control over and merged the other two enabling themes into one. (See Table 5 for the separation of these themes in the final Phase 5 column). At this stage of Phase 5, I felt confident that using interpretive description methodology I had constructed, deconstructed, reconstructed, pulled apart again, and finally reconstructed the raw data through working through the five stages of reflexive thematic analysis. This process assisted me to find new meaningful inductive interpretations of the research material (Thompson-Burdine, 2021; Thorne et al., 2004; Thorne, 2016). I felt comfortable that these ideas represent the essence of the data. I felt excited about the overarching themes and subthemes that had been iteratively and recursively constructed.

6. Producing the Report

The final step in reflexive thematic analysis is moving forward to encapsulate the themes in writing the findings, looking at providing recommendations and anchoring the discussion back to relevant literature about what is already known in the field and what new information the research puts forward. In the chapters that follow, I focus on how these findings might inform future implementation programmes to ensure sustainability of practice, and how these findings might potentially inform future healthcare practice change programmes in Aotearoa New Zealand.

Attention to Rigour

Rigour is imperative in interpretive description to demonstrate credibility and trustworthiness of the study (Hunt, 2011; Thompson Burdine et al., 2021). The congruence between the methodology and method, the strength of the research design, research conduct, robustness of processes, and ensuring findings are grounded and defensible, are all elements of rigour (Caelli et al., 2003; Thorne, 2016; Tracy, 2010). In health research, rigour is especially critical as the findings may prompt changes in health delivery, funding structures, care processes, and have the potential to impact whaiora care and outcomes; thus, it is essential that the findings are credible, defensible, and ethical. The implementation of flawed or inaccurate findings could have detrimental

effects (Thorne, 2016; Thorne et al., 2004; Tracy, 2010). Interpretive description has four markers of rigour: 1) epistemological integrity ensuring that there is a defensible line of reasoning; 2) representative credibility ensuring theoretical claims are consistent with the study sampled; 3) analytic logic demonstrating how my reasoning and inductive interpretation occurred; and 4) interpretive authority, ensuring that my interpretations are trustworthy (Thorne, 2016).

Epistemological Integrity

To demonstrate epistemological integrity, I needed to ensure that my methodology, interpretive description, and its underlying philosophies, were congruent with the research question and methods used in my research. (Caelli et al., 2003; Teodoro et al., 2018; Thorne, 2016; Thorne et al., 2004). In Chapter Four I provided details of how my research question and theoretical scaffolding is consistent with the epistemological standpoint and I showed coherence between the different parts of my research. Earlier in this current chapter I outlined how the data sources and reflexive thematic analysis were consistent with the methodological principles of interpretive description.

Reflexivity is an important part of epistemological integrity to continually reflect on how a researcher's perspectives and assumptions influence their interpretation and understanding of the topic. Unpacking my own experience to gain insights around my own disciplinary influences is an example of an activity that is closely aligned with interpretive description and demonstrates epistemological integrity (Thorne 2016). Thorne (2016) maintained that reflexivity is vital in ensuring transparency around values, pre-existing assumptions, and a researcher's subjectivities. As such, a researcher must also make overt and explicitly account for any influence they have on their methods, design, and research findings (Thorne, 2008). Before staring my data collection, a positionality interview to explore my initial thinking about my research subject was undertaken. This was completed with Gareth Terry, a senior lecturer at Auckland University of Technology on 22 July, 2022. The positionality interview was to bring to the surface and make transparent my initial preconceived stance on my research topic. The interview was also to make overt what the literature review had brought to the fore for me in terms of my understanding of what the barriers and enablers to implementing practice change programmes might be. The positionality interview helped me articulate

pre-existing assumptions I had about what my research might find. Examples of these assumptions included:

1. it would be easier to practice and embed RCP in a community setting
2. pressure of time and acute demand and flow would be the main reasons it would be more difficult to embed RCP

The first assumption influenced my study design as I recruited participants equally from the acute and community place settings. The second assumption was dominant in my thinking through Phases 1 to 3 of the thematic analysis process, and I had to hold that while also looking beyond to gain a deeper understanding of other impacting factors. While pressure of time and acute flow were a central tenet in informing my final themes, my research findings highlighted a deeper and more nuanced reasoning as to why this meant RCP was difficult to embed.

The positionality interview also formed part of my theoretical scaffold, as outlined earlier, and ensured that I was being overt about the impact of my disciplinary influence and any pre-conceived ideas. For example, as a social worker and a coach, being relational was integral to the way I worked; so I had a belief that this was an important factor in health professionals' engagement with whaiora and whānau. It was essential that I unpacked this belief to ensure that I was being transparent about it in my selection of the research topic, research methods, and analysis to document the influence this may have had as these undoubtedly coloured and shaped by my values, discipline, and background (Caelli et al., 2003; Teodoro et al., 2018; Thorne, 2016). For example, my background as a social worker and a coach facilitator had influenced my thinking that all AHPs would embrace RCP once the rationale was explained and the training was provided. This assumption initially shaped my participant interview questions. After the first interview I reviewed the transcript and on discussion with my supervisors realised that I needed to expand the questions to understand their thoughts on what RCP was and what value, if any, it provided. Ongoing supervision from my doctoral supervisors enabled my ongoing reflection and assisted to challenge my thinking, assumptions, and decisions throughout the research process. Making notes and journaling after the positionality interview and throughout the data collection and analysis stages enabled ongoing reflexivity.

Representative Credibility

Ensuring theoretical claims are consistent with the sampling that occurred is termed representative credibility (Thorne, 2016). To ensure representative credibility, I used triangulation which refers to the use of multiple data sources to develop a comprehensive understanding of phenomena (Carter et al., 2014; Sandelowski, 1995a). Data source triangulation involved purposive sampling to collect data from a range of different allied health disciplines and from a range of settings to ensure a richer account of the research phenomenon emerged (Thorne 2016). I purposefully sampled to ensure at least 25% Māori in my sample as reflective of the population demographics. The research participants' backgrounds and places of work are outlined in the findings chapter. I also used different methods of data collection about the same phenomenon to gain deeper knowledge (Carter et al., 2014; Sandelowski, 1995a). The use of interviews, member focus groups, and my key informant 'thoughtful practitioner' group elicited rich information about individual and collective perspectives, which provided a more nuanced and deeper understanding that further enhanced credibility of my research topic. It is important to note that I have not made claims in my findings beyond what is reasonable given the sample, which is a key aspect of representative credibility.

Analytic Logic

Analytic logic refers to making explicit the reasoning of the researcher from the foregrounding of the research through to the interpretations, findings, and new knowledge put forward (Thorne, 2016). It is, therefore, demonstrating the process of how my inductive interpretation occurred, to make my reasoning logical and transparent for readers to follow (Thorne, 2016). The constructing, deconstructing, and constructing again the themes over a 5-month period, through multiple approaches—my own analysis, discussions with my supervisors and my key reflection group—were all important in ensuring analytic logic was maintained.

The process of my inductive analysis and interpretation has been already documented in the thematic analysis sequence of data familiarisation, construction, and analysis outlined earlier in this chapter. At each stage, I looked behind the developing constructs for other patterns, linkages, and the deeper implications from all possible angles. I have made clear my lines of reasoning and checked it with my key informant group to ensure

my interpretations were in alignment with my methodology, that they were credible, and that I was demonstrating a logical development of my reasoning (Thorne, 2016). The use of participant quotes in my findings chapter guides the reader to follow my analytic logic and reasoning that provide the basis to the findings. I tracked this process and my positionality through my journaling, supporting reflexivity and providing evidence of logical development in my reasoning (Teodoro et al., 2018; Thorne et al., 2004).

I engaged reflexively with my positionality in an ongoing way throughout the analytic process to avoid some of the pitfalls that Thorne (2016) suggests can occur. For example, in the constructing data stage, I could have easily reached the conclusion that participants found it easier to use RCP in community settings and thereby fallen into the pitfall of what Thorne termed 'premature closure'. Premature closure is shutting down an idea too early and assuming that an initial insight is the only meaningful interpretation of the data (Thorne, 2016). Being mindful of the risks of premature closure, I remained open to more nuanced insights of the differences in power dynamic between the acute and community contexts for AHPs. I gained a deeper understanding that some participants felt less empowered in unfamiliar territory within whaiora homes in the community context.

Interpretive Authority

I also needed to be overtly clear about any claims made, ensuring that my interpretations were trustworthy. Thorne (2016) termed this element of rigour, interpretive authority. Interpretive authority can be demonstrated by being transparent about the claims being made, and testing out findings to ensure they are not subjective conclusions massaged to fit one's own version of the truth (Altheide & Johnson, 1994; Thorne et al., 2004). To assist me to reflect on aspects of the study to develop deeper insights and ensure that my interpretations were trustworthy, I met at intervals with my key informant group, whose purpose was discussed earlier in the chapter. Their expertise as clinical practitioners and cultural advisors assisted me to build a credible, defensible, and logical line of reasoning, and ensure interpretive authority. Te Ao Māori aspects and equity elements were also considered throughout my research, as the Pouwhakaruruhau Matua was part of my key informant group. I shared PowerPoint presentations at each of the three formal key informant reflection group sessions and the richness of the

discussion that ensued assisted me to see new patterns and develop other meaningful constructs. I took field notes during the session and immediately afterwards to capture the essence of the discussion, noting any new patterns and constructs that may have been constructed. The key informant group assisted to challenge my thinking and test my interpretations. For example, this group of thoughtful practitioners challenged me to think about the siloed way I was looking at the different workplace contexts and enabled me to see there was more of a continuum of enabling factors in implementing RCP from the acute to community settings. This will be further discussed in Chapter Six – Findings.

The notion of member reflections is embedded within interpretive description as a mechanism for checking the researcher's understanding of participants' contributions, explore if preliminary findings resonated for them, and to test assumptions that may be inherent in my early interpretations, as discussed previously (Thorne, 2016). Bringing the participants back together in the member reflection group session assisted me to check for resonance and test for any assumptions in my findings to further ensure credibility and interpretive authority of my study.

Developing practice insights is pivotal in interpretive description methodology. As already discussed, rigour in terms of epistemological integrity, representative credibility, analytic logic and interpretive authority are vital to ensure the research findings and claims made are robust. However, as Thorne (2016) argued, researchers have to also continually critique "the products of qualitative research taking into consideration the larger disciplinary, social and historical contexts within which they were produced" (p. 236). Ensuring rigour is particularly important in interpretive description as findings can inform future practice and service delivery in the health arena and need to be robust. As such, Thorne suggested that by looking beyond the main evaluation standards in a qualitative study a researcher can ensure enhance credibility and make the research stronger. Other aspects of rigour that are particular to interpretative description are disciplinary relevance, pragmatic obligation, contextual awareness, probable truth, and moral defensibility. The marker of rigour that was particularly relevant to this study was moral defensibility (Thorne, 2016). Moral defensibility includes having convincing rationale of why the knowledge we are constructing is necessary, and that the processes used in the research are ethical and moral. While constructing the initial candidate

concepts, a burgeoning concern was emerging for me which was confirmed in discussion with the member focus group. That concern was around whether we (RCP facilitators) were inadvertently creating a moral injustice for our whaiora and health professionals in the teaching of the RCP programme. There was a sense that in encouraging clinicians to find out 'what really mattered' to the whaiora, through Te Ao Māori models of engagement, we were setting AHPs up to fail when they could not meet these whaiora expectations within the scope of their work. The process I used to address and mitigate this concern will be discussed comprehensively in Chapter Seven, implications and recommendations, which will demonstrate the integrity and the moral defensibility of this doctoral study.

Ethics Approval

Ethics approval was sought in January 2022 from Auckland University of Technology Ethics Committee (AUTEC) and granted on 23 February, 2022 subject to meeting certain conditions (see Appendix I). AUTEC raised concerns about my position as Director of Allied Health at HBDHB and whether there were conflicts of interest and associated power imbalances given my leadership position within the organisation. In my role as Director of Allied Health, I did not have any line management, performance management, or budgetary responsibility for any of the AHPs, and none of the AHPs directly report to me. My role was more of advocacy and support to ensure AHPs were able to be as effective as possible in delivering high quality healthcare with equitable outcomes in their everyday work. In this role, I was a champion of the workforce on matters affecting them and provided a balanced approach to the group leadership decision-making. I discussed these concerns with my supervisors and Dr John Gommens, Chairperson of the HBDHB research committee. They all supported the research and felt AUTEC concerns could be addressed and mitigated.

I submitted an organisational structure and position profile so AUTEC could see where I was positioned. To further address AUTEC concerns I ensured transparency in the Participant Information Sheet about my role outlining any possible risks that may arise as a result. This transparency ensured potential participants were able to consider whether or not to participate with that in mind. If participants had any concerns about my conduct in this dual role (leader/researcher) I supplied the details of a senior human

resources advisor in the Participant Information Sheet as someone they could contact. This ensured that the participants had an avenue to address any issues that might arise through the course of their involvement in this study. Additionally, the Participant Information Sheet was amended to include advice about conflicts of interest and any perceived power imbalances and how these would be managed. It included statements around the level of confidentiality, the voluntary nature of participant involvement, measures to ensure participant safety, and processes for reporting any concerns. Guidance on how to access counselling was also included (see Appendix F for amended Participant Information Sheet). Further information addressing these concerns was furnished to AUTEC in February 2022. After discussion clarifying my position between my primary supervisor and the AUT ethics advisor, final ethics approval was given by AUTEC on 29 March, 2022 (Appendix J). Ethics approval was sought from and approved by the HBDHB Research and Ethics Committee in April 2022 (See Appendix K).

Cultural Considerations

As my research was taking place in Aotearoa New Zealand it was imperative that it met the obligations of Te Tiriti o Waitangi (Waitangi Tribunal, 2019). My research needed to be equity focused, culturally responsive, and make a contribution to improve health equity for Māori (Reid et al., 2017; Wyeth et al., 2010). The following principles of Te Tiriti o Waitangi (Waitangi Tribunal, 2019) were applied throughout this doctoral study:

Partnership: I talked through my initial research ideas and the design and methods with the Pouwhakaruruhau Matua to get cultural guidance. Working in partnership with the Pouwhakaruruhau Matua was integral to ensure alignment with tikanga (in my design and methods) and integrity of cultural understanding (in my interpretation of findings) was maintained.

Participation: Māori involvement was sought both at participant and advisory levels to ensure Te Ao Māori aspects of implementing RCP were considered, and that the interpretation of findings relevant to these were culturally appropriate. The member focus group included both Māori AHP participants. It was in this forum that I checked my understanding of some of the statements from the interviews to ensure that I was not putting my Tauiwi (non- Māori) interpretation and worldview on what had been

transcribed from the initial interviews. This links to the next principle of tino rangatiratanga, people's rights to self-determination.

Tino Rangatiratanga: I worked to ensure that Māori participants had self-determination or tino rangatiratanga by making sure they were voluntary participants and reminding them of their right to withdraw from the study at any time. As the researcher I was led by where participants felt comfortable being interviewed, starting and finishing with a karakia (a te reo Māori term meaning prayer or blessing), respecting their worldview and values. The interview format followed the Hui Process framework as described in Chapter Two to ensure all AHPs interviewed, especially Māori, felt comfortable with the process and that I, as the researcher, was culturally responsive through the process (Pitama et al., 2017).

Equity: Māori make up 27% of the Hawkes Bay population, and 13% of AHPs working at HBDHB. As already discussed, through voluntary recruitment I was able to recruit two AHPs who whakapapa Māori (a te reo Māori term used to describe the ethnicity one identifies with) within each of the settings through purposive sampling. This ensured that the study participants reflected the population demographics and percentage of Māori living in Hawkes Bay, and further supports data credibility and transferability (Thorne, 2016). Another reason for focusing on ethnicity was that the theoretical scaffold of the Aotearoa New Zealand literature review, as outlined in Chapter Three, evidenced that equity was one of the barriers to effectively implementing relational ways of working in to health professionals practice. I believed the findings would be more robust and support data credibility by ensuring that the sample reflected the ethnicity demographics of the Indigenous Māori population. The recommendations (see Chapter Seven) have an equity focus and take into consideration what factors are needed for AHPs to be more culturally responsive when embedding RCP. In the discussion (see Chapter Eight), the He Pikinga Waiora Framework was used to critically reflect on and evaluate the implementation of RCP using a cultural lens (Oetzel et al., 2017).

Protection: Honouring and respecting cultural concepts, tikanga, and equity were considered throughout my research through engagement with the Pouwhakaruruhau Matua as an integral member of the key informant group. The interview questions

followed the Hui Process and were reviewed and slightly modified by Matua to ensure cultural responsiveness prior to being included in my ethics application (Pitama et al., 2014). At various intervals, I met with the Pouwhakaruruhau Matua to discuss the cultural nuances, obtain guidance, and to ensure I was not misinterpreting data by applying my Tauiwi lens.

All these factors combined to ensure that I was meeting the obligations of Te Tiriti o Waitangi and being culturally responsive throughout my research.

Conclusion

The design of this study was consistent with interpretive description methodology (Thorne, 2016) and enabled the exploration of many different complex elements and features surrounding RCP implementation using reflexive thematic analysis (Braun & Clarke, 2023). Responding to the practice and the cultural context of HBDHB, engaging with multiple parties, and utilising techniques such as the member focus group and the key informant group added an additional layer of richness and rigour to the research process. This chapter has shown how interpretive description methodology laid the foundation for the study findings. I will now turn my attention to focus on these findings and the rich insights that this study has brought to the fore.

Chapter Six – Findings

This study aims to identify factors that impacted the implementation of Tikanga Ako Hono-Tāngata – RCP at HBDHB, by exploring the subjective experiences of AHPs who have undertaken training for this programme. Interpretive description, a qualitative research methodology, was used to assist in answering three questions:

1. What helped or hindered the implementation of RCP by AHPs?
2. What role did context and practice setting have on the meaningful implementation of RCP?
3. What is perceived to support sustained practice change for AHPs?

In this chapter I focus on the findings constructed in Phase 5 of the thematic analysis process. I then outline the research participants' demographics before going on to present the findings that were developed from interviews and member focus groups that explored my research question. As previously described, I analysed data using Braun and Clarke (2020) reflexive thematic analysis within the context of interpretive descriptive methodology (Thorne, 2016) to guide theme development. The three main findings are discussed in depth with supporting participant quotes that reflect the diverse lived working experiences of AHPs and the realities they have faced in trying to embed RCP into their practice.

Participant Demographics

Twelve AHPs responded to the invitation. One was an AHP who took part in the RCP training in the time that I was a facilitator and so was excluded consistent with the exclusion criteria. Of the 11 remaining, four were members of the same Oral Health Community Team. Consistent with my sampling strategy, where I was prioritising a breadth and diversity of perspectives, I only selected one of the four potential participants to interview. I determined there would be a lot of similarity in the perspectives from the group given they worked in the same team. In the context of limited resource, I prioritised diversity in the first instance. While I had two Occupational Therapists and two Physiotherapists in the sample, these participants were purposefully selected as, although they were from the same profession, they provided diversity of perspective as they differed in their of work area - the one in the community and one in

hospital acute care context. Given this, eight people were invited to proceed to interview. All consented to take part. All participants were AHPs working at HBDHB in either the acute or community settings. As I was interested in how setting and context influenced uptake of RCP, I aimed to recruit an equal representation of AHPs who worked in the acute and community settings. Details for each participant are included in Table 6. Their places of work have not been included as this information would risk de-dentification given the size of the hospital and community services. Summary details have been provided. Of the eight participants, six are Tauiwi (any person who is not Māori) and two are Māori descent. Seven identified as women. They were from a range of professions including occupational therapy, social work, speech-language therapy, physiotherapy, oral health, and pharmacy.

The acute AHPs worked in the paediatrics, surgical, assessment treatment and rehabilitation (AT&R), and intensive care wards. As HBDHB is a smaller regional hospital, the AHPs provided cross-cover support to other wards at times. Work settings for the community participants varied from a clinical pharmacy facilitator working in a general practitioner hub to an oral health therapist working in a community hub to two allied health therapists working in a community and early supported discharge teams.

Table 6.

Participant Demographics

Profession	Ethnicity	Pseudonym	Number of years' experience	Acute or community experience	Year RCP training completed
Pharmacist	Tauiwi	Jane	15-20 years	Community	2020
Physiotherapist	Māori	Hine	11-15 years	Community/Acute	2017
Oral health therapist	Tauiwi	Trish	25+ years	Community	2018
Physiotherapist	Tauiwi	Beth	5-10 years	Community/Acute	2017
Social worker	Māori	Bobbi	5-10 years	Acute	2018
Occupational therapist	Tauiwi	Trudy	5-10 years	Acute	
Speech language therapist	Tauiwi	Sarah	5-10 years	Acute	2019
Physiotherapist	Tauiwi	Lisa	5-10 years	Acute	2019

Pseudonyms are used for participants to provide anonymity and make the findings easier for the reader to follow.

Findings

Three themes were developed through analysis:

- Theme One: Clinicians' sense of agency was restricted due to pressure to prioritise patient flow and expediency.
- Theme Two: The internal tension experienced by clinicians.
- Theme Three: Experiencing RCP in action boosted ongoing confidence and motivation.

Theme One offers insights into the structural and systemic factors that impacted the implementation of RCP and clinicians' sense of agency. Sense of agency refers to the sense of control one has over their deeds or actions (Barlas & Obhi, 2013; Haggard & Tsakiris, 2009). The findings highlighted that the prevailing norm of prioritising workflow and expediency over practicing in a RCP way often compromised a clinician's sense of agency. However, when clinicians had a stronger sense of agency in less demanding settings, where there was not such a focus on expedient patient flow, a tension still existed between the dominant norm and implementing RCP. These findings suggest that for many clinicians RCP was not embedded as 'usual care'.

Theme Two reflects the practice challenges clinicians experienced when trying to use RCP and the resulting internal tension they sometimes experienced. This manifested in three distinct ways. First, clinicians felt tension when they were unable to meet people's expectations and goals that had been identified through the process of engaging in RCP. Second, when there was a lack of alignment between the clinician's best practice knowledge and patient choice. Finally, when a tension occurred between a clinician's discipline-specific norm of providing practical hands-on treatment and the RCP ethos of taking the time to engage with the patient.

Theme Three explores how positive experiences of using the RCP strategies empowered and enabled clinicians to be confident and motivated to embed RCP into their practice. Seeing the positive outcomes of making a real difference in the lives of whaiora and whānau appeared to be a catalyst and motivator for clinicians to continue using RCP.

Theme One – Clinicians' Sense of Agency was Restricted due to Pressure to Prioritise Patient Flow and Expediency

Overview

The findings indicated that clinicians working in acute settings felt pressure to prioritise aspects of work that enabled expediency of service delivery, patient flow through services, and active discharge. Participants perceived it was these factors that influenced their decision not to prioritise RCP. In essence, it appeared that clinicians' sense of agency to work in ways consistent with RCP was compromised in four distinct ways. These were:

1. the perceived pressure to prioritise expediency and workflow compromised clinicians' ability to be relational in practice;
2. clinicians' perception that RCP took more time to enact became a barrier to using RCP strategies when workloads were high;
3. mitigating clinical risk could override the decision to practice in a relationship-centred way;
4. the perception that clinicians were being negatively judged by colleagues when seen to be taking time to implement RCP strategies.

In some instances, clinicians appeared to be more able to retain a sense of agency and have more opportunity or inclination to use the RCP strategies. RCP appeared to be easier to implement:

1. in environments such as the AT&R, and in some community settings where work demands were slower paced;
2. for disciplines which were philosophically aligned with RCP, such as social work and occupational therapy.

The findings also suggested, however, that even within these contexts, clinicians sometimes chose not to use RCP. This appeared to be because of the competing pressures of waitlists and patient workloads. Conversely, there appeared to be more incentive for some clinicians to use RCP in their home visits in the community. In a person's home environment, clinicians perceived they had more need to build a connection to be able to work effectively with whaiora, as they, the clinician, were in an unfamiliar environment. This meant for some clinicians that they felt less comfortable and sure of themselves in a patient's home compared to a ward or hospital setting where

they knew the processes, protocols, and the way things were done. These findings indicate that sense of agency may be conditional, and clinicians made conscious decisions of when to apply the RCP strategies, or not, when they had agency to make a choice. Therefore, RCP still appeared to be seen as a tool clinicians could choose to use or *not* to use. These findings will be discussed in more depth below.

Perceived Pressure to Prioritise Flow and Referrals

AHPs reported feeling a constant pressure in their everyday work due to high patient referrals and volumes, evident in overt messages from team leaders and senior clinicians to prioritise patient flow in the acute wards. This pressure of prioritising and managing high workloads has been longstanding but was exacerbated due to AHP vacancies and increased sick leave during COVID. This is evident in a physiotherapist's descriptions of implementing RCP:

> *I found it* [using the RCP model] *more challenging on the acute wards - we could be seeing 15 people a day and have meetings … so you've got maybe 15 minutes to see someone and then there were notes to writeup, so I found it more challenging to be spending as long on the whanaungatanga*. (Lisa, Tauiwi Acute Physiotherapist)

Within the fast-paced acute ward environment, participants reported that it was harder to prioritise RCP in their interactions. Trudy, an occupational therapist on the inpatient ward, stated "*It was hard to be relationship-centred when there was pressure from the MDT to just get people out*". This quote reflects the notion that a focus on patient flow and demand-driven outcomes can impact a clinician's choice and capacity to practice in a relationship centred way. For some participants, using this approach appeared to create what one participant termed an "*ethical debate*" between connecting with a person to try and engage and use the RCP strategies, and the pressure to see the next patient on their caseload:

> *It takes time to build those relationships which means it takes time to then achieve your outcome and it impacts on trying to hit our KPIs* [key performance indicators] *for the day. So I guess with patients that we're supposed to see then it becomes an ethical debate, do I do a little bit for every patient, or do good quality practice for some patients and others miss out*. (Lisa, Tauiwi Acute Physiotherapist)

Some clinicians appeared to have to come to terms with the decision to prioritise 'good enough' interactions ensuring they had adequately assessed or treated the patient over

high-quality relational interactions. Workflow and efficiency appeared to be viewed as indicators of good practice by managers and some colleagues. This was reinforced and sustained by everyday ward processes such as MDT meetings and rapid rounds that focused on expedient discharging. Another physiotherapist, Beth, reinforced this constant grappling of decision-making stating *"you've got that discomfort of… I know I could do something for this individual but then what does that, what's the impact on the system? ... so I guess you do feel quite ..., frustrated*". This shows how one's sense of agency can feel compromised due to the balancing of what care clinicians perceive they can deliver within the context of an environment that focuses on expedient discharging, which can lead to feelings of frustration.

Prioritisation processes and managing patient flow also impacted on clinicians working in the community. An oral health therapist, Trish, commented "*It* [RCP processes] *can take a lot of time. Our appointments are often scheduled into 10 or 15 minute blocks… there is pressure to keep to schedule and see the next child*". Beth, a community physiotherapist, stated *"you really want to sit and take that time to build that relationship initially but you know you're on the clock and you've got a lot of people on a waiting list*". The overt expectation the organisation places on staff to manage their patient flow and waiting lists, even in community settings, appeared to have been internalised and was perceived to compete with the time required to put RCP strategies into practice. There was also a perceived expectation to be expedient on home visits, even though community appointments were less structured than assessments or rehabilitation in the hospital setting. The perception of expediency appeared to emanate from the constant and explicit team dialogue around the increasing length of waiting lists that participants reported was a mainstay of team meetings. It resulted in clinicians experiencing a perceived heavy workload pressure. These examples illustrate how structural factors have the potential to create an environment which fails to support, and can potentially overtly pull clinicians away from, working in a relationship-centred way. Structural factors refer to cultural, process, system, and organisational factors that guide and influence the way health professionals work.

Across both acute and community services, AHPs shared stories of being pulled between their current patient and their next patient waiting to be seen, which appeared to detract from these clinicians using RCP:

> *When you've got another client to go and see and you're feeling like you haven't got time to actually spend it doing the whakawhanaungatanga, ... that can hinder you from putting it* [RCP] *into practice … sometimes you just feel like you need to get straight to the point*. (Beth, Tauiwi Community Physiotherapist)

Beth appeared to be acutely aware and have a sense of responsibility towards the people still waiting to be seen. Similarly, Trish (oral health therapist) was aware of the pressure to keep to schedule with the next patient arriving in 10 minutes. Wanting to embed RCP but needing to work concisely in a time-constricted way, appeared to create a tension for participants. While they had a *choice* of whether to embed RCP, this choice was not simply of their own making. Their sense of *agency* was compromised by external structural or process pressures, both real (i.e., the next patient scheduled in 10 minutes) and perceived (i.e., the unseen patients on the waiting list). Clinicians appear to have internalised the norm of expediency and prioritisation as indicators of good practice to the extent that it impacted on their sense of agency. Even when they appeared to have choice, the dominance of that rhetoric meant that working to optimise patient waiting presented itself as the only legitimate 'choice'. In other words, the choice was somewhat conditional.

Some clinicians reported they felt there was more opportunity to use RCP in less pressurised environments. In settings like the AT&R ward, and in less formal home settings, there was less emphasis on expedient hospital discharging. For example, Sarah, a speech language therapist, stated "*if you're in AT&R it's* [RCP] *much easier to sort of implement as you get more time with the patients, so environment helps*". The focus on expediency that was so dominant in the acute medical setting was not so apparent in the AT&R Ward. This provided a more relaxed and not so pressured environment where clinicians felt more supported to be able to readily practice RCP.

> *I found it really good in AT&R when … you're usually working with someone every day for like at least 3 weeks. And I found in that space ... the way therapy is set out I felt like it fitted into that model quite well*. (Hine, Māori Physiotherapist)

The AT&R context with a longer length of stay, larger staff to patient ratios, and less frequent turnover, enabled staff to have more opportunities to engage with whaiora and their whānau and use the principles of RCP. In this setting, clinicians appeared to have more agency over their interaction with whaiora and whānau. This environment also encouraged rehabilitation goal setting which meant processes were aligned and colleagues supported the engagement with whaiora and whānau to find out what was important to them in their rehabilitation journey. This ethos aligns with the RCP approach.

Perceptions of RCP 'Taking Time'

The concept of the time required to implement RCP strategies into practice was woven through participants' stories. Time could be constructed as either an enabler or barrier. Some clinicians believed the process took longer, while others perceived it could be done quickly if the RCP approach was integrated into one's everyday practice. For example, Sarah, a speech language therapist from the acute wards, commented that "*if you had time ... more time and your caseload wasn't quite so high, but knowing you have five more patients to see makes it harder to practice RCP*". Time was reiterated as a barrier to implementing RCP when juggling multiple priorities. Lisa, an acute physiotherapist, stated "*A lot of the time, I will prioritise less of my caseload to help them* [physio juniors] *with theirs and that means even less time to engage in RCP*". There was a perception from some of the participants that workload pressure and being time poor were mutually exclusive to practicing in a relationship-centred way. Three participants provided counter views; that practicing RCP does not take an inordinate amount of time and that it can be integrated into routine everyday practice in a timely way. This was evidenced by Bobbi, a social worker in the acute wards, who commented, "*Starting off, with the hui process the whakawhanaungatanga, ... it's more important than anything and it's amazing how you can engage so quickly and what you can find out just in that short amount of time*". This illustrated that RCP strategies can be embedded into practice in a timely way and supports the premise that some health professionals can integrate this way of working into their routine practice. This was reinforced by Trudy, an occupational therapist, who stated "*taking even 5 minutes to build some rapport and get to know someone, it's just how much more willing to engage they* [the patient] *are*". Time appeared not to be an inhibiting factor for Hine, an inpatient physiotherapist, who had

integrated the Hui Process, one of the RCP strategies, into her everyday practice. Hine commented "*it* [the Hui Process] *can be just finding out where they are from or where they were born and just making a real quick connection*". These counterviews about the intersection of time and RCP highlight that some clinicians can retain a sense of agency over their practice decisions even with time constraints.

Clinical Risk Versus RCP

There was an internal ethical dilemma for some clinicians as they sought to both mitigate clinical risk and be relationship-centred.

> *When there is 30 people in ED and there is high clinical risk as no hospital beds and it is an unsafe situation and where there are people who are medically cleared for discharge it's about weighing the clinical risks and that often means it overrides one's belief in working as a RCP practitioner. It can be hard and frustrating at times*. (Member Focus Group Discussion; Lisa, Tauiwi Acute Physiotherapist)

Implicit within this quote is a belief that there is no clinical risk in *not* being relationship-centred in one's practice. It reinforces the concept of clinical risk being seen as more important than the relational and cultural risks, and that these elements are pitched against each other. However, it appears that weighing the clinical risk of a situation against practicing in an RCP way can promote a tension for clinicians, as the quote above illustrates. There can be a disconnect between a clinician's actions and/or choices and their belief system about how best to practice. As the above quote from Lisa highlights, this can result in clinicians feeling that they have not really connected with their patient which has left some AHPs feeling frustrated.

In contrast, some practitioners appeared able to successfully manage so-called clinical risk while also embedding relationship-centred care in their practice:

> *Knowing all the clinical issues, but building those positive relationships and working through the pressures and the obstacles, it* [RCP] *did give you more power I guess to, to argue for the patient's point so as to voice what they want and what they want to achieve and that felt really nice to actually, be able to speak and advocate for them*. (Trudy, Tauiwi Occupational Therapist)

Some clinicians appeared to be able to balance their sense of agency with the clinical risk and pressure to be expedient in their work. The quote above came from a clinician

who had 5-10 years of experience working in health, which may have made them more confident to assimilate RCP into their everyday practice. Trudy's experience may have assisted them to be more adept in reframing clinical risk and managing their caseloads alongside embedding RCP into their everyday practice. Sarah, a speech language therapist with 5-10 years of experience, commented "*relationships are an important part of the therapeutic treatment and are just as important as the clinical need, so yeah in a way RCP just helped balance that more for me to manage better*". In this quote the AHP suggests that RCP provided the strategies to support her to prioritise relationships alongside managing clinical need. The years of experience, practice knowledge, and the resulting confidence that this gives some clinicians, may make it easier for some clinicians to assimilate the RCP approach into their everyday practice.

Perception of Being Judged by Others

Some clinicians had a perception that they were being judged by their work colleagues when they drew on RCP strategies with whaiora on the acute wards. These AHPs reported they felt that colleagues in the MDT viewed them as wasting valuable assessment and therapy time when engaging in RCP.

> *When the wards are really busy and you are … really engaging with the patient you sometimes feel like the nurses and the rest of the team are thinking 'she's slacking and wasting time' as there are six other patients waiting to be seen for discharge and that does not make you feel good*. (Lisa, Tauiwi Acute Physiotherapist)

This quote suggests that clinicians might prioritise efficiency over being relationship-centred in their practice for fear of being judged or viewed as wasting valuable time. However, RCP and efficiency are not necessarily competing demands as it is possible to be both relational and efficient in one's practice, as outlined by participant quotes earlier in this chapter. Sarah, an occupational therapist, stated "*I sometimes felt guilty* [when using RCP] *but had to remind myself as to whose priorities were the most important*". Whether these AHPs were actually being judged by others or whether that was just their perception, they conveyed a sense of discomfort and even guilt when prioritising RCP. If RCP strategies are viewed by the clinician as "slacking and wasting time" or leaving a sense of "guilt" then this re-emphasises the inherent belief that RCP is an add-on with the narrative of workflow and efficiency prevailing as the dominant norm. It also supports the notion that the more concrete and tangible disciplinary processes and

practices seem to be viewed as more important than the skills of RCP and patient engagement.

Clinicians' Disciplinary Orientations that Support RCP

For some professions, such as social work, occupational therapy, and speech language therapy, RCP appeared to be more easily implemented within the context of competing demands. Clinicians from these professions seemed to be able to retain a sense of agency over their work decisions. The training and the disciplinary orientation of these professions appears to be more sensitised and aligned with the philosophy of RCP. This was supported by Trudy who pointed to the congruence of the model with specific disciplines' undergraduate training and practice approaches.

> *For OTs* [occupational therapists] *it's* [RCP] *quite natural and I think for social work as well, it's quite natural. And I guess it was a little bit surprising hearing from other professions that that didn't come as naturally and it, they found it* [RCP]*, like a really big learning curve.* (Trudy, Tauiwi Acute Occupational Therapist)

The comment that RCP practices are "*quite natural*" suggests that the skills of making connections, forming relationships, and actively engaging is an integral part of how some professions interact with patients on a daily basis. This was reaffirmed by Bobbi, a social worker who commented:

> *It* [RCP] *cemented the stuff that we were doing anyway and it* [RCP] *probably put a name to it. Because, the aim of RCP is how I like to practice anyway … so It's a confirmation of what I was doing, is okay*. (Bobbi, Māori Acute Social Worker)

This quote appears to indicate that some professional groups could find that some of the RCP strategies are already familiar to them from their training. However, having a model and language to describe this practice appeared to benchmark and legitimise this way of working. Trudy commented that "*OTs and social workers put the patients first – it is the way we work*". This idea that some professions were more attuned to a RCP way of working was further reinforced by Beth (physiotherapist) who suggested that she liked going out on dual home visits with her social work colleagues as they "*role-modelled RCP and were just naturally good at it*". While some professions may already be sensitised to a RCP way of working, it could require a shift in thinking and practice for other professions. For example, Lisa reflected "*we* [physiotherapists] *base our professional*

self-worth on the ability to get physical results" and Beth (a community physiotherapist) commented "*there is internal pressure from our training to get on the with the practical side* [of therapy]." These quotes reinforce that there is another competing force, discipline-specific norms, that impact on some clinicians' sense of agency. Therefore, a greater shift maybe required for these professions to move towards and embed a RCP way of working into their practice. These disciplines may find embracing RCP more difficult within the context of their fidelity to their professional norms and in an environment of competing workloads demands.

Actively Choosing to use RCP when Clinicians find it Beneficial

In community settings there appeared to be a subtle shift in dynamics for clinicians seeing patients in their home. In this situation, where the environment was less familiar to the clinician and there was more uncertainty for clinicians, they appeared to have a greater need to establish and make connections with the whaiora and their whānau.

> *Working in the community being on a client's turf in their own home this concept was just that much more important. The power balance is totally shifted when you're working in the community setting and making sure that your client is first and foremost was just really, really paramount to good care and building those relationships to enable patients to trust you ... and to form good ..., working relationships to get good outcomes*. (Beth, Tauiwi Community Physiotherapist)

Beth made a deliberate choice to ensure good trusting relationships were formed in the client's home. This supports the notion that clinicians do have some agency over their actions and that they have the ability to exercise choice and enact RCP. This was especially the case when they perceived it could benefit their practice and, in particular, when it enabled them to do the work they perceived they needed to do. When this concept was discussed in the member focus group, there was agreement that there was a greater perceived need to use RCP when going on a visit to a patient's home. There appeared to be more motivation for clinicians to use RCP in this unfamiliar environment. This is because it served the clinician's needs by creating a connection and a relationship of trust in order for the clinician to feel more comfortable assessing or rehabilitating the patient in this setting.

The findings in Theme One highlighted a dominant narrative of expedient workflow and efficiency as indicators of good practice. This narrative was sustained by the perceived pressure some participants felt from colleagues to prioritise patient flow, coupled with inhibiting reporting processes that reinforced expediency of work over truly engaging in RCP. It highlights that for some of the participants RCP is not deeply embedded as usual care and is viewed as optional when clinicians are short on time or in the context of complexity. For some clinicians, adopting RCP into practice appeared to be a huge mindset shift. The findings also indicated that some clinicians can and do make a conscious and deliberate choice to integrate RCP into their everyday practice. In different contexts, such as the AT&R ward or home-based settings, and for disciplines that are more aligned to working in this way, RCP appeared easier to assimilate into practice. In times of workload pressure or complexity these clinicians appeared more able to retain their sense of agency. However, even in these situations the tension between expediency and working in a RCP way was ever-present.

Theme Two – Internal Tension for Clinicians

This theme focuses on the internal tensions that some clinicians experienced when using RCP in their everyday practice. It appeared that dilemmas arose for clinicians because of the tension between their espoused values and their actual choices or actions in practice. In grappling with trying to reconcile the discomfort between their values and their actual choices or actions, clinicians appeared to experience a cognitive and/or emotional tension.

There were three distinct tensions for clinicians when trying to implement RCP into their practice. Tensions occurred when:

1. clinicians had created expectations that they would achieve what was important to whaiora, but were unable to meet their needs due to impinging work pressures, resources or external factors;
2. clinicians' practice beliefs conflicted with a patient's choice or preference; and/or
3. a clinician's sense of self-worth in providing a valuable contribution in their patient interaction was inextricably linked to their discipline-specific ethos of

providing a hands-on physical treatment and the perceived conflict with the RCP strategy of taking time to engage.

At different times all three factors appeared to create internal tensions which impacted on their ability or motivation to implement RCP into their everyday practice.

RCP and Inability to Meet Whaiora Expectations

When clinicians practiced in a RCP way to identify what was important to the whaiora, but their efforts to achieve the outcomes were hampered because of the pressure to discharge or a lack of available resources, it appeared to create an internal tension for the clinician. This tension arose from feeling that they were creating expectation with the patient or whānau through the RCP process that they, as the clinician, were then unable to meet. The RCP training programme is designed to assist clinicians to work in partnership with whaiora in a mana-enhancing or respectful way. The participants noted, however, that in finding out what was important to the patient through the Hui Process and shared decision-making, they had created an expectation that these health or rehabilitation goals were realistic and achievable. Trudy commented, "*you've taken that time to sit and understand what they* [the patient] *want and agree on those shared goals … but then when you get pressured that the hospital is full and they just need to go now, it's hard*". This highlighted a discrepancy between the intention of working towards the shared goals and what could be provided in reality.

When goals could not be met within the period of patient interactions, participants reported that they felt they had not delivered on addressing whaiora and whānau needs. This left clinicians feeling they had failed to meet patient expectations, which they perceived had the potential to jeopardise their relationship. For example, describing her experience when pushed to expediate discharge home, Trudy stated "*it almost felt like that relationship* [with patient] *crumbled a bit because you feel like you've let them down in a way and it's out of your control*". In these instances, clinicians felt their integrity was bring compromised by their failure or inability to meet these patient-centred goals.

> *I found it harder if you spent time finding out all those things to then say, no - that doesn't work for us or I agree with you, but it's just that I know that the ward's not going to, so even if I said you know ideally their discharge should be in 2-days time, that the nurse coordinator will just*

> *send them home that afternoon regardless so I have created false expectations with the person*. (Hine, Māori Community Physiotherapist)

Hine described the professional and practice constraints experienced when she had created expectations with patients that she was then unable to deliver on due to pressure to discharge. Some participants appeared to feel their sense of worth, which was linked to making a difference in the lives of the people they serve, had been eroded and undermined which, in turn, impacted their job satisfaction.

> *It's hard to know all the wants and needs and really hear a person and organise a plan with the ward, then they* [the ward] *turns around and does a 180. It is so frustrating and damages your relationship with the family*. (Hine, Māori Physiotherapist)

When this constraint was discussed as a possible theme in the member focus group, the participants noted that it was not uncommon to not be able to meet whaiora expectations. This had left some participants hesitant about using aspects of RCP to find out 'what was really important' to whaiora and whānau with whom they worked. Clinicians appeared to worry that by actively engaging with whaiora on what was important to them, that they were creating false expectations. They perceived that getting to know and understand what is important to their patients somehow served as a promise. This was reiterated in the member focus group discussion when Bobbi articulated the disconnect that occurs when an agreed upon patient plan is thwarted by the push to discharge, "*I hate it when that happens – it is so annoying and makes us* [social worker and kaiāwhina] *look so unprofessional. It undermines us and the whānau loses trust in us and the system fails them again*". This highlights that clinicians felt their integrity was compromised, leaving them feeling undermined in their practice and contributing to ruptures in their relationships with whaiora.

Perceived Tension Between Best Practice and Whānau Choice

Another practice tension occurred when whaiora goals were not in alignment with the clinician's best practice knowledge. What constitutes 'best practice' for a clinician is developed from their discipline-specific professional training and standards, together with organisational processes and norms, and something that many clinicians adhere too. It can cause a disconnect if whaiora choices for their heath goals are different to what a clinician may be recommending from their knowledge base. For example, Lisa

(physiotherapist), reflected on a colleague suggesting that they saw that they needed to "*have all the knowledge and them telling this person* [patient] *what to do, rather than using both people's strengths, or guiding but supporting their own plans and what was important to them* [the patient]". Participants noted that even after RCP training, some health professionals continued to default to 'telling' whaiora what to do, drawing from their clinical knowledge rather than 'asking' and partnering with the whaiora to establish shared goals. Trudy commented, "*they* [the health professionals] *still saw it as them having all the knowledge and guiding the patient on the correct action to take".* These quotes may indicate that clinicians still see themselves in the 'expert' role rather than being a partner in the care process, which is a central premise in RCP. Trudy also commented, "*some people* [health professionals] *didn't seem to rate the perspective that the whaiora was bringing to the party, like how their* [the patient's] *beliefs and perspectives and their strengths are important and how that could kind of contribute to a great outcome*". When the tension between perceived best practice knowledge and whaiora choice was raised in the member focus group, participants acknowledged that at times they experienced an internal tension in accepting a patient's right to self-determination and choice when it was in juxtaposition to their professional disciplinary beliefs. The participants acknowledged that they placed importance on the patient's perspective, but it was easy it was to fall back into the expert 'telling' role when they forgot or deprioritised RCP strategies in times of busyness.

A central premise of the RCP model is that the health professional provides the relevant information to fully inform the whaiora and whānau of best practice. Through the shared decision-making process and/or the DBM, goals are reached with the patient retaining a sense of self-determination or control of what they would like those goals to be. The participants articulated that agreeing to goals was sometimes really difficult to do, if they were in contrast or differed from what they, as the clinician, considered as appropriate in achieving the best health outcome.

> *You want them to share the decision but actually there's pressure to do this and you as a professional know that there's a certain way or model that's going to help them, but it's not the way they want to do it, so it's still sharing decisions on their journey and on their, yeah on their recovery but making sure they're still getting like best care. That really makes it hard*. (Trudy, Tauiwi Occupational Therapist)

Clinicians noted that at times they felt they may have moved away from the intent of the RCP model to sway the whaiora and/or whānau towards a decision that was more consistent with what they considered was best clinical practice. In trying to persuade a patient to accept their professional wisdom, these clinicians may intentionally or subconsciously have directed the patient to their way of thinking. For example, Trudy commented that her discipline-specific and practice knowledge meant that "*at times you're kind of guiding them towards what you think is the best decision still*". This well-intended persuasion by clinicians was further reinforced when discussed as a potential candidate theme in the member focus group. Lisa commented, *"shared decision-making is an interesting one for even my colleagues who have done RCP ….. I see them give all the options to the patient then guide them to the one that they think is best clinically*". As the member focus group discussion progressed, participants noted that by guiding patients to their clinical way of thinking they were likely minimising or eroding what may have been important to the whaiora and their whānau. These findings highlight the internal tension clinicians can experience when there is a lack of alignment between their clinical knowledge of best practice and patient choice.

Practical Therapy as Best Practice Belief Versus RCP Ethos

Another tension that can arise for some clinicians at the patient interface level is when their sense of identity as clinicians is tied to providing practical or hands-on therapy. When clinicians (mainly physiotherapists, occupational therapists, and oral health therapists within this study) were expected to spend more time building connections and finding out 'what is important' to the patient, at times it appeared to create a tension with their desire to provide practical therapy in every session. Physiotherapists and oral health therapists reported that the skills of talking, connecting, and whakawhanaungatanga were not valued or seen as so important for their professional groups compared to the skills of practical treatment, intervention, and rehabilitation. These participants reported that they sometimes felt they were not doing something useful as a health professional unless they were doing something practical and/or physical with whaiora. For example, Lisa stated that "*with physios you really struggle just to do the talking side. It's kind of engrained almost that if you're not doing something physical that you've wasted a session*". It was evident from participants' reflections that RCP challenged some of their deeply rooted discipline-specific beliefs and identities.

Trudy, who had earlier commented that aspects of RCP came naturally to her profession, articulated that applying practical skills in a patient interaction was a deep-rooted professional norm for occupational therapists, "*there is still that kind of internal pressure from our training to get on with the practical side, the showering assessment or getting someone independent in their transferring*". This suggests that even though occupational therapy's philosophy of practice is more aligned to the ethos of RCP, at times occupational therapists also grappled with the mindset instilled in them from their training that they need to be doing something practical to be useful or effective in practice.

Beth (physiotherapist) pointed to the shift required to embed RCP into everyday practice for many clinicians, commenting "*it's a massive mind shift for physios. People we work with expect 'action' or* [for] *us to be 'hands-on' with treatment in every session*". Beth placed importance on the patient's expectation of "*expecting action*" but not the less tangible needs of patients to be understood, heard, and validated. Lisa reiterated this, notion of needing to provide hands-on therapy stating *"I suspect we* [physiotherapist] *base a lot of our self-worth on our ability to get visible results. ... and so when that doesn't happen, through no one's fault, it can be quite disheartening*". Some participants appeared to be in an early stage of a shift to a RCP way of being despite completing the training a number of years ago. During the member focus group discussions, Lisa stated that "*we* [physiotherapists] *are trained to be very objective and our notes are very structured with a dedicated section on treatment. They don't reflect the intent of RCP*". The participants noted that the reporting mechanisms within the organisation for several disciplines reinforced a focus on practical skills and interventions by overtly having a section for treatment, but no comparative section for engagement or connection with whaiora. It appeared that the system and structures reinforced that practical skills and interventions are valued and that these are the outcomes required.

Participants of the member focus group, mainly physiotherapists, reported a sense of feeling they were not fulfilling their professional practice and/or work obligations if they were not doing practical therapy. They noted that this could sometimes lead to residual feelings of guilt when they were taking time to engage in whakawhanaungatanga and build a relationship with whaiora and whānau. In the nember focus group session, Hine

commented about what was needed to embed RCP for her profession stating, "*physios need champions as they are still very much influenced by the task-oriented biomedical model*". Physiotherapy participants noted that the sense of having to do something practical to be fulfilling their work obligations was a construct engrained in them throughout their training. This appeared to have been reinforced as a new graduate and into the workplace through profession-specific norms and regulatory body standards. The conflict between enacting RCP and doing hands-on physiotherapy appeared to result in a heavy cognitive and emotional load for clinicians as they grappled with reconciling these tensions.

Theme Three – Putting RCP in Action Boosts Clinicians' Confidence and Motivation

Putting some of the key components of RCP into practice and seeing that result in connections with patients, engagement, and other positive outcomes gave some participants more confidence and motivation to continue using RCP. The training, together with the perceived success through practical application, provided an incentive to continue using RCP in particular:

1. Using the Hui Process, a Te Ao Māori model of engagement, to support effective engagement with whaiora and whānau.
2. Using strategies such as 'listening to understand', 'finding what was important to the whaiora', and the coaching process to support relational care and effective patient interactions.
3. Using the DBM to guide people to making informed decisions about their care.

However, utilising the RCP strategies did not boost the confidence and motivation for all clinicians. As highlighted earlier, some physiotherapists, occupational therapists, and oral health therapists felt a disconnect when using some of the RCP strategies in practice.

RCP Giving Confidence to use Te Ao Māori Models of Whaiora and Whānau Engagement

The Te Ao Māori model of the Hui Process (Lacey et al., 2011) is a key component in the RCP process. In short, it provides a practical step-by-step method to invest time in whakawhanaungatanga to engage with whaiora. It appears that participants embraced and gained confidence from using the Hui Process in their everyday practice, particularly when they attributed their ability to more effectively connect and engage with whaiora

and whānau through use of the Hui Process. Trudy commented "*the Hui Process gave me some practical steps of how to really engage and once I had done it once and it kind of worked it just gave me a confidence to use it again*". Utilising the practical steps of the Hui Process—mihimihi, whakawhanaungatanga, kaupapa, and poraporaki—appeared to foster confidence and motivation for clinicians to continue using this Te Ao Māori model of engagement with whaiora. Some clinicians were anxious or unsure of using practical strategies to engage effectively with Māori and other patients, which may have inhibited their practice. For example, speech language therapist, Sarah, articulated this uncertainty stating "*I guess I was just nervous that I would sometimes get it wrong with my interactions with Māori patients, so I was probably a bit more wary or aware of how I approached things*". While staff all received training on the importance of engaging with Māori, the Hui Process appeared to provide a tangible structure to support clinicians to advance their practice with all patients. Lisa, a physiotherapist who had trained overseas, made a comparison between the organisation's mandatory equity training programme 'Engaging Effectively with Māori' and RCP training, stating "[the Māori responsiveness and competency training programme] *was great, really powerful, but the 'Hui Process' gave me the 'how', I suppose. Yeah, I guess the steps to follow to really just do it*". The practicability and applicability of the Hui Process appeared particularly important for staff who had immigrated from overseas, which Jane highlighted:

> *Coming from* [overseas] *we were taught not to share any of yourself in health care interactions, as it wasn't seen as being professional, but the hui process … once I had done it once um – and it worked, and it felt great that I had made a real connection so I use it all the time now*. (Jane, Tauiwi Community Pharmacist)

Jane's quote suggests that the Hui Process changed the practice and behaviours of some clinicians in a positive way and provided a framework or process of engagement for them to use. Clinicians born and trained in Aotearoa New Zealand also seemed to find the Hui Process provided a framework for them to follow to be more genuine and culturally congruent in their patient interactions.

Not only did the Hui Process provide a tangible step by step process, but clinicians reported that it also assisted them to engage more fully with whaiora. This was reinforced by Sarah who, when talking about the Hui Process, commented, "*understanding where someone is from and sharing a part of you and the positiveness*

that forms. It just works". When exploring what Sarah meant, it appeared that she felt that finding and sharing something in common assisted to break down any initial perceived barriers by making a connection; this contributed to trust being formed between clinician and whaiora. It created a bond which was perceived to provide a platform for more active whaiora engagement during interactions. Experiencing the Hui Process working in their day-to-day practice, and seeing first-hand the impact that it had, appeared to motivate participants to use it more. This theme was further discussed in the member focus group and there appeared to be general consensus that the 'Hui Process' was a practical, useful, and tangible tool. Participants suggested that when they saw that using the Hui Process resulted in what they felt were genuine and effective connections, it provided the motivation to use it in other healthcare encounters to support engagement. The participants viewed 'effective' connection as making a "*real connection*" with the patient they were working with, and the feeling that a reciprocal relationship of trust was being formed. Similarly, 'authentic' included a genuine sharing of self which, in turn, created a foundation for the ongoing interactions. For example, Sarah commented "*It* [the Hui Process] *just helped with relationships and slowing down to make that real connection. ... It really helped with the therapy when I had taken the time*".

When the 'Hui process' was perceived to be working successfully in practice, clinicians motivated to use it again, and felt they could better hear and more fully understand the reality of a patient's life. Jane stated "*the hui process just really changed my practice. It made me see things so differently and it gave me permission to really engage*". This notion of 'seeing things differently' refers to one of the central tenets of RCP in that clinicians are the 'experts' on clinical reality, but the patients are the 'experts' or 'holders of information' on their own lived reality. Jane's comment reinforces that taking the time to connect using the Hui Process assisted her to more fully understand the patient's reality through a culturally appropriate lens. Jane articulated that her ideas on how she thought this patient could manage their condition of gout completely changed when she took time to connect and find out what the patient's day-to-day lived reality was like. This created a bond and a trusting connection to then explore what was important to the whaiora to enable shared decision making and partnership in the healthcare interaction. Hine commented "*once you see it* [the steps of the Hui Process] *work, it gives*

you permission to use it more to really engage and then advocate". There is a powerful notion of empowerment embodied in this quote, in that the Hui Process has not only provided a framework to change clinicians' practices and behaviour with patients, but has the added spin-off of empowering clinicians to 'advocate' for their patients.

In summary, the findings showed that the steps of the Hui Process provided a practical structure to follow and assisted clinicians to more effectively connect and engage with whaiora. It also assisted clinicians to more fully hear and understand the lived reality of whaiora and their whānau. Utilising this Te Ao Māori model of care, and seeing the resulting effective engagement, appeared to give an assurance that it was a valuable practical strategy; and, at the same time, instilled a belief and confidence in their own ability to apply it. The Hui Process appeared to more fully engage the whaiora as a partner in their healthcare interaction and to leave clinicians with a greater sense of job satisfaction and fulfilment.

Having Success in Enacting RCP Gives Clinicians Confidence

The engagement that some participants perceived when using some of the RCP strategies made them more inclined and motivated to adopt it in everyday practice. Lisa stated "*just seeing how 5 minutes to build that relationship helps people to be more willing to engage and more interested in working with you ... it was amazing. It really motivated me to use it* [RCP] *in my work*". Successfully engaging with patients helped motivate clinicians to keep taking the time to build relationships. Clinicians reported the RCP training and tools refreshed their thinking around the importance of genuinely partnering with whaiora and establishing relationships of trust and partnership in their healthcare journey. Clinicians felt they were able to better understand a patient's lived reality and be attuned to what the patient required to ensure that the interaction was meaningful and effective when using the RCP strategies.

> *Sometimes it feels like, in the hospital in general, people get so fixated on length of stay and discharge and, needing beds and they kind of forget who the person is and, ... I guess this* [the RCP strategies] *was a new revival in advocating for patients and working with them and having a nice journey*. (Trudy, Tauiwi Acute Occupational Therapist)

The RCP training reminded Trudy to advocate for whaiora in terms of 'what is important to them' in their healthcare journey. The phrase "*new revival in advocating for patients*"

appeared to imply that advocating for what is important to the patient had been somewhat lost in the context of clinicians having high workload pressure and prioritising caseloads to ensure patient flow. The training seemed to validate and reinforce the belief that relationship-building and engagement are important aspects of practice. In reflecting on what the RCP training had assisted them to focus on, Sarah commented:

> *it was that reminder that ... you know you're dealing with people and that you know building relationships, even though it takes a bit more time, it's actually a really important part of that therapeutic relationship building process and the RCP training was a huge reminder of asking our patients what they actually want, what's important to them and really reminding us to advocate for them. They are the reason we are here. It reconnected me to why I do what I do*. (Sarah, Tauiwi Acute Speech Language Therapist)

Sarah referred to RCP being "*a reminder*" that "*reconnected me to the why*" which reinforces the earlier statement in this subtheme from Trudy who emphasised that the patient connection and who the person is can sometimes get lost in the everyday pressure to focus on patient flow and expediency. The RCP training appeared to assist health professionals to reconnect with their purpose, 'the why' of what they do, and gave them a renewed sense of importance in asking whaiora what is important to them.

Observing how applying the RCP key strategies assisted clinicians to more fully engage in a partnership way, appeared to also have a downstream effect on their overall work fulfilment and job satisfaction. Observing more patient engagement through making a genuine connection, as perceived by these clinicians, seemed to increase their job satisfaction. This sense of work fulfilment appeared to be an added incentive to continue using the RCP model. For example, Lisa commented "*it shortens the number of sessions you need if you do whakawhanaungatanga. It really works and the patient is more motivated. It makes me feel good and more motivated to use RCP*". The sense of job satisfaction and fulfilment that Lisa got in engaging with the patient seemed to be a motivator to continue to use RCP in practice. Jane, who used the RCP strategies, in particular the DBM, with one patient to assist them to understand their condition better and make a shared decision, reported feeling more invigorated and getting job satisfaction by the result of the interaction.

> *I asked what would motivate him, and once he knew more about the condition, he was like oh my gosh I should be taking that every day and*

> *then we talked about how he could come up with a solution of taking his medication by using this* [DBM patient activation strategy] *he came up with his own solution to how he could remember. It felt really good and motivated me to keep on using RCP. It felt great*. (Jane, Tauiwi Clinical Pharmacist Facilitator)

When clinicians saw how partnering with whaiora on what was important to them helped the patient to be more engaged in their own healthcare, the clinicians noted that they felt a greater sense of job satisfaction. The participants recognised that using RCP strategies in their practice had positively influenced their patient clinician interaction helping to form a solid relationship. Observing how the RCP strategies worked, and seeing the resulting engagement with whaiora and whānau, re-energised and focused these participants, and supported continued use of this relational model in their practice.

Summary and Conclusion

The findings highlighted three distinct but inter-related themes. First, clinicians perceived their sense of agency in using RCP was compromised by dominant prevailing structures and processes which created an environment where patient flow and expediency were valued over being relational in everyday practice. Clinicians had to continuously grapple, both cognitively and emotionally, with decisions about how to practice. They often found themselves pulled toward expediting patient flow through services over relational interactions with their patients. In settings where the biomedical model was less dominant, such as the AT&R ward and in home-based community settings, the pressures of the system were not as evident. However, even though participants perceived they had more agency in these situations, some clinicians still grappled with practicing RCP because of a fear of being judged by others or due to concerns about patient flow and/or patient waitlists. RCP was not deeply embedded as part of usual care. Instead, it was seen as optional by clinicians and as a way of working that could be discarded in busy times. These findings suggest there was a conditional sense of agency in some contexts. RCP became more valuable to clinicians when it benefited their practice in unfamiliar environments, such as on home visits where they needed to build a bond of trust and connection. The findings highlighted that when participants were short on time or there was more complexity involved, they appeared to place more value on prioritising patient caseloads to ensure good flow and

discharging. In these situations, clinicians appeared to revert back to a more transactional and, at times, biomedical way of working.

The second theme highlighted the internal tensions that can occur for health professionals when trying to implement RCP into their everyday practice. The findings showed there were three different situations where these internal tensions manifested for clinicians implementing RCP into their practice. Firstly, when clinicians had created expectations about what might be achievable for the patients and when they could not meet these expectations due to work pressures. Secondly, the tension between clinicians' belief in their clinical knowledge and the choices made by patients. Thirdly, where clinicians' sense of self-worth was tied to providing hands-on physical therapy which was sometimes in contrast to the RCP approach. These challenges highlight the difficulties clinicians face in balancing organisational requirements, their professional responsibilities, personal beliefs, and the needs and choices of their patients. All of these situations appeared to create tensions between clinicians' values and working in an RCP way. As a consequence, participants appeared to experience an emotional and cognitive load as they grappled with reconciling this difference which, in turn, appeared to impact their ability or motivation to implement RCP into their everyday practice. The findings also highlighted that for some clinicians the concept of RCP was a noticeable shift from their disciplinary norms and that they needed more support to reinforce and embed this way of working.

Finally, Theme Three highlighted the RCP training and the practical utility of the RCP tools boosted some clinicians' confidence in using the Te Ao Māori model of practice and fostering connection and engagement. It also showed that when clinicians could observe and reflect on the effectiveness of RCP working in everyday practice, it appeared to re-energise and motivate them to continue using key RCP strategies. Seeing the positive engagement of whaiora and whānau when using aspects of the RCP model appeared to incentivise clinicians to keep on working in this way and adopting these strategies into their everyday practice. It also appeared to have positive impacts on clinicians' job satisfaction and engagement in their own work which is important in the current healthcare environment.

The implications and recommendations from these findings for future iterations of RCP at Te Matau a Māui Hawke's Bay, will be discussed in depth in Chapter Seven.

Chapter Seven – Clinical Implications and Recommendations

Congruent with the applied nature of interpretative description methodology (Thorne, 2016), the findings have produced insights to support and inform future iterations of the RCP training programme at Te Matau a Māui Hawke's Bay. Consistent with the Doctor of Health Science programme, which gives emphasis to making a novel contribution to practice knowledge, I am committed to ensuring these findings meaningfully inform practice change in the field of patient engagement and PCC.

I begin this chapter by offering a personal reflection that shaped my thinking around an issue that was highlighted during the process of this doctoral study. I was concerned that we (facilitators) were setting clinicians up to fail with the current model of RCP. I explore the process through which I resolved my concerns before going on to link findings to current evidence and identifying implications for practice. I put forward recommendations for training, clinical practice, organisational processes, and higher healthcare structures to support the embedding and integration of the RCP programme for clinicians at Te Matau a Māui Hawke's Bay. There may be some transferability of these recommendations to programmes in similar fields seeking to integrate new ways of working more generally.

Personal Reflections on Current RCP Training Programme

A concern had arisen for me about whether we were doing whaiora and our clinicians a disservice by teaching RCP principles and Te Ao Māori models of engagement through the RCP programme. This concern arose when constructing the initial candidate categories in the analysis stage and has been already highlighted in the rigour section around moral defensibility in Chapter Five. This concern was further reinforced by the discussion in the member focus group session. The AHPs had identified an internal tension of often not being able to meet the needs of what was important to the whaiora because of the pressure to focus on patient flow and discharge whaiora as soon as medically stable. While the RCP model focuses on rangatiratanga, giving the whaiora the right to self-determination, the high demand for hospital services and the push to discharge patients meant that ensuring rangatiratanga occurred was not always possible.

I had a sense of unease that the RCP model, without substantive structural change and supports in place, may be leaving whaiora with unfulfilled expectations and a perception that the health system may have failed them. I was also concerned that in not being able to meet whaiora needs, it left some clinicians with a sense of unease; that they had raised an expectation with the whaiora and then been unable to assist in meeting that expectation. This appeared to result in disillusionment for some clinicians, with some also feeling a sense of dissatisfaction with their work.

When grappling with this concern in late January 2023, I met with the Pouwhakaruruhau Matua who sat on my key informant group and had also been part of the RCP programme from the co-design stage. I talked with him through the disconnect between the Māori models of engagement and RCP strategies taught in the programme, and the system demands. We discussed the emphasis on and pressure to prioritise patient flow which appeared to dominate over whaiora choices, with AHPs not feeling they had the ability to genuinely and authentically apply the essence of the RCP model. My discussion with the Pouwhakaruruhau Matua was invaluable as talking through an issue out loud helps me think through a situation, consolidate my thoughts, and reflect to gain new insights. It gave me the space to see that RCP had an enablement function that addresses, upholds, and embraces the human factor of 'he tangata, he tangata, he tangata' (a Māori whakataukī (proverb) that translates as 'the people, the people, the people'). The Pouwhakaruruhau Matua was able to assist me to see why this research was so important as it identified the discomfort for clinicians. Looking at recent research helped me see this was not unique to our organisation. For example, Bright et al. (2024) study found that clinicians prioritised assessment and care related to physical recovery over engagement and support of whānau and supporting whaiora psychosocial well-being in stroke rehabilitation in Aotearoa New Zealand. This finding reflected tensions between whaiora psychosocial needs and healthcare organisations' requirements of patient flow and expediency. Attention to well-being was secondary to the organisational imperatives which privileged physical recovery and patient flow (Bright et al., 2024). Consistent with that finding, my study illuminates the discomfort that some clinicians are left feeling in situations where there are competing priorities. The Pouwhakaruruhau Matua assisted me to see that we, as programme co-designers and facilitators, have an obligation to prepare and assist clinicians for navigating this discomfort. This moral responsibility has

ramifications for current and future iterations of RCP. My findings point to opportunities for embedding the necessary supports at the training stage, at the clinical practice interface, and in processes at the organisational and structural levels to better enable clinicians to move forward to embrace RCP. This is reflected in the implications and recommendations for future RCP programmes, presented in this chapter.

Overview of the Implications for Practice

From my findings it was clear that running a training programme and expecting clinicians to embed RCP into their everyday patient interactions did not sustain practice. The design, facilitation, and implementation of the RCP programme needs to take into consideration the clinician's sense of agency and the context in which they are working. Training should not be a standalone event; rather, extra support must be provided for all participants prior, during, and after the training. AHPs came into the RCP training programme with different understandings and philosophies of practice. Through the course of the training programme, the facilitators need to be able to better prepare participants whose discipline-specific core beliefs are perceived to not be aligned with the concept of RCP. This can be done by making this aspect of perceived misalignment explicit within the training and providing additional tools to assist with the necessary paradigm shift.

The findings also point to better equipping *all* participants with additional skills and strategies to be able to navigate any barriers they come across when implementing RCP in clinical practice. My findings highlight that it will be important to acknowledge the internal tension that some clinicians may face when grappling with the perceived competing demands of expediency, patient flow, and relational practice. Additionally, the training will need to acknowledge and prepare clinicians for the tensions they may experience when what patients think can be achieved does not meet with what the clinician 'knows' can be achieved based on their knowledge and evidence. Finally, there will also be a need to reassure some clinicians that being relational and ensuring good patient engagement can be equally as important as providing practical therapy, depending on the situation and context. Providing practical demonstrations of how to integrate and weave these two aspects of practice together may be important. Addressing the possibility of these tensions arising up front to prepare clinicians for any

emotional or cognitive overload and/or moral distress[1] will be important to the success of the programme.

The findings also highlighted the importance of this type of programme being supported by system and structural changes to reinforce this way of working and assist clinicians in embedding the practice change. Introducing RCP concepts into ward processes, such as MDT meetings, and aligning clinical documentation and reporting processes will assist to reinforce and embed this way of working into everyday practice for clinicians.

In summary, my findings delineated implications for practice in three distinct areas:

1. training to equip clinicians with tools for practice;
2. supporting RCP at a clinical practice level; and
3. introducing organisational and structural supports to enable and embed new ways of working.

The focus of this chapter is on strategies and support mechanisms for clinicians in embedding practice change into their everyday work. While there is a lot of research that examines the challenges of implementing PCC, there is very limited evidence about what works to implement it effectively in practice. As such, the approach taken in proposing areas for change is based on the evidence for implementation strategies that have been found to be useful in other, related contexts and settings .

To support uptake of these findings into practice, drawing on evidence of effective implementation strategies in other contexts, I have produced a set of tangible recommendations for the design and implementation of RCP going forward. These recommendations are split into considerations for training, clinical practice, and organisational processes and structures. They are summarised in Table 7 and expanded on in the sections that follow.

[1] Moral distress is defined as the inability to fulfil the perceived moral obligation to patients and the resulting negative consequences of frustration, feelings of failure, guilt, and anger that can arise for that clinician. Austin, W. (2012). Moral distress and the contemporary plight of health professionals. *Springer, 24*(1), 27-38. https://doi.org/10.1007/s10730-012-9179-8 .

Table 7.

Overview Design and Implementation Recommendations

Training

Equip clinicians with tools for practice

- Acknowledge quantum leap and discomfort of some disciplines in moving to RCP and provide strategies to assist this paradigm shift
    1. introduce a pre-training readiness assessment tool to tailor training
    2. clinician led RCP educational video
    3. critical reflexivity
    4. DBM
- Build understanding that movement towards whaiora goals is important versus goal attainment being the only hallmark of success in RCP
- Incorporate a module to assist understanding of sense of agency and the compromise or internal dilemma that can occur at a practice level, include strategies to manage these tensions
- Role model and provide opportunities to practice how to integrate RCP when time limited
- Build confidence in use of Te Ao Māori models of engagement by incorporating opportunities for practice

Clinical Practice

Support change at a practice level

- Train workplace cohorts to support coherence and culture change
- Implement champions on ward or in community for quick access to support
- Develop Communities of Practice (COP) to increase knowledge and proactively address issues
- Bring cohorts back together after a period of implementation, providing a refresher and coaching session
- Build confidence in use of Te Ao Māori model by providing ongoing refresher courses on the 'Hui Process' by the Pouwhakaruruhau Matua

Organisational Processes and Structures

Introduce structural supports to enable new ways of working

- Train workplace cohorts together to support coherence and cultural change
- Make changes to key service and organisational processes to capture and reinforce RCP (i.e., introducing to MDT meetings; align clinical documentation and reporting to reflect RCP; ensure appointments and waitlists align with a RCP way of working)
- Adopt a values-based approach to recruitment, interviews, and performance development reviews to align with RCP
- Senior clinicians/leaders to be encouraged to complete the RCP training to engage and assist them to understand and be able to use the strategies

Stages of Change and Different Processes Required

It is important to acknowledge that my research indicates that implementing RCP requires change; therefore, drawing from models of behaviour change might be helpful when looking at redesigning the RCP programme. Prochaska et al. (2013) transtheoretical behavioural change model articulates different stages of readiness, and that processes of change should be tailored to where a person is at. The model proposes

five stages of change including precontemplation, contemplation, preparation, action, and maintenance. It also articulates 10 processes of change which can be deployed depending on the stage of change someone is in. For example, if someone is in a precontemplation stage, then drawing on strategies that help the person raise their consciousness about the benefits of and their potential for change can be helpful. In contrast, if someone is in the action stage, strategies focused on supporting them to implement the change would be more useful (Prochaska et al., 2013). I have chosen to draw on the transtheoretical behavioural change model to inform my recommendations because it is primarily used to understand and guide the process of individual behaviour change (Prochaska, 2013) which was the focus of this research. The notion of readiness to change came through in my data when the participants reflected back on their uptake of the RCP approach in which they appeared to have had differing levels of commitment and intention towards this way of working. Recognising where a person falls within the transtheoretical behavioural change model could help tailor interventions and support strategies to clinicians' mindset and needs at the outset. For example, someone in the contemplation stage may benefit from motivational encouragement while someone in the preparation stage might require practical resources and support (Prochaska, 2013).

It is acknowledged, however, that the findings in this doctoral study have highlighted that focusing on sustaining individual clinician behaviour change without addressing the supporting elements that were required at a system and organisational level for clinicians to embed RCP was a pitfall of the programme. Other models, such as the consolidated framework for implementation research (CFIR), which centres on understanding the barriers, facilitators, and complexities in implementing change and assists to identify what is required at a systems and organisational level to support these interventions (Damschroder, et al., 2022), will be focused on later in this chapter and in the discussion chapter. The transtheoretical behavioural change model assisted me to focus on what strategies or techniques clinicians might need at the different stages they are at, in terms of their readiness and acceptance of the RCP ethos (see Table 8). This model has helped me centre my recommendations on what programme participants might require in order for them to progress through the stages to embed RCP into their everyday practice.

Table 8.

Recommendations of Different Techniques and Strategies to Assist Clinicians to Move to a RCP Way of Working Using the 5 Stages of Transtheoretical Behavioural Change Model

Stage One Precontemplation	Stage Two Contemplation	Stage Three Preparation	Stage Four Action	Stage Five Maintenance
Little awareness or no intention of changing - Readiness Ruler to assist the clinician and facilitator understand their level of knowledge and confidence - Video to provide education about RCP	**Considering a change but not committed** - Applying the DBM for clinicians to consider the pros and cons of embedding RCP - Facilitating critical reflexivity as a tool to assist reflecting and evaluation of actions	**Planning to change in the near future but not yet acting on intention** - Sense of agency training module to highlight cognitive dissonance - Provide Te Ao Māori models practice opportunities	**Started action <6 months** - Ongoing refresher and coaching sessions - Champion and knowledge brokers to provide support - Training workplace cohorts - Developing CoP	**Change embedded** - Ongoing refresher and coaching sessions - Champions to provide support - Developing CoP

Adapted from Prachaska et al. (2013).

The transtheoretical behavioural change model assisted me to focus on the order in which clinicians might require different techniques and strategies, depending on the stage of readiness they might be currently in, to enable them to move forward to develop a RCP approach. This readiness model of change has helped to inform the order of the tangible recommendations highlighted in Table 8 above, and presented in the next section.

Implications and Recommendations for Training – Equipping Clinicians with Tools for Practice

Recommendation: Acknowledging Quantum Leap and Discomfort of some Disciplines in Moving to RCP to Assist the Paradigm Shift

The programme had been designed to take all clinicians on a journey of understanding, teaching key strategies to embed RCP into their repertoire of skills. However, this premise assumes that all clinicians are on an equal playing field in terms of their readiness to adopt this way of working into their practice. The findings showed that this was not always the case, and at times pushed some clinicians outside their comfort zone and dominant ways of knowing and doing. As such, different techniques will be required

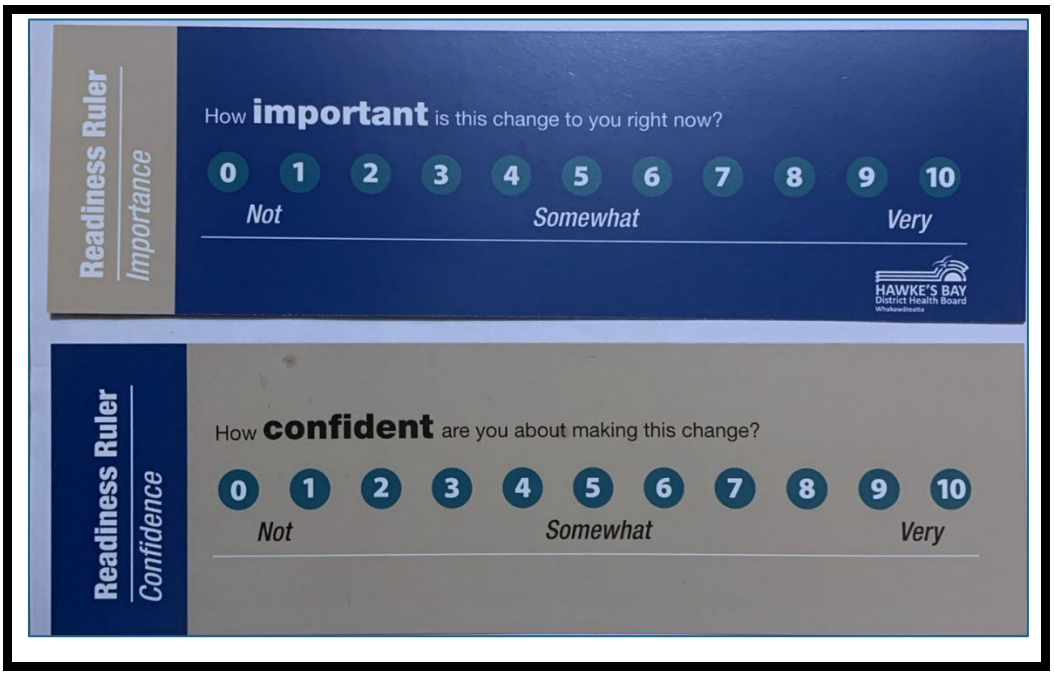
depending on where people are at in terms of their readiness to take up RCP as a way of working.

Assessing Readiness for Change

Assessing clinicians' readiness for change prior to the training may be useful so that facilitators can tailor supports to address the stage of change that clinicians are currently in. Prochaska et al. (2013) suggested that assessing a person's readiness to change is important to raise self-awareness. The readiness to change ruler (see Figure 12) draws from this theoretical model and supports self-assessment of one's current state of confidence and the importance placed on moving forward to make a change. This is a tool that was developed by the co-design group as a resource for the initial RCP training to support motivational interviewing for health professionals (Browne, 2024; Heather et al., 2008). It also provides a platform for discussion of any perceived barriers to making that change (Beasley et al., 2021; Prochaska et al., 2013). It is recommended this tool be incorporated into the RCP programme. Using the readiness to change ruler to determine where clinicians are at would be useful to assist the facilitators to identify supports that are tailored to where the clinician is at in order to increase their likelihood of successfully embedding RCP into practice.

Figure 12.

Readiness Ruler



Targeted Information and Education to Raise Consciousness

One strategy to raise consciousness and promote readiness to change for clinicians in the precontemplation stage might be to provide targeted information and education about the RCP model prior to the training. Learning experiences and professional growth need to be more than knowledge transfers or the teaching of new material (Ramani et al. (2019). Ramani et al. (2019) suggested that health professionals need education that supports them to have self-awareness, humility, and a motivation for mastery to enhance patient interactions. One strategy to support such education came from a suggestion made by Lisa in the member focus group discussion. Lisa suggested pre-recording a training video of a physiotherapist talking about their journey from starting their clinical practice with the belief of practical hands-on therapy as best practice, the discomfort of implementing RCP which challenged that belief, and then moving forward to adopt RCP into everyday practice. The video could provide the prompt to support participants to reflect on where they are with their own practice, creating the self-awareness that Ramani et al. (2019)suggested is important. This would overtly highlight the mindset change required and make visible the dominant mindsets and views of which people are often not fully conscious.

This video would also demonstrate the beneficial effect of using RCP to engage with whaiora and whānau from a clinician specific viewpoint. Incorporating the perspective of an active clinician who had been through the programme and who had assimilated RCP into their practice into future trainings was perceived by participants as a way of highlighting the potential of RCP, generating buy-in, and providing a platform for motivation and mastery that Ramani et al. (2019) identified. The training video could provide a trigger for a reflexive exercise in the training programme to help people unpack their pre-existing assumptions or beliefs. Such an exercise would be designed to assist health professionals to better understand the paradigm they currently practice in and what RCP offers as a complementary approach that can be woven into their practice. This strategy resonates with social cognitive theory which supports the notion that vicarious learning and learning from the experiences of others can assist in building confidence (Bandura, 2013; Cummings & Connelly, 2016). Davies et al. (2018) suggested that a transformative and supportive learning process is required to assist health professionals to focus on unpacking their values and beliefs.

The readiness ruler and reflexive techniques, together with a training video, would enable clinicians to be ready to move from the precontemplation to contemplation phase in the transtheoretical behavioural change model (Proschaska et al., 2013). These three strategies might assist participants to more accurately assess where they are by creating self-awareness of their current readiness and understanding, and move them forward to begin to contemplate embracing the practice change.

DBM

In the contemplation stage of Prochaska et al. (2013) transtheoretical behavioural change model, when clinicians are considering a change but not yet committed to it, strategies that make overt the pros and cons of a situation can be useful in moving people's thinking forward towards making a change in practice. Enabling people to articulate the advantages and disadvantages of a situation can assist them to work through their current thinking and consider the possible benefits of making a change. One tool that facilitates this is the DBM. The DBM is a motivational interviewing technique introduced as a strategy that can be used with whaiora in the RCP Programme (see RCP Toolkit in Appendix A). It may also be a useful tool to support critical reflection regarding the pros and cons of change for health professionals. Using this tool within the training would have a dual purpose of both supporting clinicians to examine their own readiness to change, while also modelling the use of this RCP strategy as a tool for practice. Using the DBM would also assist in addressing ambivalence in the contemplation stage of Prochaska et al.'s behavioural change model, where people have acknowledged the issue but have not yet committed to taking action. Specifically, utilising the motivational interviewing questions in the DBM would assist these clinicians to focus on and address ambivalence by helping them weigh up the perceived pros and cons of embedding RCP into practice. Asking questions like 'What are the benefits of making this change?' and 'What is the downside of making this change?' and 'What will happen if you do not make this change?' may assist clinicians to see the benefits of weaving this concept into their practice. It has been argued that the DBM can help people become unstuck and enhance their readiness to change (Miller & Rose, 2015). The understanding and motivation required to start the paradigm shift to embed RCP may be realised by applying these strategies to change the philosophies of practice (Cox,

2022; Gruber, 2003; McGrath, 2017). Normalisation process theory suggests for a change to be normalised into practice, people need to have coherence and make sense of that change to be able to then become cognitively engaged (May et al., 2007). The facilitators of the RCP programme need to ensure clinicians are able to find coherence between their beliefs about their discipline-specific practice norms and a RCP way of working. The DBM is a tool that can assist to explore consequences, identify and overcome perceived obstacles, and assist to make sense of a situation or an issue. Ensuring a degree of compatibility between one's own practice beliefs, professional identity, and the RCP model may support clinicians to become cognitively engaged and normalise the practice change (May et al., 2007). Utilising the DBM in future trainings may be a useful way to assist clinicians to cognitively process and critically think through any uncertainty or ambivalence in moving to embrace the practice of RCP. However, it is acknowledged that other supports and tools will be required to assist them to move forward to put these changes into practice.

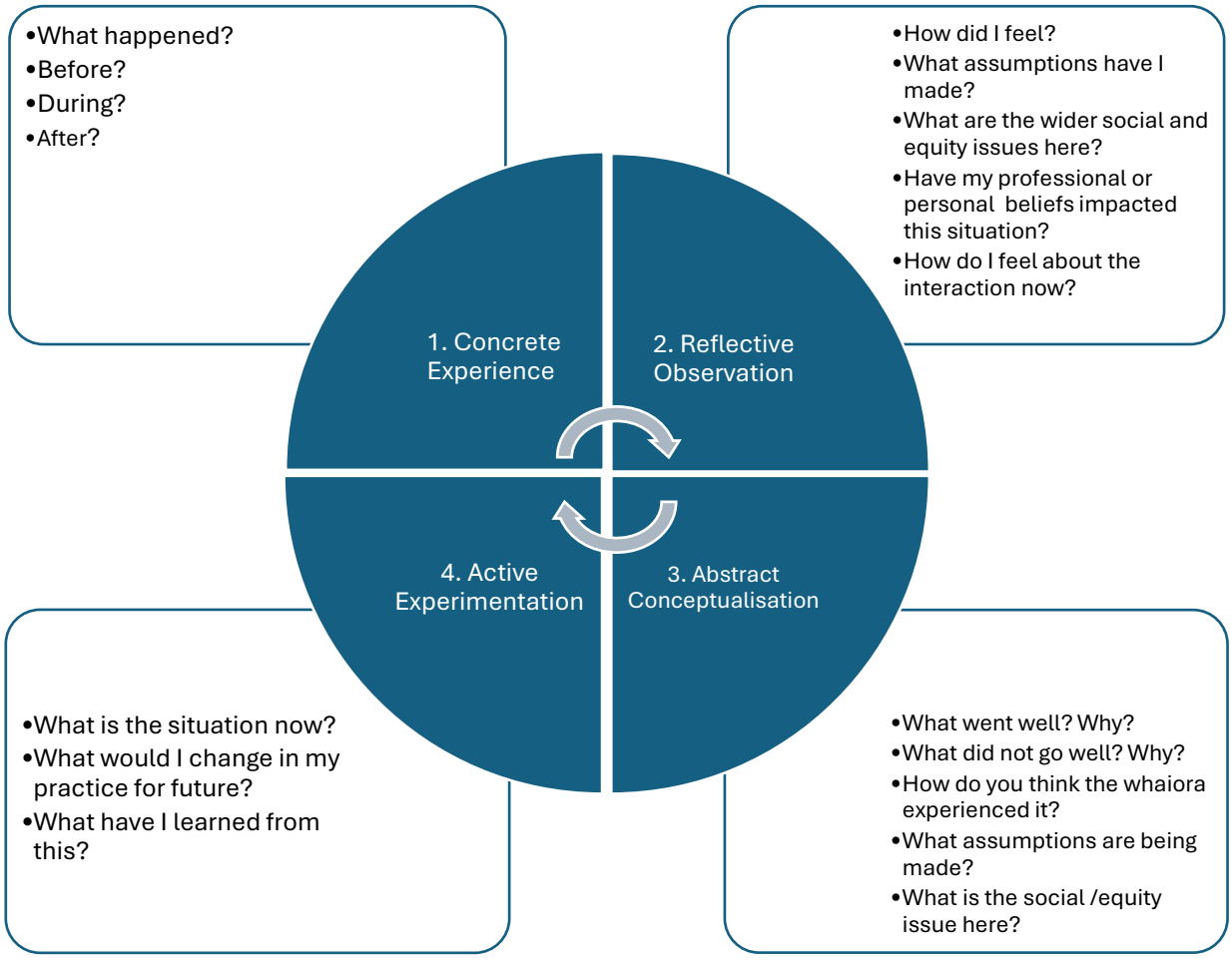
Critical Reflexivity

Another strategy that may assist health professionals who are still in the contemplation stage, and not yet fully engaged or committed to making a change, is critical reflexivity. Critical reflexivity is defined as the reflective process used to think critically and systematically about the impact of one's beliefs and values and how this impacts their actions in practice (Rolfe & Freshwater, 2020). All clinicians need to be able to recognise the parameters and norms of their professional practice, and need to recognise their tendency to want to ensure the 'best outcome' from their perspective for their patients. At times this transpires to wanting to retain control of the patient/clinician interaction and being the 'expert'. This desire highlights the importance of clinicians having tools that can support them to be critically reflexive about the impact that their beliefs have on their practice and how this, in turn, impacts the patients with whom they are working (Cunliffe, 2016). Setting up critically reflexive dialogues, drawing on scenarios, and asking key questions can assist clinicians to re-evaluate and rethink about how they practice. It can also assist to unpack their worldviews, beliefs, assumptions, histories, subjectivities that may underpin or exert influence over their practice.

Critical reflexivity can assist health professionals to become more critically aware by illuminating how their actions impact the whaiora with whom they work. It has been shown to highlight how clinicians' actions are influenced by workplace culture, existing power dynamics, and organisational expectations (Mescouto et al., 2022). Mescouto et al. (2024) maintained that critical reflexivity is a useful tool that can assist clinicians to critically examine social issues, help foster dialogue, and enable clinicians to challenge power relations to work towards a more equitable workplace culture. The current Professional Supervision Action/Reflection Model taught at Te Matua a Māui Hawkes's Bay leans towards practice reflection. However, this model could be expanded, developed, and enhanced to encompass a more reflexive approach to allow for the examination of beliefs and assumptions that underpin practices and ways of thinking (See example of expanded model in Figure 13 below). While critical reflexivity may be part of the initial training, it is also possible that clinicians' ongoing monthly supervision would support ongoing critical reflexivity and assist clinicians to focus on their clinical practice and how they are weaving relational ways of working through their practice.

Figure 13.

Critical Reflexivity Model of Patient Engagement



Adapted from Davys and Beddoe (2020).

Strategies to Resolve Practice Tensions

Clinicians who are at the preparation stage of Prochaska et al. (2013) transtheoretical behavioural change model, who are wanting to implement RCP but experiencing practice tensions that affect their ability to follow through with this intention, may benefit from learning strategies to navigate this tension. As indicated in the findings chapter, some clinicians grappled with trying to reconcile the difference between a biomedical orientation to practice and RCP. For certain disciplines (mainly physiotherapists, occupational therapists, and oral health therapists) doing something practical and/or physical appeared to be instilled as a hallmark of best practice and was inextricably linked to clinicians' feeling a sense of worth by perceiving they were adding value as a health practitioner. Existing research reflects that clinical practice in many areas is still

predominantly slanted towards a biomedical approach (Mudge et al., 2014; Nicholls et al., 2016) which can challenge a clinician's ability to move towards a more person-centred way of working (Mudge et al., 2015). When there is a conflict between two or more beliefs, values, or attitudes this can lead to a feeling of internal cognitive or emotional tension (Harmon-Jones & Mills, 2019). When clinicians face such a tension such, they can feel uncertain and anxious which affects their decision-making ability and impacts their job satisfaction and sense of self-worth (McCormack et al., 2011a). This internal tension can also sometimes manifest to cause cognitive dissonance, which is the discomfort a person feels when their behaviour does not align with their values or beliefs (McGrath, 2017).

Resolving cognitive dissonance can be a challenging process. Yet it is recognised that cognitive dissonance can create conditions to enact change, so capitalising on this discomfort can be a catalyst to motivate people to align their beliefs and actions (Gruber, 2003; McCormack et al., 2011a). Overtly discussing and creating an understanding that context-appropriate care that balances the right mix of technical competence with a relational approach is fundamental, will be an essential component in future trainings (Fadyl et al., 2011a). Surfacing tensions so that they are visible can also be a catalyst to developing a person's understanding and provide the platform for clinicians to enact practice change (Mease, 2019). Therefore, the internal tension experienced by clinicians can provide an opportunity to discuss possible solutions and may assist in moving them forward with embedding RCP (Gruber, 2003; McGrath, 2017).

Creating a culture that supports clinicians to embed RCP into practice and providing strategies to help reduce dissonance will be essential (McGrath, 2017). Strategies already discussed above, such as targeted education to raise consciousness, critical reflexivity, and utilising the DBM, may assist clinicians to adjust their attitudes and practice towards a more relational way of working. In future iterations of the RCP training, brainstorming and devising a collective list of strategies to help prepare clinicians with dissonance reduction strategies has the potential to a provide a feedback loop, create buy-in, and raise consciousness.

Recommendation: Acknowledge and Facilitate Mindset Change – Goal Attainment versus Goal Progress

One of the central tenets of RCP is finding out what is important to whaiora and, through shared decision making, negotiating expectations and setting goals for that episode of care. My findings showed that clinicians became disheartened if they could not assist whaiora to achieve their goal within the episode of care due to the focus on patient flow or resource constraints. However, this finding offers an opportunity to question whether goal attainment is the best focus, or whether progress toward a goal is equally important in working towards that outcome. The preparation stage of the transtheoretical behavioural change model offers the opportunity to challenge the perspective that goal attainment is the only marker of success, which could support the shift to viewing goal progress as being a positive outcome. One approach to support this opportunity could be to help clinicians contextualise their episode of care in the context of the patient's whole journey. Assisting clinicians to view RCP as an enabler across the continuum of care, including the person's life after discharge, may help clinicians view their contribution as a stepping stone towards reaching whaiora goals. Finding out 'what really matters' to whaiora is essential. It is important to understand that patient expectations, hopes and aspirations, and a stated goal are sometimes not congruent; thus, a clinician's thinking needs to go a step further to consider how that goal relates to, and needs to be addressed within, the episode of care ((Bright & Davison, 2022; MacDonald et al., 2013). A key focus within the time available might be the clinician harnessing the strengths and resources that already reside within whaiora and whānau so they have belief in their capacity to continue to work towards what matters to them. If this belief, together with agreed supports and onward referrals, is put in place for whaiora to continue to work towards their goals after discharge, then these clinicians may be able to view this as goal progress. This concept needs to be socialised and reiterated in future RCP trainings.

Developing skills to hold space for the hopes and aspirations of whaiora, while also being able to anchor the tasks and activities in achievable rehabilitation goals, will be essential for clinicians. It is, therefore, important for clinicians to acknowledge whaiora hopes and aspirations and to work out how to break these down into a series of actions and sub-goals that are achievable and reflect and contribute to the wider goal (Bright et al., 2013). Assessing progress made towards achieving sub-goals with a patient and

discussing this progress has been shown to be a motivator to energising a patient towards effective self-management and promote behavioural change. McPherson et al. (2015) suggested valuing what is truly meaningful to that patient and checking in at intervals on progress can provide a sense of achievement, enhance mood, and assist patient motivation. However, the RCP training alone will not shift clinicians from focusing on goal attainment toward goal progress. Ongoing support and coaching beyond the training will be important to embed these changes. This will be discussed further in the practice level recommendations later in this chapter.

Recommendation: Facilitate Strategies to Manage Challenges to Sense of Agency

The findings highlighted that a clinician's sense of agency is often compromised by resource constraints and the organisational priority of focusing on patient flow and expediency. Tilburt (2014) suggested that the conflict between a PCC approach and the demand on healthcare resources leaves clinicians feeling pulled in different directions within their healthcare interactions. They termed this as clinicians having "dual agency" (Tilburt, 2014, p. 19). Increasing clinicians' understanding and confidence in enacting their agency, along with equipping them with practical strategies to maximise their ability to prioritise relational practices when work demands are high, will be important in future RCP training. However, this responsibility cannot sit solely with the clinicians and needs to be supported by systemic changes (discussed further below). Regardless, having some strategies in their toolbox may assist clinicians to be able to reconcile the dilemmas they face between their sense of agency to enact RCP and organisational demands (Sirris, 2022; Waitzberg et al., 2022). Using facilitating strategies to support decision-making will be important. Strategies such as the DBM and using the MDT meeting to ensure the team are being relational, with each patient discussed even when there is pressure to prioritise and be expedient, may help to mitigate these practice dilemmas (Sirris, 2022; Waitzberg et al., 2022).

Time was perceived as a barrier to enacting RCP by some participants; a finding consistent with prior research where time has been identified as a perceived barrier to the implementation of PCC (Bombeke et al., 2010; Elton, 2016; Jackson, 2022; Moore et al., 2017). However, some acute and primary care literature suggest that being relational has minimal impact on time, and can save time in patient interactions later on because

a strong foundation of trust has been built (Ekman et al., 2012; Hansson et al., 2016; Ormrod, 2016). For example, a Aotearoa New Zealand study investigating a PCC model in primary care found that spending more time building relationships and trust with patients in the initial patient interaction appeared to be a contributing factor to patients being more engaged in their healthcare, which meant less appointments and time spent with the general practitioner downstream (Ormrod, 2016). Taking time in patient interactions to be relational and person-centred in approach may, over a lifetime of a person's healthcare, mean less time overall. Therefore, it is important to challenge the assumption that PCC takes more time in the RCP training and provide clinicians with strategies to embed relational approaches when time is limited or in times of high pressure. Gillam and Yusuf (2019) have highlighted strategies of how clinicians in an oral health environment can be patient-centred, collaborative, and effective in time constrained interactions. They proposed a brief four-step motivational interviewing structure to support child and parent engagement and positive behaviour change (Gillam & Yusuf, 2019) which involves the clinician engaging with the child and care-giver in a relational way. It has also been shown that PCC can be enacted in an expedient and effective manner, if there is authentic engagement, active listening, and management of patient expectations by the clinician (McCance et al., 2013; McCormack et al., 2011a). King (2022) critical review of listening in healthcare conversations showed effective listening, that is actively listening to understand the meaning behind the words, was the most important factor to ensure mutual understanding, build relationships, and engage the person in their rehabilitation journey. This is reiterated by Lawton et al. (2020) study of therapeutic alliances from the perspectives of people with aphasia. Their research identified the elements of therapeutic alliance that were most important to people including clinicians acknowledging, respecting, hearing, and helping them to understand, and listening. It will be important to extend the existing RCP training module on active listening to include a more in-depth session on listening to understand and strategies to check mutual understanding has been attained. Further, future iterations of the RCP training need to provide strategies for clinicians to change how they approach patient interactions and how to make those quick connections when time is limited. Additionally, incorporating a brainstorming session to generate ideas on how clinicians can work relationally in the context of competing demands may bring to the fore novel

or innovative techniques that others might be able to assimilate into their practice (Montani et al., 2017; Paulus & Kenworthy, 2019).

Recommendation: Practice using Te Ao Māori Models to Boost Confidence and Competence

Some clinicians appeared to experience effective whaiora engagement when they applied the step-by-step Te Ao Māori model of the Hui Process. This positive result appeared to reassure clinicians that the Hui Process was an effective practical strategy which built confidence in clinicians' belief in their own ability and increased their motivation to use this model. For future RCP training it appears important to provide more space and opportunity for all clinicians to practice and gain confidence in effectively using these Te Ao Māori models of engagement before returning to the workplace. This resonates with self determination theory which provides a framework for understanding the role of motivation in supporting behaviour change. Deci and Ryan (1980) argued that in self determination theory there are three basic psychological needs need to be met (autonomy, competence, relatedness) and when they are met, they will be autonomously motivated or self-determining. Deci and Ryan's work on self determination theory has had a significant impact on understanding motivation in the health context. Their research emphasises the importance of supporting individuals' autonomy, competence, and relatedness to foster optimal motivation and psychological growth (Deci & Ryan, 1980).

Deci and Ryan (1980) suggested that motivation is at two ends of a continuum depending on the level of internalisation. To be entirely intrinsically motivated would mean one is doing something entirely for joy or interest. Whereas, identified or integrated regulation may be more what PCR facilitators would aspire to for health professionals when seeking to embed practice change. *Identified regulation* refers to when a person consciously identifies with, or personally endorses, the value of an activity, and thus experiences a relatively high degree of volition or willingness to act. *Integrated regulation* refers to when a person not only recognises and identifies with the value of the activity, but also finds it to be congruent with other core interests and values. Experiencing effective whaiora engagement when using the Hui Process and clinicians observing benefit, in turn

compelled them to continue to use that strategy. Clinicians experiencing success assisted with them with identified regulation and moved them towards integrated regulation. This success has implications for clinicians' wanting to practically apply and master the Hui Process. Repeated, simulated, and positive experiences can lead to more confidence in applying the skills in practice (Cummings & Connelly, 2016). As such, providing opportunities to practice, become familiar with, and experience success with the Hui Process during the training has the potential to build confidence and belief in one's own capabilities and will assist with identified regulation. Following up with practice opportunities of the Hui Process through ongoing regular coaching sessions (discussed further in recommendations below), may also reinforce clinicians' confidence and competence to embed this in model of care and assist in moving towards integrated regulation. Furthermore, providing exemplar's of where clinicians have successfully used the Hui Process to engage with whaiora, maybe a strategy to assist other clinicians to recognise the benefits and consider what was at the heart of that experience and seek to mimic that when using aspects of RCP in their own work.

Using the Hui Process highlights a potential risk for practice that needs to be mitigated. That is authentically applying an Indigenous model by non-indigenous clinicians (Hoskins & Jones, 2020). It is clear from the literature that non-Māori clinicians may misinterpret or superficially apply models without a deep understanding, leading to cultural misappropriation or tokenistic practices that do not genuinely improve healthcare outcomes for Māori patients (Curtis et al., 2019; Hoskins & Jones, 2020). This could lead to ineffective practice or potentially practices that cause patient harm (Curtis et al., 2019; Pitama et al., 2014). Therefore, a recommendation for future iterations of the RCP programme is to provide clinicians with ongoing opportunities for regular cultural supervision and mentorship from kaumātua or experienced Māori practitioners through regular wānanga to assist Tauiwi clinicians to engage with these models to ensure cultural safety and responsiveness (Durie, 2004; Hoskins & Jones, 2020; Jones, 2017). Collaborative wānanga learning could strengthen clinicians' commitment to embedding the Hui Process into their everyday practice to provide culturally appropriate care, and build a supportive workplace network committed to addressing inequities.

Implications and Recommendations at the Clinical Practice Level

My findings suggest one-off training is unlikely to be sufficient on its own to assist clinicians to embed RCP into their everyday practice. The importance of supporting clinicians with RCP at the patient interface was identified in the findings chapter and has the potential to enable clinicians to break the cycle of reverting back to transactional interactions with whaiora. The findings draw attention to the need to create conditions for RCP to be foregrounded and prioritised in the everyday work context so it can be more easily assimilated into practice. To maintain practice at the action stage of Prochaska et al. (2013) transtheoretical behavioural change model, different scaffolds will be required at the clinical practice level. Therefore, I suggest that future iterations of RCP need to consider implementing the following three recommendations for successful practice change programmes:

1. training workplace cohorts as CoP to provide a platform for a shared culture to grow;
2. training RCP workplace champions to support and address issues; and
3. provide monthly case review and coaching sessions for clinicians to reflect on and develop strategies to embed RCP into everyday practice.

Recommendation: Training Workplace Cohorts

Participants suggested it was importance for all clinicians working in the same physical workplace location undertaking RCP training to ensure they all had a shared understanding of the central concepts. My findings suggest that taking a new way of working back to a workplace where it is not the norm or dominant way of working, makes it challenging to embed into everyday practice. Therefore, at the preparation stage of Prochaska et al. (2013) transtheoretical behavioural change model, training workplace cohorts may assist with embedding and normalising RCP into everyday practice. Being a participant in workshop is an example of someone preparing to make change, and training in workplace cohorts sets the context for a supportive environment which is relevant to the 'helping relationships' process of change in the transtheoretical behavioural change model. May et al. (2007) argued that involving the whole MDT assists with coherence; that is, making sense of this new way of working for the entire team. This would ensure that clinicians are on the practice change journey together, which has the potential for collective action. This is a key element in normalisation process theory,

helping normalise a new way of working into everyday practice (May et al., 2007). While workload demands, expediency, and pressure to discharge will still be present, having others in the MDT who are cognisant of and working in a relationship-centred way may support individuals to embed RCP. It may also go some way towards addressing the perception of being judged by other colleagues for working in a relational way that some participants reported. Training workplace cohorts may allow a collective understanding to grow and feel more supported by colleagues to use and embed the key RCP strategies (May et al., 2007; Nicholls, 2009a).

Training in cohorts may also provide an opportunity for CoP to develop (May et al., 2007). CoP are groups of individuals who share an interest about a problem and want to make a difference, and regularly meet to deepen their knowledge and look at innovative ways to improve practice (Ranmuthugala et al. 2011). CoP provide a platform for knowledge to disseminate across professional boundaries and create opportunities for drawing on a collective understanding to support and strengthen practice change at the workplace level (Ranmuthugala et al., 2011). Clinicians who are part of a CoP have the potential to assist in supporting others in the workplace to embrace a practice change, and can be catalysts in developing a sense of community, fostering trust, and mutual engagement (Delgado et al., 2020). For CoPs to develop and flourish, leadership support is critical to enable clinicians with the time to be able to regularly meet to deepen their knowledge and look at innovative ways to improve practice (May et al., 2007). Developing CoP may provide a group of multidisciplinary health professionals who champion RCP in the workplace, thereby ensuring a supportive and learning culture develops.

Recommendation: Creating an RCP Workplace Champions Role

The findings suggest that having day-to-day support would augment, support, and coach clinicians in the workplace and may be a component in maintaining RCP. Another suggestion, then, would be having clinicians champion RCP in everyday practice to support the implementation and embedding of this practice change (Wye et al., 2019). Bornbaum et al. (2015) suggested champions can bridge the gap and support knowledge exchange at a practice level, as linkage agents and capacity builders. This was evidenced by Gerrish et al. (2011) in their study with nurses, showing that workplace champions promoted nurses to embed and sustain practice change through being available, role-

modelling, coaching and addressing issues. Bonawitz et al. (2020) put forward six key attributes that champions require including ownership, physical presence at the point of change, influence, persuasiveness, grit, and a participative leadership style. Having RCP champions available in workplaces to coach and support others through workplace conversations, may assist in embedding this practice change (Wye et al., 2019). It would be important to ensure that these champions were consistently embedding it in practice, aligned with the intended philosophy, and were confident and competent working in this way (Gerrish et al., 2011; Wye et al., 2019).

Institutional siloing of ward or professional teams and resistance to change can make the role of being a champion at times uneasy and difficult (Bonawitz et al., 2020). Ensuring organisational-level support for champions from Clinical Leaders and Managers is essential to ensure any change that the champions are advocating for is overtly seen to have organisational buy-in and backing. Ensuring that champions have the key attributes that Bonawitz et al. (2020) suggest will assist in helping them overcome and navigate any siloing, cultivate positive learning climates and create the tension needed for change. Encouraging champions to build on and use their existing professional networks to leverage change will also be important. These might include working with the health professionals that they have already have a strong relationship with and those that may already ork using a RCP approach. Finally, providing ongoing coaching and debriefs, and enabling opportunities for reflection will actively support the champions. Together, these strategies will maximise support, gain traction and sustain momentum for these champions (Bonawitz et al., 2020; Gerrish et al., 2011; Wye et al., 2019).

These champions would be integral in being involved with the development of a workplace CoP, mentioned in the previous recommendation. The CoP would provide ongoing support and continue to assist in building the workplace champions' knowledge base.

Recommendation: Regular Coaching Sessions to Support Practice Change Initiatives

In the maintenance stage of Prochaska et al. (2013) transtheoretical behavioural change model, having regular coaching sessions to support the practice change will be important element. The participants reflected that follow up sessions to review concepts and

reflect on the challenges and opportunities for integrating RCP into practice would have consolidated their knowledge, supported practice, and introduced some accountability. As such, including regular RCP refreshers to undertake case reviews, provide group coaching, and support reflection is recommended. Having access to mentorship, support, guidance, and coaching, which provide meaningful learning opportunities, is key to supporting practitioners to develop themselves and to embed change initiatives into daily practice (Weaver et al. 2014; Westcott & Rosser, 2022). Pedersen et al.'s (2021) study on a team change initiative for physicians and nurses found that regular coaching sessions had two key benefits – skill reinforcement and sustained behaviour change. The authors showed that clinicians who attended coaching reported an increased sense of self-worth and appeared to be more effective in their engagement with patients. The patient satisfaction scores reiterated this finding, showing improvements in these clinicians' healthcare interactions ratings (Pedersen et al., 2021). Introducing regular RCP coaching sessions at Te Matau a Māui Hawke's Bay would also provide a safe place for clinicians to share experiences and address any barriers, particularly if they struggled to enact their sense of agency, or to reflect on any internal dilemmas they may be experiencing. Regular coaching sessions, together with the provision of workplace champions, would provide safe places for clinicians to have conversations to reflect and grow.

Implications and Recommendations for Organisational Structures and Processes

Existing systems and structures in the healthcare arena appear to reinforce an emphasis on ensuring good patient flow and prioritising expedient discharge. Additionally, from an AHP perspective, hands on or practical therapy appears to be valued as good practice. Participants provided insight into how these structural factors can contribute to creating an environment which fails to support and potentially overtly *pulls* clinicians away from embedding RCP in practice. My findings highlighted that there is a lot of responsibility placed on the individual clinician to embed practice change through the way the RCP programme is structured and taught, with little consideration of the need for fundamental system change. My findings highlight that changes are required to address some of these structural barriers. For instance, I argue that redefining service priorities and communication around patient flow to emphasise that decision-making based on whaiora best interest should be considered and introduced. The theoretical domain framework purports that for any sustained individual practice change, system and

environmental reinforcement is essential to support and maintain that change (Michie et al., 2011). Therefore, further examination of the broader structural influences that may impede the embedding of behavioural change initiatives will be required. Identifying or developing strategies to address these structural barriers requires further research which I discuss in the discussion chapter. In this chapter, I have only focused on what the participants specifically identified in the study around the processes that clinicians are required to engage and practice within.

Recommendation: Changing Reporting, Appointment Scheduling, and Processes to Reflect and Support RCP

A recommendation for future iterations of RCP is to critically consider what organisational processes can be altered to augment and support change at a practice level. For instance, participants in the member focus group noted that reporting mechanisms reinforced a transactional way of working by having designated sections for reporting on treatment in their assessment forms. By comparison, there was no section for reporting engagement or connection with whaiora and whānau. Including prompts on engagement and connection within the clinical assessment and reporting documentation would normalise a culture of relational intent in day-to-day patient clinician interactions, while making this work more visible to others. Luxford et al. (2011) highlighted that modifying recording and reporting of assessment and treatment interventions to reflect PCC improved patient experience and reinforced clinicians' practice. Similarly, Boaz et al. (2011) found that encouraging the reporting of practice change interventions overtly in clinical notes reinforced that practice change. Making changes at a process level to align assessment and reporting requirements with an RCP way of working would reinforce and support this relational practice.

Introducing a more patient-centred focus in the MDT daily meeting to talk about what matters to whaiora, what their needs and preferences are, how the MDT might attend to those things, and work together to each contribute to that as a shared focus would assist with championing RCP. This notion is reinforced by Ahmed et al. (2019) who suggested that PCC can be reinforced through implementing a more patient-centred focus into MDT meetings and rounds. This approach has also been utilised by Te Whatu Ora Whanganui's acute rehabilitation stroke service who used the psychosocial toolkit

to discuss the psychosocial well-being of patient and whānau. Their case study showed that implementing a more patient-centred focus into their team rapid rounds was integral to embedding this approach into everyday practice (Bright & Davison, 2022). A recommendation for consideration in the next iteration of the RCP programme at Te Matua a Maui Hawkes Bay, would be to introduce a patient-centred focus into the MDT daily meetings.

As discussed in the implications and recommendations for training earlier in this chapter, guiding participants to brainstorm other processes that may be tweaked to support an RCP way of working may identify other areas that might be modified. For instance, in relation to constricting and time limited appointments, other ideas may be generated by clinicians on how Te Matua a Maui Hawkes Bay can structure appointments differently to prioritise time for relationship-building. Clinicians are the knowledge experts in their work areas, and they will have insights into where there might be easy wins to support working in a more relational way. Scheduling systems led by patient choice, and prioritising patient needs and preferences, has been shown to be an effective system change strategy to augment a PCC way of working (Ahmed et al., 2019; Luxford et al., 2011). Services which have 15-minute block appointments, like oral health, may need to consider change at the triaging stage. For instance, scheduling those whaiora that oral health kaiāwhina have flagged as having moderate to severe caries or tooth decay, or having more complexity into 30-minute appointments, may be appropriate. This may ensure clinicians have the appropriate time to connect in a relational way to make shared decisions over health goals.

The RCP programme facilitators may want to consider working with the Organisational Development and Human Resource teams to look at aligning performance plans with RCP principles. Using the performance plan process to create a climate and expectation around required knowledge, skills, and abilities, and linking this to the strategic goals of the organisation, could be transformational in supporting and reinforcing practice change at an individual level (DeNisi & Smith, 2014). Performance reviews can contribute to normalising practice by setting performance objectives through verbalising practice expectations and may reinforce change (Johnson & May, 2015). Ensuring that RCP practices are reflected in health professionals' performance plans may support and

promote a shared meaning, language, and culture to grow across the organisation. Discussion during performance plan goal setting might also provide opportunities for clinicians to make visible the wider supports that they may require to help them embed RCP into their practice.

Recommendation: RCP Training for Doctors and Leaders to Engineer Support

Getting buy-in from doctors and leaders will be an important factor to consider as there is evidence of a hierarchical power differential with doctors still influencing how things are done, particularly at ward level (McCance et al. 2013; McCormack et al. 2011). My findings showed that the participants felt that not all doctors were on board with being relational with their patient interactions. Getting support from leaders is important to ensure efficient commitment and resourcing for the programme. The consolidated framework for implementation research (CFIR) highlights that there are many interacting, complex, and multi-faceted components to embedding change in healthcare (Damschroder et al., 2009). Damschroder et al. (2009) argued that one essential element to support change at the practice interface and process levels is leadership commitment, involvement, and engagement. In practice, getting doctors to attend training is always fraught as they too are caught up in the pressures of prioritisation, expediency, and ensuring patient flow. An option to engage these clinicians would be to consider showcasing the RCP practice mode, and the Hui Process as a key strategy at a weekly Grand Round lunchtime session. A further option would be capitalising on the doctors and senior leaders who are committed to RCP by approaching and encouraging them to champion the programme in their peer groups to socialise and create awareness of the approach. Creating a shared vision and networking through existing relationships is an inner construct of the consolidated framework for implementation research (CFIR), and Damschroder et al. (2009)purported that this can be a strategy to socialise and positively influence implementation of practice change. Recommendations for future RCP iterations will be to target and encourage leaders and medical staff to attend RCP trainings, provide Grand Round sessions, and canvas doctors to champion the approach among peers to socialise and encourage increased uptake of this relational way of working.

Conclusion

This chapter has presented recommendations for future iterations of the RCP programme at Te Matau a Māui Hawke's Bay to optimise the likelihood that the ways of working promoted through RCP are able to be implemented into practice. These recommendations are informed by and underpinned by my findings which highlighted that standalone training is not sufficient on its own to change clinician practice. Rather, a range of tailored and multi-level strategies are proposed at the training, clinical practice, and organisation process and structural levels to create the conditions for successful uptake of RCP. Using Prochaska et al. (2013) transtheoretical behavioural change model, I have highlighted the different strategies that clinicians may require to embed this practice change depending on their readiness for change.

The recommendations outlined in this chapter highlight that clinicians need to be supported to retain their sense of agency by equipping them with strategies and skills to address inhibiting barriers and to navigate the cognitive tensions that they may experience in implementing RCP. The strategies and supports required are summarised in Table 7 and need to be considered in any future iterations of the RCP programme.

Chapter Eight – Discussion

The primary objective of this research was to explore what helped or hindered the implementation of Tikanga Ako Hono-Tāngata – RCP by AHPs within HBDHB. A comprehensive literature search was undertaken to explore what was already known about the enablers and barriers to implementing PCC both globally and in Aotearoa New Zealand (Chapter Three). Utilising interpretive description as the methodology to inform this study, I interviewed 8 AHPs to get an in-depth understanding of their perspectives on what they perceived helped or hindered them implement RCP in an Aotearoa New Zealand setting. My research findings highlighted three interrelated factors that appeared to impact how clinicians implemented RCP (Chapter Six). First, patient flow and expediency were valued over being relationship-centred in everyday practice. A clinician's sense of agency to be able to embed RCP was compromised by the prevailing structures and processes within the organisation, meaning they were often pulled in different directions. The second theme highlighted the internal tension that clinicians sometimes experienced when a) patient preference was perceived to conflict with their discipline-specific practice norms; or b) providing practical treatment was strongly linked to a clinician's self-image of making a valuable contribution. Clinicians experienced an emotional and cognitive load in trying to reconcile their professional beliefs with the RCP approach in these circumstances. The third theme highlighted that when clinicians used RCP strategies in their practice and observed the resulting impact on patient engagement, this appeared to enhance their confidence and motivation to continue to use the Hui Process and other RCP strategies.

Several implications have emerged from my findings. A successful change programme needs to be comprehensive, supporting clinicians at every level. It needs to include support mechanisms before, during, and after training, including mechanisms within organisational processes and structures. As detailed in the previous chapter, recommendations include assessing clinician readiness to change prior to the training taking place so that supports can be tailored to meet them where they are at. To support the implementation of RCP at the practice level, strategies such as training workplace cohorts to increase understanding and provide a common language, training RCP champions, and providing regular refresher coaching sessions to support clinicians, may

be critical to embedding this way of working. At the structural level, aligning reporting and MDT processes, appointment scheduling, and performance development review expectations to reflect a relational approach were some of the strategies put forward to assist in embedding an RCP way of working.

I now turn to focus on three key contributions this doctoral research has made to knowledge and practice that may be pertinent in influencing the implementation of PCC in healthcare settings. While some learnings may be generalisable to change programmes seeking to integrate new ways of working more broadly, the contributions that I discuss in depth below are likely to be unique to the implementation of person-centred and relational ways of working. There are also specific learnings for change within the Aotearoa New Zealand context. Along with theory and evidence, I weave some of my own reflections into this discussion chapter. The key contributions discussed include that:

1. any change programme needs to take into account the divided sense of responsibility that clinicians have that is split three ways between the whaiora they are working with, their discipline-specific norms, and the organisation;
2. practice change programmes in healthcare in Aotearoa New Zealand need to be supported by an overarching organisational wide change programme which considers cultural responsiveness and equity to ensure their uptake and sustainability;
3. practice change is unlikely to be sustained without a paradigmatic and transformational shift in how training programmes, regulatory bodies, and healthcare organisations socialise and support the integration of PCC.

In this chapter I also discuss the key strengths and limitations of this doctoral work and identify further research opportunities that may enhance knowledge in this area.

1. Divided Sense of Responsibility which Impacts Sense of Agency

In implementing RCP, clinicians in my study were often faced with a divided sense of responsibility. Clinicians felt a responsibility towards the organisational requirements which put emphasis on expediency and prioritisation of patients to ensure efficient flow through the hospital or on addressing caseloads in community settings. Clinicians also

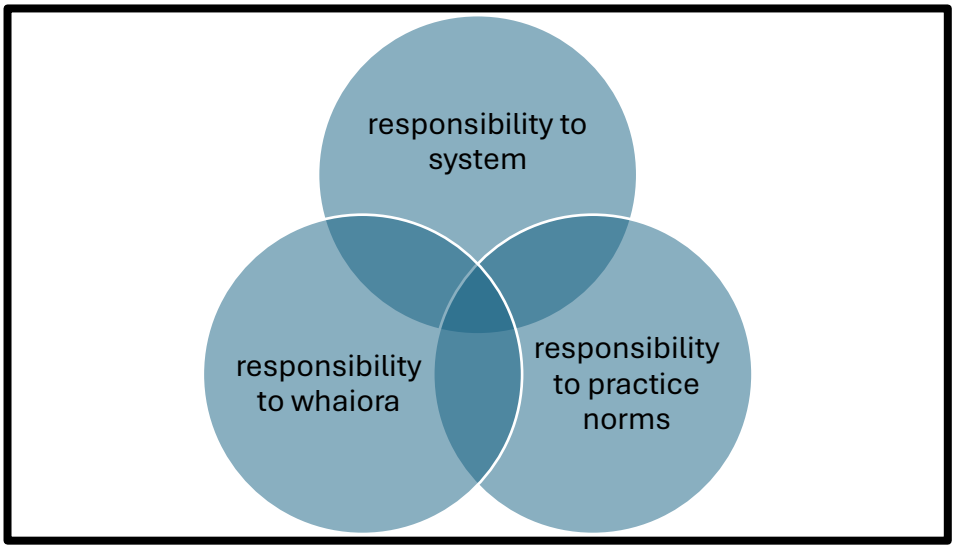
felt a sense of responsibility to address the needs of patients. This experience is not isolated to Te Matau a Māui Hawke's Bay. Existing evidence has highlighted that clinicians are often caught in a bind between the competing agendas of institutional requirements and meeting the needs of their patients (McCance et al., 2013; Norris & Kilbride, 2014; Rogers et al., 2005). The ability to embrace PCC in practice is often impeded by the tussle between conflicting priorities of patient need and the available time and resources (McCance et al., 2013; Norris & Kilbride, 2014; Rogers et al., 2005). However, my findings highlighted a *third* sense of responsibility linked to clinicians' training and professional identity, in that there was also a pull towards the established practice norms of a clinician's respective profession. Clinicians' professional identity and their discipline-specific norms appear to be strongly ingrained and are an integral part of their everyday practice. Some clinicians did not appear overtly aware or conscious of these factors. These practice norms have been socialised through undergraduate training programmes to ensure students are competent to practice in their chosen field (Smith et al., 2021; Thibault, 2013). Professional norms are perpetuated and reinforced through the ongoing evolvement of the profession through competency frameworks, professional registration boards, professional development, conferences, and workplace socialisation (Smith et al., 2021).

Clinicians use their disciplinary knowledge with good intent, to minimise risk and to try and direct patient's behaviour and subsequent management of their health condition through education and instruction (Dillon et al., 2023; Moore & Kaplan, 2018). However, this direction and education from clinicians sometimes does not align with the patient's goal or agenda (Entwistle et al., 2018; Moore & Kaplan, 2018; Mudge et al., 2015; Norris & Kilbride, 2014). Gibson et al. (2020) talked about "benevolent manipulation" (p. 1533). where clinicians, with the best intent, lead whaiora to making a decision in alignment with the clinicians' best practice ethos. Norris and Kilbride (2014) also had put forward a similar notion in what they termed "benign dictatorship" (p. 35) suggesting that this can occur when clinicians are committed to helping their patients move forward but are still more comfortable with being in control of the patient interaction. The idea of trying to direct whaiora decision-making was discussed in the member focus group. While clearly wanting the best outcome for the whaiora, participants acknowledged they often guided the patient towards their own clinical agenda due to that being perceived as 'best

practice' according to their discipline-specific and practice guidelines. This suggests that clinicians can unconsciously or consciously try to sway a patient's choice to their way of thinking (Dillon et al., 2023; Gibson, 2001; Gibson et al., 2020; Katz, 2002; Norris & Kilbride, 2014; Sullivan et al., 2021). In essence, discipline-specific training, professional identity, and practice ethos can impact a clinician's ability to embed RCP into their everyday encounters with whaiora, as depicted in Figure 14.

Figure 14.

Factors Compromising a Clinician's Sense of Agency



Existing PCC literature points to the tension between organisational demands and/or patient needs; however, the tension of discipline-specific practice norms is often talked about separately (Carlström & Ekman, 2012; Hebblethwaite, 2013; McCance et al., 2013; McCormack et al., 2011a). My research demonstrates the cumulative effect that these factors have on clinicians and how they grapple with this in the moment, when all these things collectively come to bear on their practice and clinical decision-making. The cognitive and emotional load that clinicians experienced because of these competing demands could, at times, feel irreconcilable to participants in my study. Trying to resolve these competing demands appeared to compromise clinicians' sense of agency to meaningfully fulfil the aspirations of RCP. My research highlighted that this cognitive and emotional load resulted in some clinicians experiencing cognitive dissonance which occurs when there are inconsistencies among cognitions of knowledge, values, attitudes, or beliefs about oneself or one's behaviour (Vaidis, 2014). My findings suggest that the

emotional and cognitive load that these tensions created for clinicians sometimes eroded their sense of fulfilment and achievement as a health professional.

Being unable to meet expectations that were set up with the whaiora through the process of RCP appeared to impact job satisfaction and potentially caused moral distress for some clinicians. It is increasingly being used by health professionals to describe experiences of internal frustration and failure (Fourie, 2015). My findings highlighted that when some clinicians were not able to meet what they saw as whaiora perceive expectations, they appeared to experience residual feelings of discomfort in that they had failed the whaiora and whānau by not fulfilling their perceived responsibility to them. If that is, in fact, perceived by whaiora and whānau, there is a very real potential for these experiences to add to the cumulative impact of system failures for whaiora and whānau in Aotearoa New Zealand's healthcare system. It is well evidenced in the literature that Māori experience institutional barriers of racism and discrimination in the Aotearoa New Zealand public health system which can culminate in whaiora and whānau feeling marginalised and not receiving culturally appropriate care (Graham & Masters-Awatere, 2020; Wepa & Wilson, 2020). Wilson et al. (2021) maintained that negative healthcare interactions can lead to sub-standard care with whaiora needs not being met and trust being eroded, and this can sometimes lead to avoidance and an unwillingness for whaiora to engage in healthcare interactions. Therefore, if clinicians create expectations through RCP and do not meet these expectations, there is potential to add to the marginalisation and system failure that Māori already experience.

The literature suggests that if health professionals must choose between meeting the needs of the system and the patient, then this internal tension may impact their well-being and, at times, lead to some clinicians experiencing moral distress (Adamopoulos, 2022; Sullivan et al., 2021). If a third competing 'pull' of a clinician's professional norms is added, this furthers the tension experienced by health professionals. In turn, it may affect whether clinician feel they have made a difference through the therapeutic interaction, and whether they have been able to fully and meaningfully contribute to the patient's treatment or rehabilitation. Job satisfaction is derived from the positive or negative response a person has about their work related to those internal or environmental factors that provide a sense of reward, fulfilment, and/or motivation

(Adamopoulos, 2022). Nolan et al. (2006) suggested that a clinician needs to feel secure, have purpose, a sense of fulfilment, and feel significant in order to have a sense of worth to ensure workplace well-being. My findings show that the experiences of clinicians having to navigate these competing 'pulls' can impact on their sense of purpose and well-being. It is essential, therefore, to proactively address this issue through the RCP programme so that clinicians still feel they are contributing in a meaningful way and that whaiora are not left feeling let down or further marginalised. As discussed in Chapter Seven, RCP is part of a continuum and it is important that clinicians are able to view whaiora movement towards goal attainment as progress. Having workplace champions and colleagues also trained in RCP at the practice level will assist in providing the practice level support that clinicians require, reinforcing that they are contributing in a meaningful way towards whaiora goal progress. This is in line with de Silva (2011) findings that highlighted the importance of clinicians having support mechanisms in place at all levels to assist them to resolve competing pressures.

2. Need for an Overarching Organisational Change Programme

The findings highlight that putting the RCP training programme in place without any critical consideration of the implementation process was problematic. My findings highlighted that change programme initiatives cannot rely on processes that target individual behavioural change without addressing structural change as well. Individual behaviour change appeared to be unable to be sustained without support at the practice and patient interface, and concurrently addressing some of the inhibiting processes and structures. These insights are particularly important for Tikanga Ako Hono-Tangata, the RCP training programme, at Te Matau a Māui Hawke's Bay, given that historically the training has existed on its own without any practice or organisational supports for implementation beyond the initial training.

There are a range of theories, models, frameworks, and evidence around implementation science that offer insights for practice that the co-design group and I could have engaged with earlier in formulating the RCP programme at HBDHB.. In this section I put forward some of my findings, synthesised with some of the evidence from the literature. I also focus on a couple of implementation science frameworks; namely, the CFIR and the He Pikinga Waiora implementation framework, an Aotearoa New

Zealand model, as exemplars to demonstrate that if the co-design team and I had engaged with these beforehand we may have better positioned clinicians and HBDHB to adopt and embed RCP. By applying these frameworks at the outset, we may have discovered that we required an overarching organisational change programme, with support structures in place at all levels, to maximise and facilitate the up-take and provide traction to fully embed these practices. We may also have learned that a focus on equity and cultural centredness needed to be woven through every level of the programme. The learnings from this process may be of use to other services seeking to embed similar programmes into routine practice.

It was the combined passion and commitment of the designers and facilitators for patient engagement and equity that brought us together to co-design the RCP training programme in 2017. However, our main focus from the outset was on changing individual clinician behaviour. We had full time commitments in other work areas and had limited time to put into the RCP project. Through this research, I now recognise that the co-design group and I may have inadvertently limited the success of the programme by not having considered the broader environmental conditions and the change required to assist clinicians to embed RCP into their practice. There is a range of literature that supports the implementation of programmes like RCP.

My findings have extended understanding of aspects that could potentially enhance the effectiveness of practice change programmes in this field. One particular aspect is that a culture of care needs to be built across an organisation that supports the sustainability of a relational way of working at every level. To build a relational culture of care, 'person-centred moments' need to be a part of everyday practice which can only be achieved by having a system-wide commitment to whānau centred or PCC (Kayes & Papadimitriou, 2023; McCormack et al., 2011b). This premise was also put forward by Donabedian (1966) who suggested that health professionals needed to reimagine the way they worked, reengineering processes and structures to support the embedding of a culture of care. Having well-designed support and delivery systems for PCC at the training, practice patient interface, and structural levels has been shown to be critical to enable health professionals to consistently focus on and enact patients' needs and priorities (Greene et al., 2012; Phelan et al., 2020). To ensure sustainable change, health systems

and organisations need to systematically design for person-centred and equity-oriented care from the outset. Initiatives like the Nuka System of Care that have designed their entire system and structures based on relationships and fostering a culture of wellness of the whole person and their family is such an example (Gottlieb et al., 2008). Nuka's system design was focused on relationships, ensuring equity, maximising coordination, and minimising duplication, with the patient needs always being central (Gottlieb et al., 2008). Te Whānau o Waipareira is another example of an organisational transformation that embedded whānau centred practice into all aspects and levels of the organisation (Fanselow & Hughes, 2019). The organisation's strategic vision strongly focused on whānau centred care. This way of working was reinforced through expectations articulated in staff induction, aligning workplace language, whaiora and whānau assessment models, and reporting mechanisms. These strategies assisted to comprehensively reinforce and embed equity-oriented relationships across the organisation for staff and the whaiora and whānau they worked with (Fanselow & Hughes, 2019). A system wide approach, such as this, is vital to ensure sustainability of a change programme like RCP.

The notion that practice change needs to be supported system-wide is consistent with the implementation science literature. For example, the theoretical domains framework (Michie et al., 2005), the behavioural change wheel (Michie et al., 2011), and normalisation process theory (May et al., 2007), all provide variations of models that both focus on motivational factors and skills required at an individual level, and make visible the environmental and structural elements required to support practice change. These models contend that the elements at the individual, process, and organisational levels are inextricably linked and are fundamental in implementing and evaluating practice or behavioural change processes (May et al., 2007; Michie et al., 2005; Michie et al., 2011). The behavioural change wheel, for instance, may have assisted the RCP co-design group in identifying the determinants of behaviour required for clinicians to successfully embed a RCP way of working (Michie et al. 2014). Using these models in RCP design may have guided better design for systems support.

To demonstrate what could have been potentially useful in shaping the design of RCP, I have applied one such framework, the CFIR (Damschroder et al., 2022). Applying an implementation science framework could have assisted the co-design group to identify

implementation factors that may have influenced and impacted the effectiveness of RCP. I have focused on the CFIR as it has been highly cited in the literature and has been used to guide the evaluation of healthcare intervention initiatives and identify factors that may have influenced implementation at multiple levels (Keith et al., 2017; Soklaridis et al., 2016). The CFIR can assist in highlighting barriers and predict implementation effectiveness (Breimaier et al., 2015; Kirk et al., 2015). It can be used to pre-emptively identify possible barriers to change and/or opportunities that could be leveraged to support change. The CFIR purports that 39 constructs interact to influence implementation effectiveness, and synthesises these constructs into five domains;

1. Intervention characteristics – the features of the programme
2. Inner setting – the features of the organisation
3. Outer setting – the features of the external environment
4. Individual characteristics – the features of the individual
5. Implementation process – the strategies that might influence implementation (Keith et al., 2017).

An analysis drawing on the CFIR could have helped deepen the co-design group's understandings of the possible challenges in implementing the RCP programme and assisted the group to identify strategies to mitigate these factors and tailor a robust organisational-wide approach to the programme (Damschroder et al., 2009). In Table 9, I explicitly map some of what I now know from my findings and recommendations against the CFIR domains and a few of the constructs within these domains. I then put forward strategies that relate to each construct that could have been generated at the outset of the design and implementation stages of the RCP programme. There is an overlap between the recommendations that I put forward in Chapter Seven and what is shown in Table 9. By the co-design group applying a framework, such as the CFIR, it may have set the RCP programme up for more successful implementation. Not only does the Table 9 help me to critically reflect on how the programme could have been designed differently with the need for organisation change, it may also be a useful tool for others who wish to implement change programmes in a similar field.

Table 9.

Evaluation of the RCP Programme utilising the CFIR

CFIR domains	Constructs	Research findings on barriers and enablers of RCP	Strategies to address these factors as identified in the recommendation chapter
Intervention characteristics – the features of the programme	Innovation source	-The co-design group was reputable and credible	- No action
	Innovation evidence base	-Evidence supporting PCC strong -Evidence to support effective embedding weak	-Look at applying effective implementation support strategies (see inner setting)
	Innovation complexity	-Practice and process implementation supports not in place -Paradigm shift is required for some specific disciplines to shift to a RCP way of thinking	-Need for an over-arching organisational-wide programme to support implementation -Acknowledge the discomfort of some disciplines in moving to RCP and provide strategies to assist this paradigm shift (e.g., clinician led RCP educational video and applying the DBM)
Inner setting – the features of the organisation	Relative priority	-Pressure to prioritise patient flow and expediency	-Training workplace cohorts to support coherence, common language, and cultural change
	Mission alignment	-Sense of agency compromised	-Incorporate a module to assist understanding of sense of agency and strategies to alleviate any internal tension
	Culture	-Perception that clinicians felt they were being judged by others	-Build understanding that RCP is part of a continuum with movement towards goal attainment being progress
	Information technology infrastructure	-Reporting templates, scheduling etc., do not reflect RCP	-Align processes such as appointment scheduling, reporting, MDT meetings and Professional Development Reviews to reflect RCP
Outer setting – the features of the external environment	Performance measure pressure	-Leadership engagement -Pressure to meet government targets	-Train Leaders in RCP -Strategies to align and balance
	Policies and laws	-External government policies	-Strategies to influence

CFIR domains	Constructs	Research findings on barriers and enablers of RCP	Strategies to address these factors as identified in the recommendation chapter
Individual characteristics – the features of the individual	Capability	-Clinician's practice beliefs conflicting with a patient's choice or preference -Inability to meet whaiora needs due to constraints	-Applying the DBM for whaiora to consider the pros and cons of situation -Training module to instil understanding that progress towards goal attainment is progress
	Motivation	-Self-worth inextricably linked to providing hands-on physical therapy -Some disciplinary orientations supported RCP	-Facilitating critical reflexivity as a tool to assist clinicians to reflect and evaluate actions -Use these disciplines as champions
	Capacity	-Perception that RCP takes more time	-Introduce training module to illustrate how RCP can be enacted quickly
Implementation process – the strategies that might influence implementation	Innovation deliverers	-Experiencing RCP in action boosted clinicians ongoing confidence and motivation.	-Build confidence in use of Te Ao Māori models by incorporating more opportunities for practice
	Tailoring strategies	-Continue weighing up of clinical risk	-Facilitating critical reflexivity as a tool to assist reflecting on and evaluation of actions -Ongoing refresher and coaching sessions -Champion and knowledge brokers to provide support -Training workplace cohorts -Developing CoP

(Adapted from Damschroder et al. (2022).

If the RCP co-design group had utilised the CFIR and analysed each of the component parts of the intervention quality characteristics, it may have added greater understanding, pre-empting any barriers or implementation supports required as highlighted in Table 9.

However, the CFIR may not be fully fit for purpose in designing or evaluating a practice change programme in Aotearoa New Zealand, as there is no focus on equity and cultural responsiveness which are fundamental to healthcare provision in this country (Ahuriri-

Driscoll et al., 2022; Came et al., 2020; Rae et al., 2023). Ensuring cultural responsiveness and having an equity focus in service provision are central tenets of the Tikanga Ako Hono-Tangata, the RCP training programme, at Te Matau a Māui Hawke's Bay. In this context, an Aotearoa New Zealand framework, such as the He Pikinga Waiora implementation framework, may have been a useful tool to plan and implement RCP (Oetzel et al., 2017) or even assisted the co-design group to have designed the programme differently. The He Pikanga Waiora is an Indigenous co-design framework which has self-determination (rangatiratanga) and knowledge (tikanga) at its core, and aligns with advancing implementation science for Māori healthcare initiatives. The framework ensures that the principles of Te Tiriti o Waitangi, whānau voice, and Māori aspirations are central and integrated into any programme development. The four core elements central to this framework are cultural centredness, integrated knowledge translation, systems thinking, and community engagement (Oetzel et al., 2017). This framework has guided the implementation of successful health interventions in diabetes and in the context of peer health education for older Māori (Beaton et al., 2019; Masters-Awatere et al., 2019; Oetzel et al., 2017). Applying He Pikinga Waiora at the initial stage may have guided the RCP co-design team on the four core elements that needed to be in place to ensure that the programme was integrated successfully within an Aotearoa New Zealand healthcare context. A post evaluation of the RCP programme drawing on He Pikinga Waiora is shown in Table 10.

Mapping the RCP programme using the He Pikinga Waiora implementation framework gives insight into the areas the RCP co-design could have focused on to ensure successful RCP adoption and ongoing sustainability of the programme. From the evaluation against the framework in Table 10, it is evident that the co-design group designed the programme with whānau voice, community engagement, and cultural centredness, and integrated this knowledge into the programme content (Oetzel et al., 2017). Equity, alongside whaiora and whānau right to self-determination, was also a central premise of the co-design process. However, the concept of cultural centredness and equity did not strongly permeate through the roll-out of the RCP programme at a system level.

Table 10.

Evaluation of the RCP Programme Utilising the He Pikinga Waiora Implementation Framework

	Variable	High - addressed the key element	Medium - somewhat addressed	Low - addressed in a limited capacity	Negative - not addressed the key element
Cultural Centredness	Community voice	Co-design involved consumers, iwi, primary care and clinicans			
	Reflexivity		Some evidence of reflexivity during training and initial implementation	No follow-up to ensure self-reflection and practice change aligned with Te Tiriti o Waitangi	
	Structural transformation and resource				No structural transformation or resources to ensure cultural centred
Community Engagement	Community engagement	Strong community leadership - Māori Relationship Board input into programme design		No community engagement and/or evaluation post implementation	
Integrated Knowledge	Integrated knowledge translation	Mutual learning process established; knowledge was tailored to clinicians' needs. Hui Process practice evident.		No follow-up of clinician's confidence and ability to use Te Ao Models of Care in day-to-day practice	
	System perspectives	System perspectives included in design with whānau and health professional voice			Intervention did not include alignment of systems at the practice level
	System relationships			Understanding of the complex multidimensional relationships but not enough robust strategies to overcome these	No understanding of the complex multidimensional relationships required to sustain RCP at a system level
System Thinking	System Levels	The intervention targeted training individual clinicians in practice change at the micro level			Did not target change at practice interface or structural level to change policies, processes, or systems to align change

Adapted from Oetzel et al. (2017).

Support was not given to participants beyond the training to ensure competence in using the Te Ao Māori model or to support reflexivity of their clinical and cultural practice. Furthermore, no attention was given to any process or structural change that may have been required at the practice level to support clinicians to use this cultural model of engagement. Moreover, as highlighted above when discussing the theoretical domains framework, the behavioural change wheel, normalisation process theory, and the CFIR, (Keith et al., 2017; May et al., 2007; Michie et al., 2005; Michie et al., 2011), not enough attention was given by the RCP co-design group to what system-wide interventions were required to sustain the programme. System thinking and focusing on relationships and intervention targets at a practice and structural level are core elements of He Pikinga Waiora (Beaton et al., 2019). A more targeted approach that focused on the supports required at practice and system levels to enhance the effectiveness of the RCP programme may have been achieved if this Aotearoa New Zealand implementation framework had been applied. Moreover, the He Pikinga Waiora implementation framework would assist in developing the RCP programme further by addressing the elements highlighted in amber, red, and blue in Table 10.

In the RCP training programme at Te Matau a Māui Hawke's Bay, the focus has been on individual behaviour change, with interventions being targeted at the clinician, as previously discussed. Applying an Aotearoa New Zealand Indigenous framework, such as He Pikinga Waiora, in conjunction with a framework like the CFIR, may have illuminated that cultural centredness and equity were essential at both practice and systems levels to effect sustainable practice change at the co-design stage. Unless conditions to support this change are introduced at a process and structural level, then the programme is less likely to gain traction and be successful. Analysing the implementation process retrospectively can create opportunities to look forward and consider how things can be improved in the future. Health systems and organisations need to be more systematic in addressing implementation effectiveness from the outset by designing for person, whānau, and equity-oriented care (Forslund et al., 2023; McCormack et al., 2011b; Scott et al., 2018). It is, therefore, essential to use implementation science theories or frameworks to evaluate and co-design what is required, to ensure that the support needed for the desired practice change is in place at every level. This is useful

contribution for others who wish to implement change programmes in the field who will be able to learn from how the RCP programme was implemented, how it is positioned against the evidence in the wider implementation literature, and the learnings acquired through evaluating it against frameworks such as the CFIR and He Pikinga Waiora.

3. The need for a Transformational Shift in Practice Paradigms

A third key contribution to research and practice that this doctoral research puts forward is the need for a transformational shift in practice paradigms. While many of the allied health professions have moved towards a PCC approach it is not always consistent. In times of high demand and busyness there is a tendency for some clinicians to revert to a more directive biomedical approach in their practice. This is consistent with my findings which suggest that some professions appeared to be pulled towards a biomedical way of working and became more task-focused, transactional, and practical in their approach when there was high workload demand and pressure to prioritise patient flow. A paradigm shift is required. Until professions are challenged on defining who they are, what they contribute, and what their role is, and support is provided at both a pre-qualifying training and healthcare organisational level, then it will be difficult to embed programmes like RCP. A paradigm is a framework or model of thought that guides a person's beliefs, values, and practices in a given context, and influences how problems are understood and acted on (Rogoff, 2016). A paradigm shift refers to a fundamental change in the underlying assumptions or methodologies leading to the adoption of a new model or framework that redefines the understanding and practices of that field. Paradigm shifts are often transformational, changing the way knowledge is conceptualised and practiced (Cox, 2022; Mertens, 2012). My research identified four interrelated areas where a shift is required to support some disciplines to move towards a more relational way of working. They are where: 1) there is a pull towards the biomedical model and task-focused approach; 2) one's sense of self-worth is linked to applying practical skills; 3) clinicians prioritise their expert knowledge over whaiora preference; and 4) where practice norms are strongly linked to professional identity. Below, I discuss the paradigm shifts required in each of these four areas to move to a more relational way of working.

It is acknowledged at the outset that RCP is a programme for health professionals, including doctors and nurses. However, as my study only looked at the barriers and enablers that AHPs experienced in implementing RCP, I retain an allied health focus in my discussion. In particular, my discussion draws on literature relevant to the professions of physiotherapy, occupational therapy, speech language therapy, social work, pharmacy, and oral health, given these professions were included in my study.

The Pull Towards a Biomedical Model and Task-focused Approach

While the participants in my study appeared to want to implement RCP strategies, my research suggests that the pull towards a task-focused biomedical way of working was strong for some disciplines. Many of the participants struggled to enact RCP when work pressures were high and there was a focus on expediency of patient flow with their default approach appearing to be more task-focused and biomedical. There is evidence across a range of professions that that fallback to a more task-focused biomedical approach when demand and work pressures are high is default, including physiotherapy (Nicholls, 2009b; Santos et al., 2022), pharmacy (Murad et al., 2014; Wolters et al., 2017), speech language therapy (Forsgren et al., 2022; Mahomed-Asmail et al., 2024), and occupational therapy (Carroll & Lawson, 2014; Lysack et al., 2001).

In physiotherapy and pharmacy this default appears to be attributed to a strong biomedical orientation where these disciplines focus on the physical and biological aspects and tasks of treating symptoms, dysfunction, or illness, and providing information (Murad et al., 2014; Nicholls et al., 2016). In speech language therapy, despite communication being inherent to this discipline's therapeutic focus, research has shown that this profession can also revert back to being task-focused when work is pressured (Mahomed-Asmail et al., 2024). Consistent with the literature, my findings highlighted that the speech language therapist in my study became more task-focused in approach when patient volumes were high and there was pressure to work expediently, prioritising her caseload. Occupational therapy has historically been more holistic in its orientation with clinicians often considering the broader social context of a patient's life; nonetheless, the evidence suggests that this profession can also become more task-focused where workloads and demand are high (Carroll & Lawson, 2014; Christiansen & Haertl, 2014). My findings support this notion suggesting that when the

occupational therapist in my study had to prioritise workload or there was pressure to discharge, she appeared to at times revert to a more biomedical approach of being task-focused in her practice. A shift in paradigms needs to occur if these disciplines are going to retain and embed a PCC approach into their practice in times of high workload, so they do not revert entirely to a task-orientated biomedical way of working. Ways of addressing and sustaining a paradigm shift in this area will be discussed later in this chapter.

Sense of Self Worth Linked to Practical Skills

Aligned with a task-focused approach, some professions' sense of competence and usefulness as clinicians appeared to be tied to practical or hands-on therapy. My findings showed that some professions, namely physiotherapists, occupational therapists, speech language therapists, and oral health therapists, all had an innate sense of needing to do something practical to feel that they were fulfilling their work obligations. This was a construct that appeared to have been engrained in them throughout their pre-qualifying training.

The literature has highlighted the dominance of practical therapy being the norm for some professions and the difficulty these clinicians have in moving from this stance to implement PCC. Speech language therapy, physiotherapy, occupational therapy, and oral health are all disciplines that emphasise hands-on or practical therapy as key due to the perceived effectiveness of direct, physical interventions in achieving therapeutic outcomes (Dwight, 2022; Leggett et al., 2017; Mudge et al., 2014; Nicholls et al., 2016). Providing practical therapy and being relational are not mutually exclusive and can exist together in practice. My findings showed that clinicians wanted to both ensure their contribution was meaningful to the whaiora and they were providing effective assessment and treatment as health professionals. However, despite this long-standing recognition, the emphasis on hands-on or practical therapy persists.

There still appears to be an inherent belief that these ways of working are pitted against each other when, indeed, practical therapy and RCP do not need to be an either/or decision as they can be applied in tandem. My findings suggest that until clinicians are supported by pre-qualifying curriculums and healthcare organisations to equally value

PCC alongside practical or hands-on therapy, they will struggle to embrace an RCP approach. In their development of a universal framework Cook et al. (2022) demonstrated how reflexive PCC processes of design and evaluation can be integrated into pre-qualifying health curricula and built-in to professional or regulatory requirements. My findings, together with the evidence, highlight the need for a fundamental shift in training and education at the outset and a critical look at how PCC and relational ways of working are positioned alongside practical or hands-on therapy in allied health curriculums.

Clinicians Prioritising Their Expert Practice Knowledge Over Whaiora Preference

Findings showed that participants from all disciplines included in my study appeared, at times, to experience tensions when their professional practice beliefs conflicted with whaiora choice or goal preferences. This is consistent with existing literature included in Chapter Three, which discussed clinicians as the holders of expert knowledge in their field of expertise. However, it is important to acknowledge the whaiora as an expert on their own life and lived reality (Santana et al., 2018). Clinicians hold expertise on the condition, the pathological, or biomechanical processes that might be at play, and the evidence for how best to treat and address that. However, the whaiora holds expertise on how the condition is experienced by them and how context, whānau, and environmental factors impact their lived experience of that condition (McCance & McCormack, 2017; Santana et al., 2018). This is evidenced by Worrall et al. (2017) who argued that speech language therapists often face the challenge of balancing their expert practice knowledge with patient preferences during treatment. While their discipline-specific knowledge gives them insight into the most effective treatment interventions, this expertise can sometimes be in contrast to the individual preferences or goals of the patient. Research suggests that in certain cases, speech language therapists may prioritise their clinical knowledge and standardised treatment techniques over the preferences or goals of the patient, believing that this approach will obtain the best clinical outcomes (Worrall et al., 2017). Likewise, Killingback et al. (2022) suggested that physiotherapists can theoretically embrace PCC but sometimes struggle to fully involve the person's perspectives and preferences in practice.

The literature also suggests that other professions, such as occupational therapy, can sometimes struggle with patient preferences when working in a PCC way (Brown, 2013; Parker, 2013; Ripat et al., 2013). Brown (2013) suggested occupational therapists can still make decisions on behalf of patients in times of busyness and that PCC can sometimes be a misnomer in these periods; a notion. Whalley Hammell (2015) reiterated in her study of client perceptions of occupational therapy practice. Whalley Hammell (2015)suggested that while the profession has moved towards adopting a PCC approach in their everyday practice, occupational therapists do not consistently embody PCC in all their practice interactions. Similarly, oral health therapists who are responsible for delivering preventive and therapeutic dental care, also struggle to balance the demands of clinical best practice with the preferences of their patients (Curtis et al., 2021). This aligns with my study's findings, where the oral health participant articulated that they often had to prioritise their clinical knowledge to quickly assess and treat the child which sometimes was not aligned with patient or whānau preferences.

In contrast, social work appears to have a practice philosophy that might better align with a PCC or RCP approach. Social work is inherently more of a talking profession; whereas professions like physiotherapy, occupational therapy, and speech language therapy are more oriented towards doing and function (Carroll & Lawson, 2014; DiLollo & Favreau, 2010; Murphy et al., 2013; Nicholls et al., 2016). Understanding a patient's perspective, empathy, and relationship building are seen as essential skills for carrying out good social work practice (Murphy et al., 2013; van Breda, 2022). These skills are fundamental tools taught at an undergraduate level and shape the formation of a social worker's professional identity (Murphy et al., 2013). Therefore, adopting RCP strategies may be a more natural transition for this profession. However, my findings did show that at times the social worker prioritised their practice knowledge over whaiora preferences. This appeared to be mainly due to the pressure to discharge or because of safety concerns. However, social work's underlying practice philosophy appears to be better aligned with PCC. This discipline may then find it easier to integrate this approach into their everyday practice; however, at times, they too can experience a tension with whaiora choice.

My findings, together with the literature, suggests that while many allied health professions have moved towards a PCC approach that this is not always consistent. In times of high demand and busyness, there is a tendency for some clinicians to revert to a more directive expert approach prioritising their clinical knowledge over patient preferences. However, the way expertise is perceived, maintained, and sustained by some disciplines appears to be another contributing factor that creates tension with whaiora preferences. Clinicians appear to hold on to the role of being expert as this appears to enhance credibility and legitimises their profession (Molloy & Bearman, 2019). Molloy and Bearman (2019) suggested that the credibility of health professionals is maintained through this sense of being the 'expert'; therefore, clinicians hold on to the position of being the 'expert'. Challenging the way some disciplines view expertise, and what knowledge and expertise is privileged and perceived as being credible, will be essential. To that end, it is necessary to create conditions in pre-qualifying curriculums and in healthcare organisations to allow students and clinicians a safe place to express their vulnerability in working in this relational way (Molloy & Bearman, 2019). Clinicians and students need to be challenged and supported to balance their technical knowledge with a relational way of working. Furthermore, they need to be assisted to change the rhetoric to view this combined knowledge and expertise as a new way of viewing and honouring their discipline-specific credibility (Molloy & Bearman, 2019). This will be discussed further in the forthcoming section on professional identity.

My findings highlighted that, at times, participants had to remind themselves to find out what was important to the whaiora and that their clinical knowledge was just as important as the whaiora knowledge and expertise. Both viewpoints are critical for effective PCC implementation (Entwistle et al., 2018; McCance & McCormack, 2017). As Jensen et al. (2000) argued, there needs to be a paradigmatic shift in thinking to where expertise is viewed as not so much about technical knowledge and skills, but more about how that technical knowledge and skill is applied in the context of PCC interactions and whaiora preference. PCC strategies need to be threaded through the fabric of clinical reasoning, assessment, rehabilitation, and reporting to ensure a relational focus is part of clinicians' everyday practice psyche (Bright, 2015; Jensen et al., 2000; McCormack, 2022). There needs to be a fundamental shift in thinking in the way the professions and the health system value this form of knowledge. Until clinicians and health systems instil

and integrate a different way of viewing expertise, so that it is not about *what* clinicians know, but *how* what they know is *applied* in the context of the unique circumstances of the whaiora and their preferences, then changing to a RCP approach may be more difficult.

The key to advancing clinicians' relational abilities is creating an awareness on how they can apply their knowledge alongside integrating the patient's perspective and attitudes of their health into their practice interactions, to uphold and maintain the therapeutic relationship (Miciak et al., 2018). In their study of physiotherapists and PCC, Miciak et al. (2018) suggested that self-awareness and good communication are critical to ensure therapeutic relationships are maintained and sit alongside striving to achieve good rehabilitation outcomes. In their autoethnography, Bright et al. (2012) put forward the notion that technical rehabilitation skills can be balanced with a more human approach. They suggested that this is achieved through active listening and unpacking and examining a patient's perspective to create a fuller understanding. Fadyl et al. (2011b) reiterate this point in their New Zealand study of disabled people accessing healthcare, suggesting a context-appropriate mix of technical skills and competence, coupled with a human approach, constitutes good quality care. Encouraging critical reflexivity and on-going coaching will help to equip these therapists with the skills to ensure a relational approach is weaved into their practice (Nolan et al., 2006; Sullivan et al., 2021). The evidence highlights that neither a relational approach nor practical skills are better than the other, but integrating these and holding space for both may be the pathway forward to embed PCC into practice (Nolan et al., 2006)

Professional Identity

Recognising *why* allied health professions may emphasise biomedical practices is important. Historically, AHPs were viewed as being supplementary to their medical and nursing colleagues, and only initiated treatment on medical instructions. These professions fought to be recognised as independent practitioners forging professional identities and associated practice standards (Nancarrow & Borthwick, 2021). While these professions have advanced their professional credibility and legitimacy over the last 60 years, Nancarrow and Bortwick (2021) suggested that allied professions have still not attained equality with their medical colleagues. It is important then to acknowledge

that allied health professions have invested energy fighting for legitimacy alongside their medical colleagues which, perhaps, has also worked to sustain their biomedical orientation (Nancarrow & Borthwick, 2021). The long journey these disciplines have had in establishing a credible professional identity may shed light on why it is such a paradigm shift for some professions to move away from the biomedical model to embrace a more PCC oriented approach.

Professional identity develops from early in education. Pre-qualifying programmes socialise, educate, and instil a way of working in students which is then reinforced in the workplace by colleagues, the MDT, and organisational expectations of their profession. When working with people with complex presentations, or dealing with workload pressure and high demand, Gabbay and May (2022) suggested that clinicians can revert to the tacit knowledge and technical skills that they have internalised through their professional education to guide their actions. They term these 'mindlines'. These mindlines provide an internal framework of practices and boundaries that allow a health professional to make a rapid and instinctive clinical decision. Mindlines develop over a period of time through acculturation from pre-qualifying curriculums and workplace environments, and are reinforced by regulatory bodies and disciplinary professional identities (Grove, 2023). Grove (2023) suggested this results in internalised discipline-specific cultural norms which may explain why, in times of high workload pressure where expediency and patient flow are prioritised, some clinicians revert to their discipline-specific mindlines and RCP becomes secondary in their practice if this approach has not been fully integrated into their disciplinary mindlines (Gabbay & May, 2022).

As discussed earlier in this section, Molloy and Bearman (2019) suggested that a way of getting students and clinicians to integrate PCC into their practice is for educators in pre-qualifying curriculums to engage in "intellectual candour" (p. 35) to create an environment of trust. Intellectual candour is a process by which educators share their inner struggles and early doubts of adopting a PCC approach with students. This can be a way of inviting reciprocal vulnerability with getting students to share their thoughts and struggles which, in turn, builds trust and creates a learning opportunity (Molloy & Bearman, 2019). This may be a way of assimilating a PCC approach into discipline-specific norms and mindlines.

The concept of mindlines might also help explain why social workers may find it easier to embed RCP as their internalised framework of practices and boundaries are based around being relational in approach. The underlying philosophy and values of the profession are to understand whaiora and whānau perspectives to support, resource, and empower them to make decisions about their healthcare and social situations (Murphy et al., 2013; van Breda, 2022). Therefore, adopting RCP strategies appears to be more congruent with the mindlines of this profession.

Personality Traits

The literature shows that people are more likely to be drawn to healthcare professions that are aligned to their personality traits (Campbell et al., 2013). Some have suggested that healthcare professions can be categorised as either people oriented, being relationship focused and socially motivated; or technically oriented, being skill and procedure focused (Hartung et al., 2005; Turnbull et al., 2009). Professions such as physiotherapy, pharmacy, and oral health therapy are technically oriented, while social work is a more people focused profession (Campbell et al., 2013). Campbell et al. (2013) argued that people who have a high degree of empathy and are relational in approach may gravitate towards a profession in social work. This may provide deeper insight into why my findings highlighted that the social worker in my study was more attuned to a relational approach and appeared more successful in being able to embed RCP into her everyday practice. Physiotherapy appears to attract people with personality traits aligned with being technical and skills focused (Campbell et al., 2013; Louwen et al., 2023). This was evidenced in my findings where physiotherapists' sense of self-worth in providing a valuable contribution appeared to be inextricably linked to applying the technical skills and providing practical treatment to the patient. Hence, these clinicians felt challenged when trying to implement the softer skills of RCP. Occupational therapy and speech language therapy, while having a degree of alignment to technical skills, appeared to be more holistic and aligned to a person-centred approach (Campbell et al., 2013). Louwen et al. (2023) reinforced the notion that occupational therapists, speech language therapists, and particularly social workers exhibit higher degrees of sensing-perceiving and intuitive-feeling in their personality traits, and it may be that people with these traits gravitate towards these professions. This may provide insight into why some

professions that are people focused may be more easily able to assimilate RCP into their everyday practice, while other professions, whose personality traits are aligned to being more technically oriented and task-focused, struggle with this paradigm shift. However, a focus on personality traits does not take in to account the processes of socialisation that occur through pre-qualifying training, work placements, the forming of professional identity and existing workplace cultures which also mould and shape a practitioner's practice (Campbell et al., 2013; Hartung et al., 2005). All these factors can assist in informing and developing a clinician's professional practice model, and attention will be given to this later in the chapter.

A greater focus on PCC in health pre-qualifying curriculum may help to reshape and realign professional identities at a formative stage in a health professional's career. Ashby et al. (2016) found that practical education and professional socialisation at a pre-qualifying level has the greatest influence on professional identity. However, PCC content in pre-qualifying health programmes appears to still be very limited (Wallengren et al., 2022). In their Swedish study, Wallengren et al. (2022) found only 15% of health pre-qualifying courses included PCC as a learning outcome and queried whether students or new graduates actually translated this PCC approach into their clinical practice. In their study around the conceptualisation of good communication of undergraduate physiotherapy students, Bright et al. (2018) suggested there is a hidden curriculum and implicit messages are given to students about what is important and what they should focus on. Hidden curriculum is the subliminal messaging and assumptions that sit behind that curriculum and are the commonly held understandings and customs that tacitly underlie what is being taught (Chen, 2015; Hafferty & O'Donnell, 2015). For instance, Wright-Petersen and Bender (2015) suggested that the focus on practical skills over relational aspects in evaluating student competencies unintentionally reiterates that practical skills are more important. This is congruent with Bright et al. (2018)study which showed that while attention was given to being relational in physiotherapy education, positioning students to be knowledge providers and technical experts appeared to be given greater importance. This implicit messaging also appears to be reinforced in student placements where weighting is placed heavily on the evaluation of clinical reasoning, assessment, treatment and rehabilitation competencies, and less emphasis

placed on patient engagement and relationship building skills (Wright-Petersen & Bender, 2015).

It is essential then that relational care is viewed as equally important as technical competence and embedded in curriculum in pre-qualifying training programmes with reinforcement in student workplace placements (Bright et al., 2018). A core component in the initial stages of pre-qualifying healthcare programmes may be to assist individuals to recognise what implicit assumptions they bring with them. Assisting students to make these assumptions overt at the start of their training, through critical reflexivity, may increase their self-awareness. This self-awareness might make it easier for clinicians to be able to adopt and embed PCC or RCP into their mindlines and profession-specific norms. PCC needs to be front and centre of the assessment and treatment techniques taught to future health professionals to ensure they are socialised into this way of 'thinking' and 'being' from the outset. If the tide to this new way of working is going to truly change, health care organisations, health educators and regulatory bodies need to not only think about paradigmatic shifts for individual clinicians but also a transformative shift in the pre-qualifying curricula, regulatory bodies, and organisations that socialise, educate, and regulate these clinicians.

The importance of weaving relational approaches through pre-qualifying health education is evident. McCormack et al. (2022) highlighted this in their person-centred curriculum framework. The authors put forward three 'hard' elements (strategy, structure, and systems) and four 'soft' elements (shared values, skills, style, and staff), which they suggested allow for the analysis and identification of good PCC practice and address the gaps in healthcare pre-qualifying programmes. Jensen et al. (2000) also suggested three key elements were essential to teach physiotherapists students including to: 1) value their patient's knowledge and reality; 2) carefully listen to patients to understand their meaning of their health; and 3) develop cognitive and technical skills to ensure clinical reasoning and competent practical application. The authors suggested that students emerging as novice practitioners who practice in a person-centred way, need to be nurtured, and supported in the workplace (Jensen et al., 2000). Furthermore, Jensen et al. (2000)purported that this way of working will only be reinforced and solidified by witnessing other clinicians demonstrate this patient-centred practice in the

workplace and by being challenged to emulate these behaviours as emerging practitioners in their own practice. These findings highlight that weaving these patient-centred and relational ways of working through clinical reasoning, assessment and treatment skills taught in pre-qualifying programmes, may assist in changing professional practice norms and solidifying this with disciplines' mindlines. It also shows the value of witnessing experienced clinicians role model these practices in the workplace to consolidate and solidify this way of working for the emerging practitioner (Jensen et al., 2000; McCormack et al., 2022).

As discussed previously in this chapter, professional identity is reinforced and maintained by regulatory bodies and professional associations with the ongoing requirements of professional competence and development. Higgs et al. (2009) termed this 'professional socialisation', referring to the acculturation process that starts in pre-qualifying training and is reinforced into the workplace by the need for health professionals to meet codes of conduct and regulatory standards and other ongoing professional activities. All these elements interact to reinforce and maintain the expected capabilities, roles, and responsibilities of the discipline which create a strong professional identity (Higgs et al., 2009). Professional socialisation immerses new graduates in the norms and culture of a profession through this gradual acculturation. Buy-in and commitment to PCC from these regulatory bodies and professional associations is, therefore, essential, as these entities would need to align their standards, competencies, and expectations of professional practice with this way of working (Dickson et al., 2020; Kayes & Papadimitriou, 2023; McCormack, 2022). Supporting a fundamental paradigm shift to being more person-centred requires a combined responsibility between education providers, regulatory bodies, and employing organisations to reinforce and uphold the importance of PCC in practice for emerging clinicians.

Summary

This doctoral research puts forward three key contributions to research and practice that may be pertinent in influencing the implementation of PCC in healthcare settings in Aotearoa New Zealand. While some learnings may be generalisable to change programmes seeking to integrate new ways of working more broadly, the contributions

that I have put forward are likely to be unique to the implementation of person-centred and relational ways of working and to advancing knowledge in this area.

First, clinicians have a divided three-way sense of responsibility to the organisation, to whaiora, and to their discipline-specific and established practice norms that can sometimes create practice tensions. Second, practice change through the RCP programme at Te Matau a Māui Hawke's Bay needs to be supported by an overarching organisational wide change programme. Applying the CFIR (Damschroder et al., 2022) allowed me to look in a more nuanced way at the factors that may have helped with the successful co-design and implementation of RCP at multiple levels at the outset. Using the CFIR, in conjunction with the He Pikinga Waiora Implementation Framework (Oetzel et al., 2017), to assess the RCP programme, illuminates that cultural centredness and equity are also essential at a learning and systems level to effect sustainable practice change. This may provide insight for other services seeking to integrate relational practices into their organisations in that applying implementation science frameworks at the outset can inform and influence programme design.

Finally, the research has enriched understanding of the paradigm shift required for some disciplines, pre-qualifying health training, and organisations to move to a PCC approach. My study has highlighted the default fallback position of reverting to a biomedical and task-focused way of working in times of high workload pressure. It has also evidenced the deep ethos that some disciplines hold, where hands-on practical therapy and technical skills are ingrained as a best practice norm. This may be related to clinicians' personality traits and being drawn to a more technical or person-centred disciplinary orientation. The importance of teaching person-centred and relational ways of working in pre-qualifying health programmes was something that my findings led me to reflect on. Ensuring that this way of 'being' is weaved through the clinical reasoning, assessment, and treatment skills in these pre-qualifying training curricula will assist in changing professional practice norms. Without a paradigmatic shift in how some professions define who they are, what they contribute, and what their role is, alongside regulatory bodies and healthcare organisations supporting this practice, change is not likely to occur. These three key contributions to research and practice highlight aspects

that that may be most pertinent in influencing the implementation of successful change programmes in this area in Aotearoa New Zealand.

Strengths and Limitations

There are both strengths and limitations to this qualitative study that must be acknowledged. As experienced clinicians, leaders, and facilitators of the programme, the key informant group was a strength of this research. This group provided support and insights through dialogue around my emergent concepts in our engagement forums. The group acted as "thoughtful practitioners" in that their expertise as clinical practitioners and cultural advisors served to sense check my analysis and assist me to ensure that my interpretation and reasoning was congruent and credible (Teodoro et al., 2018; Thorne, 2016; Thorne et al., 2004). Talking things over with others allowed for the discovery of connections and the generation of nuances or ideas that may have not been initially apparent to me. Articulating developing themes with this group of thoughtful practitioners reaffirmed my thinking that there were choices both within and outside of a clinician's control. This group assisted in challenging my thinking and interpretation to ensure integrity of my analytic logic.

In healthcare in Aotearoa New Zealand there is a commitment to equity and honouring Te Tiriti o Waitangi by enacting five key principles, as outlined in Chapter One (Ministry of Health, 2002, 2014; Te Whatu Ora, 2022). This is fundamental to all work in the healthcare arena. As a novice Tauiwi researcher, I recognised my limitations as I had been brought up and socialised in Aotearoa New Zealand with white privilege. White privilege is the advantage one has in life due to living in a society where the social order has been determined by the norms, practices, and laws of British colonisation (Came et al., 2020; Durie, 1994). Disparities for Indigenous Māori are evident in health, access, education, and many other facets of life. In meeting my commitment to equity and my obligations of partnership under Te Tiriti, I was acutely aware that I needed to ensure attentiveness to the cultural nuances of my research. As a Tauiwi researcher I needed cultural guidance to ensure that I was hearing and interpreting the Māori participants' contribution to this study appropriately. I discussed my interpretations of the transcripts with the Pouwhakaruruhau Matua, senior cultural advisor. This enabled me to work in partnership to ensure that I was understanding the cultural voice correctly and was able

to consider a Māori worldview. In this way I was ensuring that I was not perpetuating inequities by placing my Tauiwi lens over these participants' rich contributions.

Ongoing cultural consultation makes it more likely that the research is culturally responsive and that participants' mana is maintained (Francis et al., 2019). Cultural discussion and consultation concerning the developing themes around the Te Ao Māori model of engagement taught in the programme was ongoing and occurred throughout my study. I also discussed with the Pouwhakaruruhau Matua my concerns about cognitive dissonance that clinicians sometimes experienced when using RCP strategies when they were not able to meet agreed whaiora goals because of workflow pressures. He assisted me to realise that this very disconnect was a firm indication of why this research was so important in identifying what supports are required for clinicians to better embrace RCP and Te Ao Māori models of care.

Using interpretive description as a methodology was a strength as it guided me to engage reflexively with my assumptions, pre-conceived ideas, and disciplinary perspectives around what the enablers and barriers to implementing RCP at HBDHB may have been. Using interpretive description methodology also enabled the unpacking of participants' insights through rigorous analysis of interviews to construct, deconstruct, and reconstruct again the social complexities and themes. Being open to my initial ideas being challenged was a critical part of the unpacking. It enabled me to engage and continually question my assumptions and the emerging thematic patterns to seek new meaning and go beyond the obvious to fully explore and explain the phenomena (Thorne, 2016). This was supported through my self-reflection, journaling, supervision, and meetings with my key informant group to ensure flexibility as more understandings emerged (Thorne, 2016). These avenues and forums assisted me to reflect on my pre-conceived assumptions and provided transparency. They also provided a platform for me to explore emerging patterns to then generate deeper meaning from the participant narratives (Teodoro et al., 2018; Thorne, 2016). Embedding reflexivity and engaging with and challenging my pre-existing ideas and conceptions to create a deeper, more nuanced understanding of the phenomena through interpretative description methodology, is a strength of this study.

There were some challenges and limitations in this research. Data collection did not always go as planned, primarily due to COVID restrictions. Not all interviews were able to be held face to face as originally planned; in those cases, Zoom interviews were used as an alternative. On one occasion connectivity of the Zoom link was patchy which meant that some of the interview responses were difficult to decipher in the moment making follow up questions and further investigative inquiry challenging. To ensure robust data capture, the transcript was checked for accuracy by the participant after the interview and modified accordingly to ensure rigour.

The findings of this research are highly contextualised to AHPs who completed the RCP training at Te Matau a Māui Hawke's Bay. However, I believe my findings have significant breadth and depth having sought maximum variation in my sample group. They have the potential to provide insights which may be transferable to other similar contexts, and they have provided sufficient detail to support the reader to transfer to their own unique context. Furthermore, I drew on Malterud et al. (2016) notion of information power which suggests the more information a sample holds relevant to the study aims, fewer participants are required. Although it was a small sample, the depth of dialogue and the specificity of the participants' experiences was high, given all had direct experience of the phenomenon of interest and offered insights into the lived experience of embedding RCP. The design features of my study, building on existing evidence and theory coupled with the application of interpretive description methodology, and being able to continually question and reframe the emerging thematic patterns, ensured richness of analysis and understanding, and a strength of information power (Malterud et al., 2016; Nicholls, 2009b; Thorne, 2016). This is in alignment with Malterud et al.'s notion of information power, in that my sample specificity, the quality and richness of dialogue, and the theoretical basis meant that my sample had enough information relevant to the study aims.

In the initial stages of my doctoral study, I researched implementation frameworks and models and debated the merit of using these frameworks to guide my data collection in the earlier stages. However, consistent with Interpretive Description, I made the decision to prioritise the perspectives of my participants in my data collection and analysis, rather than pre-emptively applying a framework to structure these processes.

I was concerned that applying an implementation science framework may inadvertently limit my focus and my ability to attune to all the richness in the interviews. As a result, my analysis is built from the experiences shared by participants. However, on reflection, I can see how implementation science frameworks may have been able to be employed for secondary analysis to support a more nuanced attunement to contextual factors that supported implementation alongside this my primary analysis. This may be an area that others wish to pursue in the future.

As a practice-oriented study, the findings highlighted several implications for practice which will inform future iterations of the RCP training programme at Te Matau a Māui Hawke's Bay. The findings may also be pertinent in influencing the implementation of similar change programmes in Aotearoa New Zealand and further afield. Many of the limitations identified here, and the novel contributions to practice discussed earlier in this chapter, inform possible areas for future research.

Further Research

This doctoral study highlights some opportunities for future research. To advance knowledge in the field, Thorne (2016) contended it is best to position further research recommendations around the initial research question, having regard to the limitations of one's study design and approach. Together with the insights that the findings and discussion have generated, the recommendations inform further research topics that would expand understanding and increase knowledge related to practice change in Aotearoa New Zealand and further afield. Key opportunities for further research areas are highlighted below.

While the aim of this doctoral research was to develop an understanding of what helped or hindered the implementation of the RCP programme by Allied Health professionals at HBDHB, it is acknowledged it may have been also useful to have looked at how RCP occurred in the wider MDT context. Exploring how RCP is embedded with the wider team including by doctors & nurses, and how a wider range of disciplines exprience RCP, is an area for future research.

Examining implementation frameworks to determine if Aotearoa New Zealand based frameworks do lead to the implementation of more culturally responsive practice for Māori may be an area for further research. For instance, evaluating the He Pikinga Waiora implementation framework to test whether its use does indeed lead to the implementation of more culturally responsive practice and equity for whaiora may be a future research opportunity in the healthcare arena (Oetzel et al., 2017). Late in writing this document I became aware of a new Aotearoa New Zealand framework, the Equity-focused Implementation Framework, that has just been published (Gustafson et al., 2024). While I have focused my discussion on He Pikinga Waiora, there may be value in considering what each of these frameworks might bring to research in the practice change arena in Aotearoa New Zealand.

A further area for future research is the examination of the broader systemic and structural influences that get in the way of person-centred and relational ways of working at the practice-patient interface level in the healthcare environment. A future research opportunity could be to critically examine the structures and systems that sustain a particular way of working that may need to be challenged to embed PCC or RCP into routine practice.

There is also a role for drawing on implementation science frameworks or models for when programme designers are trying to implement new ways of working to identify the factors that would inform the practice change at the practice and structural level. Using these frameworks or models may highlight what is required at these levels to embed a sustainable PCC or whānau centred culture.

My research also highlighted the deep-seated belief and alignment of some professions to their discipline-specific practice norms. I have argued that discipline-specific practice norms may emanate from the education and socialisation at pre-qualifying health training levels. A suggestion for further study, therefore, is the analysis of how effective allied health curricula in Aotearoa New Zealand are in balancing the teaching of discipline-specific practice norms and preparing emerging health professionals to work in a person-centred or whānau centred way.

Conclusion

This doctoral research began with my desire to know what impeded or enabled AHPs to implement RCP strategies into their everyday practice at Te Matau a Māui Hawke's Bay. Using interpretive descriptive methodology assisted me to unpack, analyse, and gain a richer understanding of what was required to embed RCP. This study explored experiences and perspectives of AHPs working across the continuum, from acute care to community facing services, in a provincial health service in Aotearoa New Zealand.

This practice-oriented doctoral study contributes three key concepts that have potential to influence and impact the implementation of successful change programmes in Aotearoa New Zealand. My findings have illustrated that effectively implementing PCC or RCP relies on a complex interplay of factors including: 1) being able to reconcile the competing drivers of whaiora needs and preferences, disciplinary perspectives of what constitutes a good outcome, and organisational demands; 2) organisational teams, processes and structures which value and legitimise RCP and which create the conditions for person-centred and relational ways of working to prevail; and 3) professional identities which are based on an integrated mix of practical skills and a relational approach that is reinforced through pre-qualifying curricula, regulatory bodies, and the workplace context.

This study has advanced existing understandings of what is required to successfully implement programmes, such as RCP, into everyday practice. For future iterations of RCP at Te Matau a Māui Hawke's Bay, the programme designers and facilitators need to consider expanding the RCP programme to be more than just training. It needs to be accompanied by supports at the clinical and patient interface, as well as at the structural and organisational levels. It is also imperative that cultural centredness and equity is woven through the programme at every level.

This research demonstrates the need for a paradigmatic shift in healthcare organisations, structures, and delivery, and in clinicians' professional identity, if PCC practices are to be effectively implemented in everyday contexts. A fundamental rethink of what supports and changes are required in education curricula and healthcare

systems is necessary if these approaches are to be actively, legitimately, and readily embedded in health professionals' everyday practice.

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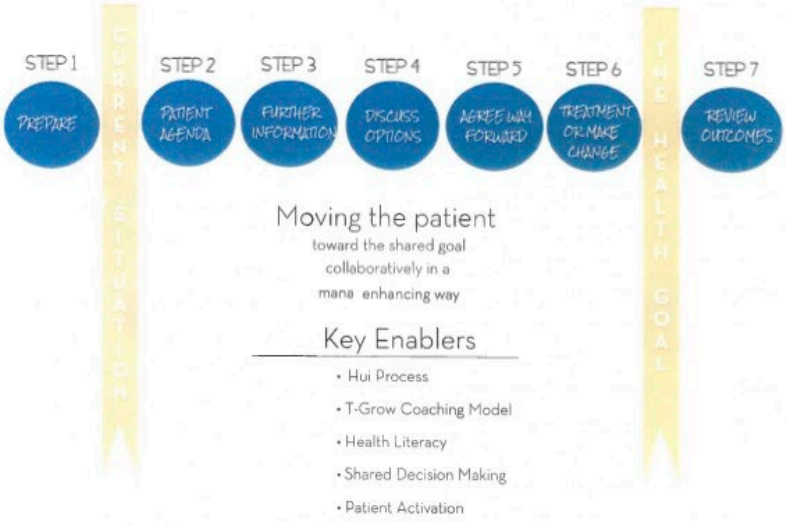
Appendices

Appendix A: RCP Toolkit

This symbolism depicts the creation story as espoused by Tipuna Māori (Māori ancestors). In the story, Ranginui (sky) and Papatūānuku (earth) were in a state of eternal embrace. At their point of separation light entered the world for the first time. This is illustrated by the dark line separating Rangi and Papa, and depicts the point just before first light, when the first streak of light cuts across the darkness of a new day.

The creation story illustrates coming together in partnership and the koro design on the front depicts new beginnings and growth. Together they depict Relationship Centred Practice - coming together in partnership to grow and move forward towards better health outcomes.

THE RELATIONSHIP CENTRED PRACTICE FRAMEWORK



HUI - ENGAGING WITH MĀORI FAMILIES

T - GROW COACHING CONVERSATION MODEL

T - GROW COACHING CONVERSATION MODEL

1./ Topic - Initial understanding

- What would you like to talk about today? (avoid temptation to use 'how can I help you?, what can I do for you?')
- What is the most important thing for you right now? OR
- We need to discuss your diabetes control/ your blood pressure - which aspect do you want to talk about today?
- Out of those things which do you feel is your priority?
- What were you hoping would happen/we would achieve today?

2./ Goal - Outcome for Session

- Out of those things, which do you feel is most important to focus on today?
- What were you hoping would happen/we would achieve today?
- If you could change one thing what would that be?
- What is the most important thing for you right now?
- What are the reasons it is important to you?
- Where do you want to be in 3 month's time (6 month's time) with this?

3./ Reality - Current Situation

- What do things look like at the moment?
- How is this situation impacting you you/ your whanau?
- What else might be impacting on your health (environment, wairua, hinengaro)?
- What would you like to achieve?
- What is preventing you from achieving this?
- What do you feel you are ready to change?

4./ Options - Discovering possibilities

- What has worked well for you in the past?
- What do you think might work for you now?
- What are the possible ways forward?
- What have you seen work for others?
- If you knew that you would succeed what would you do?
- What else could you try? What else?

5./ Way Forward - Accountability

- So now we have discussed all the options and we have decided a plan going forward, tell me exactly what you are going to do?
- Is anything going to stop you from moving forward with this?
- What would support you to achieve this?
- When will you start?
- What do you need to do to remember this?
- How would you like me to support you with this?

COMPONENTS OF MANAGING HEALTH - DIAMOND MADE

CONTROL

CONFIDENCE — MANAGING HEALTH — LEARNING

MOTIVATION

Questions:

1. Where are you now and what has contributed to this?
2. Where would you like to be and what are the reasons for that?
3. What can you do that is within your control to move this forward?

DECISIONAL MAKING - MOTIVATIONAL INTERVIEWING

	Don't Change Anything	Make Some Changes
Good Outcomes	1. What's working for you now?	4. What benefits would you expect from changing things?
Not so good Outcomes	What's the downside (short /long term) of what you are doing now?	3.What's the downside of changing things?

We have talked about a lot of aspects - what's standing out for you here?

What might your next step be?

(Adapted from Mill & Rollnick and McDowell - Motivating interviewing)

Appendix B - Qualitative and Systematic CASP Checklists – Global Literature

Qualitative CASP Checklist

Author and Year	Clear aims	Qualitative methodology appropriate	Research design appropriate	Recruitment strategy appropriate	Were data collected appropriately	Researcher and participants relationship adequately considered	Ethical issues considered	Data analysis sufficiently rigorous	Statement of findings clear	How valuable is the research
Bradshaw et al., 2021	√	√	√	√	unclear	unclear	unclear	√	√	√
Bright et al., 2012	√	√	√	√	√	unclear	unclear	√	√	√
Dickson et al., 2020	√	√	√	√	√	unclear	unclear	√	√	not met
Dyb et al., 2021	√	√	√	unclear	unclear	unclear	unclear	√	√	not met
Entwistle et al., 2018	√	unclear	√	√	unclear	unclear	√	√	√	√
Gibson et al., 2020	√	√	unclear	√	√	unclear	√	√	√	√
Greene et al., 2012	√	unclear	√	√	√	unclear	√	not met	√	√
Hebblethwaite 2013	√	√	√	√	√	unclear	unclear	unclear	√	√
McCance et al., 2012	√	√	√	√	√	√	unclear	unclear	√	√
McCormack et al., 2011	√	√	√	unclear	√	unclear	√	√	√	√
Moore et al., 2016	√	√	√	√	√	unclear	unclear	√	√	√
Mudge et al., 2014	√	√	√	√	√	√	√	√	√	√
Naldemirci et al., 2017	√	√	√	√	unclear	unclear	not met	√	√	√

Author and Year	Clear aims	Qualitative methodology appropriate	Research design appropriate	Recruitment strategy appropriate	Were data collected appropriately	Researcher and participants relationship adequately considered	Ethical issues considered	Data analysis sufficiently rigorous	Statement of findings clear	How valuable is the research
Rockwell., 2011	√	√	√	unclear	unclear	not met	not met	unclear	√	√
Timlin et al., 2018	√	unclear	unclear	√	√	not met	√	√	√	unclear

Systematic CASP Checklist Global Literature

Author/Year	Did the review clearly address the focused question?	Did the authors look for the right type of papers?	Were all the relevant studies included	Was quality of included studies assessed adequately	Was it reasonable to combine the results of the review	Were the overall results clear?	How precise are the results?	Can the results be applied locally?	Were important outcomes considered?	Are the benefits worth the harms and costs?
Edgar et al., 2020	√	√	√	√	unclear	unclear	not met	√	√	√
Manley et al., 2011	√	√	√	√	√	not met	unclear	unclear	√	√
Phelan et el., 2020	√	√	√	√	unclear	√	√	not met	√	unclear

Appendix C: Systematic CASP Checklist Aotearoa New Zealand Literature

Author/Year	Did the review clearly address the focused question?	Did the authors look for the right type of papers?	Were all the relevant studies included?	Was quality of included studies assessed adequately?	Was it reasonable to combine the results of the review	Were the overall results clear?	How precise are the results?	Can the results be applied locally?	Were important outcomes considered?	Are the benefits worth the harms and costs?
Graham & Masters-Awatere., 2020	√	√	√	√	√	√	√	√	√	√
Palmer et al., 2019	√	√	unclear	unclear	√	√	unclear	√	√	√
Wilson, et al., 2020	not met	√	√	unclear	√	unclear	not met	√	√	√

Qualitative CASP Checklist Aotearoa New Zealand Literature

Author and year	Clear aims	Qualitative methodology appropriate	Research design appropriate	Recruitment strategy appropriate	Were data collected appropriately	Researcher and participants relationship adequately considered	Ethical issues considered	Data analysis sufficiently rigorous	Statement of findings dlear	How valuable is the research
Ormrod 2016	√	√	unclear	unclear	√	unclear	unclear	not met	√	unclear
Sheridan & Kenealy., 2016	√	√	√	unclear	unclear	unclear	unclear	√	√	√

Appendix D: Methodologies – Initial Thinking

My research question is around what are the enablers and barriers to behavioural change in health professionals (HPs) in an acute medical setting in contrast to a community health setting? In particular, this work focused on the RCP Behavioural Change Programme that has been co-designed and delivered to HPs at Hawkes Bay DHB over the last 4-5 years.

Researching this area would allow insight into introducing a sustaining behavioural change model in an acute hospital versus primary health setting. It will give insights into ensure factors are present to ensure a programme's success and also mitigate any obstacles in each of these settings. The intent of this paper is to compare, contrast, and critique research methodologies and data analysis to really focus in and answer my research question.

On reflection, qualitative research methodologies appear to be the best at focusing in on behavioural change and my research topic. From the reading I had done and the research exemplars from our contact course, I had resonated with phenomenological, hermeneutic, appreciative inquiry, and interpretive description as methodologies that had merit in investigating further.

Methodology	Initial understanding of the methodology	What benefits would this bring to my research?	What drawbacks would this bring to my research?
Appreciative Inquiry (AI)	Focuses on the positive Participative and focused on success Co-constructs and embeds a desired reality built on participants' experiences and aspirations Uses 4 'Ds' to lead inquiry into the social potential of a social system – Discovery, Dream, Design, and Delivery	Could add value to RCP through focusing on the positive aspects of patient engagement AI can be a transformational change agent in itself if the questions and language are structured in a way that advances thinking based on the notion that people move towards what they focus on Enhances relationships and communications while building a sense of collegial purpose and commitment to an	Would not get to the essence of my research question as would not allow participants to focus on the barriers/ enablers to truly adopting RCP Focusing on the positive may invalidate the negative experiences and repress important conversations May have been a methodology to use before introducing a behavioural change programme in the first place as would allowed more in-depth co-design

Methodology	Initial understanding of the methodology	What benefits would this bring to my research?	What drawbacks would this bring to my research?
		idea or process. In this way it could move RCP forward – but may not answer the research question	
Phenomenology	Questions knowledge, experience, and understanding How do we know what we know? What does it mean to be the person in this context? Founded on the belief that a person can truly understand their situation The "lived experience" helps to construct insightful interpretive accounts that can lead to deeper and deeper understanding	Could add value to understanding the "lived experience" of fully embedding RCP into practice and what it means to be the person in that context in their daily interactions with whaiora /whānau and MDT Could enrich understanding of the lived experience of what the enablers and barriers were/are to RCP Acknowledges the researcher's prior conceptions/biases which would strengthen the authenticity of research approach	In this approach the historical approach is irrelevant – the lived experience is deemed more important. The current societal, cultural, and political environment may well enable or impede behavioural change. Indeed, the learnings from **HEAL910** highlighted that the bio-medical model, embedded institutional racism, tensions between reducing costs and increasing health demand, and the resulting stress and frustrations of health care workers, may all be inhibiting factors
Hermeneutic phenomenology	Also questions experience and understanding; however, historical context is implicit in understanding the concept Looks in detail how someone makes sense of the life experience to then focus on interpreting the account to	Goes a step further than phenomenology in that it takes into account the historical factors important in working in a different patient centred way. This could give an added depth of understanding to the HPs' experience	Will it accurately capture the meaning of the experience of embedding RCP or just get an opinion about it? This approach could help me understand the lived experience but would not give me the insight needed to understand why it has occurred

Methodology	Initial understanding of the methodology	What benefits would this bring to my research?	What drawbacks would this bring to my research?
	understand that experience	of trying to embed RCP into practice within the immediate history of their profession, process and place of work (whether hospital or community) Allows me to understand the experience of that person's practice and their career trajectory Might assist me understanding whether the training within their qualification has had any impact on the adoption or embedding of RCP	While taking in the historical context, I am not sure it would allow me full insight into the social, cultural, and political factors that have enabled or blocked the embedding of RCP Connect to the participants' real life world and illuminates key elements of their experience that otherwise remain under the surface; but is it enough to really get to the crux of my research question May be a possibility of using this approach blended with another approach to address these shortcomings?? Not sure whether it gives me much adaptability if I have to rigorously adhere to the hermeneutic circle method of data analysis
Interpretive Description (ID)	Analysis of what is already known informs this framework which allows the design of research to centre the enquiry It allows delineation of boundaries, overtness of biases, and preconceived assumptions of the researcher to ensure transparency	Would assist me to focus the research question having regard to prior knowledge and experience of the participant Would enable an understanding of experiences to guide future behavioural change and real practice approaches	Is this approach to clinically focused in its methodological design for looking at behavioural change inhibitors and enablers The researcher's preconceived view could lead to jumping to conclusions too early in the data analysis – although this approach does

Methodology	Initial understanding of the methodology	What benefits would this bring to my research?	What drawbacks would this bring to my research?
	Acknowledges that reality is complex, contextual, constructed, and subjective Allows for social, cultural, and political context Premise is that the researcher and participant interact and influence each other Identifies patterns between data within the subjective environment which, in turn, informs an ID that makes conceptual links to create understanding Helps explore meaning and understanding by bringing an appreciative lens to data analysis What is going on here? What are we learning about this?	that would be made by HPs Acknowledges the social, cultural, and political environment that the HPs work in and that informs practice Provides transparency to biases in the research to pre-conceived ideas or assumptions Allows an appreciative lens of inquiry to exist at every stage of the research, selection of participants, data collection techniques, data analysis and interpretation Allows for methodological flexibility as more understanding emerges	allow for continually questioning the meaning throughout the data analysis process so this could counter this and allow for deeper understating and meaning to grow. Likewise, contextual patterns could be misleading; however, rigorous questioning about what else this can mean?

At this stage my initial thoughts are further investigating ID as to whether this is the best fit to answer my research question.

Early thoughts on the 'how' prior to doing any reading around this is working with the co-facilitators and key stakeholders in the co-design stage to formulate questions.
Participants: 6-8 from an acute hospital setting and 6-8 from a community setting that have participated in RCP training in the last 1-3 years.
Data collection: semi-structured interviews, recorded and transcribed.

I need to be transparently reflexive in my approach as my positionality is me inside an organisation researching others. As the person who was part of the co-design team and facilitated many of the training sessions, there may be an assumption from participants that I am expecting that they would have embedded in RCP. Also, as I am the Director of Allied Health there is a perceived and probably a real power imbalance between the researcher and the participants. Furthermore, because I have been fully immersed in RCP for a number of years, added to the work done in the Health Analysis paper, I have some very real preconceived ideas as to the enhancers and inhibitors to embedding RCP. My thinking: Do I need to have a positionality interview with another ID researcher to see where I am positionally now?

Need to be constantly journaling my thoughts to document my journey and questioning of my assumptions during the next 2 years.

Resources shaping my thinking so far are:

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Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *Evidence-Based Nursing, 22*(1), 7-9. https://doi.org/10.1136/ebnurs-2018-103017

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Teodoro, I., Thorne, V., de Souza, S., de Brito, N., Alencar, L., & Garcia, A. (2018). Interpretive description: A viable methodological approach for nursing research. *Anna Nery School Journal of Nursing / Escola Anna Nery Revista de Enfermagem, 22*(3), 1-8. https://doi.org/10.1590/2177-9465-EAN-2017-0287

Thorne, S., Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20*(2), 169-177. https://doi.org/10.1002/(SICI)1098-

Thorne, S., Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1), 1-11. https://doi.org/10.1177%2F160940690400300101

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Whitney, D., Trosten-Bloom, A., & Rader, K. (2010). Leading positive performance: A conversation about appreciative leadership. *Performance Improvement, 49*(3), 5-10. https://www.taosinstitute.net/files/Content/5692967/whitney_Leading-Positive-Performance.pdf

Appendix E: Participant Invitation Poster

An Invitiation to take part in RCP (RCP) Programme Research

If you are an AHP and have undertaken the RCP Training (RCP) in the last four years, I would like to invite you to take part in some research I am undertaking. The purpose of the study is to explore your experiences of attempting to implement the skills learnt through the RCP Training Programme at Hawkes Bay DHB.

Anne McLeod - Director Allied Health Whānau & Communities

What would I like to do?

I would like to interview AHPs about their experiences of implementing RCP into their everyday work. How easy or difficult was that for you as a health professional working in a busy healthcare environment?

Why am I doing this?

I am really interested in your responses as I am hoping they will not only inform a refresh of the RCP Programme at HBDHB, but that your experiences will also inform future health care practice change initiatives in Aotearoa/New Zealand. This is part of my research for my PhD in Health Science at Auckland Institute of Technology.

If you are interested in taking part or want to find out more please contact me on anne.mcleod@hbdhb.govt.nz or on 027 6368592

Participant Information Sheet for staff

This information sheet is provided for staff who may be able to assist in this research about 'RCP.'
Date Information Sheet Produced: 9 March 2022

Project Title
What helps or hinders the implementation of RCP?

An Invitation
My name is Anne McLeod. I am the Allied Health Director for Whānau & Communities. I am also a student at Auckland University of Technology (AUT) carrying out research into the implementation of RCP as part of my Doctor of Health Science qualification.

My research is aimed at understanding the experience of AHPs attempting to implement the RCP (RCP) skills learnt through the RCP Training Programme at Hawkes Bay DHB. I hope the findings of this research will build on the knowledge we already have, to inform a refresh of the Relationship Centred Programme at Hawkes Bay DHB and inform future health practice change initiatives in Aotearoa.

I plan to interview AHPs working in the acute secondary and community settings about their experiences of implementing RCP.

I would like to invite you to participate in this study if you have previously participated in the RCP Training Programme. Whether or not you decide to take part will not have any influence on your current position. You are free to join the study or not take part, it is up to you.

What is the purpose of this research?
The reason I am doing this research is to better understand the experience of AHPs in the acute and community settings trying to implement a practice change programme into their everyday work. When this research is finished, I hope it will help inform the way health practice change initiatives are delivered in the health care arena in Aotearoa. My results will be published as a thesis, in journal articles and presented at conferences. I am carrying out this study as part of my Doctor of Health Science qualification at AUT.

How was I identified and why am I being invited to participate in this research?
You have been invited to take part in this study because you are an AHP working at Hawkes Bay DHB. You are eligible to take part if you have previously participated in the RCP Training Programme. Your experience of implementing RCP into practice having

taken part in that programme will add to the information that is collated. I hope to talk to a diversity of people like you as a range of perspectives will add depth and richness to the study findings.

How do I agree to participate in this research?
You can indicate your interest in taking part by emailing me directly with your interest on anne.mcleod@hbdhb.govt.nz. Or if you have questions about the research, you are welcome to contact me directly by email.

If, after having all your questions answered, you decide you would like to take part, you will be asked to complete, sign and return a consent form. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?
Taking part in this research will involve taking part in an interview and talking to me about your experience of implementing RCP in the acute or community setting. I will ask a few questions to explore your experience and perspectives with you. I will audio-record our conversation and it will be transcribed. The transcript of your interview will be provided to you for checking. We will meet at the hospital in a meeting room, off site at the BNZ Rooms in Hastings, or by zoom - depending on your preference and what is most logistically viable. The interview will be held on a day and time that is convenient to you. I anticipate that the interview could take up to one hour of your time.

Once I have analysed the information provided to me from a range of interviews with AHPs, I will invite you to come together in with the other participants from the acute setting or the community setting in a 'focus group'. If you choose to take part in this focus group, you will be invited to complete a separate consent form for this purpose. In this focus group, I will share my preliminary findings with you and explore how much they resonate for you, clarify understanding and ensure no assumptions have been made. Participation in this this 'focus group' is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. Taking part in this focus group will take a further one hour of your time. Like the individual interview, the focus group will be held either a Meeting Room at the Hospital or the Napier Health Centre, or by zoom. I will aim to hold the focus group at a time that suits the majority of participants who wish to take part.

What are the discomforts and risks?
I am hoping that if you agree to participate that you will be willing to tell me your experience of implementing RCP. Reflecting on this might invoke some feelings related

to this experience, good, bad or indifferent. Therefore, some participants may experience some discomfort in sharing their perspectives.

It is possible you may feel uncomfortable taking part given my role as Director of Allied Health (DAH) for Whānau and Communities.

How will these discomforts and risks be alleviated?
As DAH, I have no line management responsibilities for you and see myself as an Allied Health colleague in the DHB. I am interested in your answers whether good, bad, or indifferent as it will help inform my research and future practice change initiatives here in Aotearoa New Zealand. I am looking for participants to be completely honest and open and direct with me, as this will provide the richness of information I require to get a holistic picture of the barriers and enablers you experienced when implementing RCP into your everyday work practice. This in no way has any bearing on the position you hold as an AHP at this DHB. There is no compulsion for you to be part of this research. If you do decide to participate you are able to withdraw from the research up to the time that the data is being analysed. Being part of this research programme is completely voluntary and your safety and comfort will be paramount at all times.

If you have any concerns about the research or my conduct as a DHB leader/researcher at any time then you can contact [redacted], Senior Human Resources Advisor, at Hawkes Bay DHB on [redacted]. She will listen to your concerns and provide guidance in dealing with these concerns in an appropriate way.

If you feel any distress or wish to discuss anything that comes up from telling me your story, there is other support available. You are able to contact the Employee Assistance Programme on 0800 327 669. This is a free and confidential service funded by the DHB offering up to three sessions.

How will my privacy be protected?
All information that you provide will be kept confidential so that you cannot be recognised in any publications or presentations about the experience of implementing RCP.

If you agree to participate in the 'focus group' then you will be meeting the other research participants in either the acute or community group. All participants will have signed the informed consent form including agreeing to keep participants identities and contributions confidential. However, we cannot guarantee that all participants will respect this.

Once prospective partcipants have indicated their interest, purposive sampling af those interested and the consent process can then be operationalised. This will ensure no one, other than myself, knows who ultimately agrees to take part. This helps maintain your confidentiality.

Your Professional Leads, your immediate Managers, or other DHB employees will not have any indication that you may have responded or that you have been selected (unless you decide to disclose this information to others yourself).

What are the costs of participating in this research?
The only cost to you is your time. I estimate that the interview of you telling me about your experience of implementing RCP will be approximately one hour. If you agree to participate in the Focus Group this will be another one hour session. There should be no other financial costs involved in taking part in the study. This study has the support of the DHB so time for the interview can be negotiated with your manager, I am happy to assist you with gaining permission to arrange this.

What opportunity do I have to consider this invitation?
You have two weeks to consider this invitation. If you would like to be part of this study, please email your interest to me directly **anne.mcleod@hbdhb.govt.nz** within the next two weeks and I will make contact with you.

Will I receive feedback on the results of this research?
When the study is finished, the thesis will be available in the Hawkes Bay DHB library, and online via the AUT library. I will also provide you with a short summary of the main findings of the study for your information.

What do I do if I have concerns about this research?
Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Nicola Kayes who can be contacted at nicola.kayes@aut.ac.nz or by phone on +64 9 921 9999 ext. 7309

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz 0800 288 864

Whom do I contact for further information about this research?
Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the researcher as follows:

Researcher Contact Details
Anne McLeod: anne.mcleod@hbdhb.govt.nz or +64 27 636 8592
Project Supervisor Contact Details
Nicola Kayes: nicola.kayes@aut.ac.nz or +64 9 921 9999 ext. 7309

Approved by the Auckland University of Technology Ethics Committee on type the date final ethics approval was granted, AUTEC Reference number type the reference number.

Appendix G: Draft Interview Questions

Morena/Kia Ora - Mihi/Introductions

Thank you for agreeing to be part of this study. I really appreciate you taking time out of your busy schedule to meet with me. The interview will focus on your experience of the RCP process. Before we get started is it OK if we start with a karakia?

Karakia

I would really like to gain your insights into RCP - around the training programme and how it was for you when you took the concept of RCP back to your area of work and tried to put it into practice from a (discipline-specific) perspective and a service delivery point of view.

I would really appreciate your honesty with all your insights whether positive or negative, as they will be invaluable to provide meaning along with the other participants experiences to inform a future refresh of the RCP programme.

Your answers will be confidential and your anonymity will be maintained. As outlined in the introductory email, there will be an opportunity to come together with the other participants to look at the general patterns and themes of what helps or helps or hinders the implementation of RCP in the (acute or community) setting as a cohort focus groups. This group interaction may facilitate dialogue that may collectively enhance understanding or bring new meaning to the study. You can decide whether you would lie to be a part of this or not.

Before we get started I just want to go over the *informed consent form*.

Tell me how you were selected or signed up to be part of the RCP programme?

How was the RCP training experience for you?

What was your understanding of the meaning of RCP? The advantages for your practice? The disadvantages?

What (if any) were the concepts that you found valuable from the RCP Training programme?

What (if any) were the concepts that you did not find useful from the RCP programme?

What was you initial experiences of taking RCP back to your workplace from the training?

What concepts (if any) did you try and embed in your everyday practice?

What was your experience of trying to work in a RCP way in your area of work?

What were your successes? How was that for you? How did it feel? What difference(if any) did it make? What did that look like, do you think, from a patient/whaiora point of view?

What was difficult in trying to practice in a RCP way? What hindered you working in this way? What else (if any) were blocks to you practicing in a RCP way? How was this for you?

What support did you have to work in a RCP way?

Which RCP concepts were easier to embed? (if any) Which were harder to practice?

Were there days you were able to practice RCP well? What would have helped to support you more? (if anything?)

Reflecting on what the participant has said: What do you mean when you say…? Tell me more about… Why do you think that is?

Concluding: Would you like to add anything else about your experience of embedding RCP into your practice? Any other thoughts or comments?

I really appreciate the time and the valuable insight you have given to me today. I will be in contact again when I have a confirmed date, to see if you are interested in being part of the (acute HP or Community HP) cohort focus group.

Offer koha/gift
Can we please finish with a karakia?
Karakia

Appendix H: Power Point Slides

He Rauora Hōhou Tangata, Hōhou Whānau
Relationship Centred Practice Initial Candidate and Provisional Concepts

AUT DHSc Doctoral Study

November 2022

Research Questions

1./ To explore what helps or hinders the implementation of RCP

2./ To examine the role that context and setting has on meaningful implementation of RCP (community versus acute)

3./ To explore what is perceived to support sustained practice change

4./ What is specifically known about this in the context of Aotearoa, in relation to the embedding of Te Ao Māori ways of working?

- Analysis of current healthcare environment
- Practice and behavioural change theories and models
- Extensive literature review internationally N= 321 N=19
- Extensive literature view of Aotearoa/New Zealand N=35 N=6
- Critical Skills Appraisal, rigour and validity

Literature Early Concepts

- Context of Current Environment
- Culture
- Leadership
- Communication and Relations
- Practice Level Considerations

Aotearoa/New Zealand Concepts

- Context of Current Environment
- Culture
- Leadership
- Communication and Relations
- Practice Level Considerations

Additionally …..

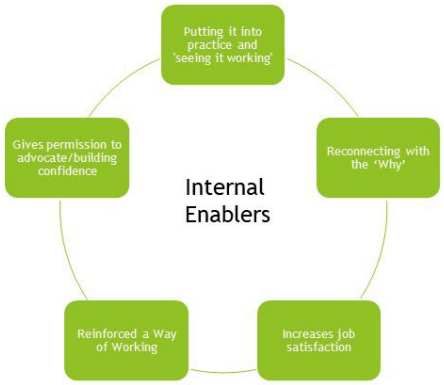
- Racism Embedded in the Health System at Every Level

Participants

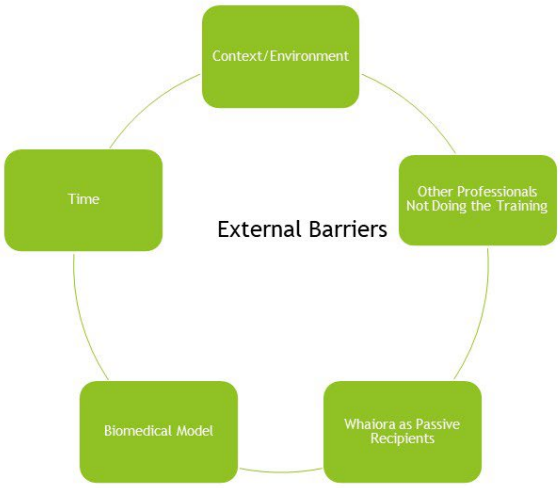
- Allied Health Professionals
- 4 from Community
- 4 from Acute
- 25% of sample identified as Māori practitioners
- Represented 6 different AH Professions

External Enablers

Findings – Health Professional Enablers



External Barriers



Internal Health Professional Barriers

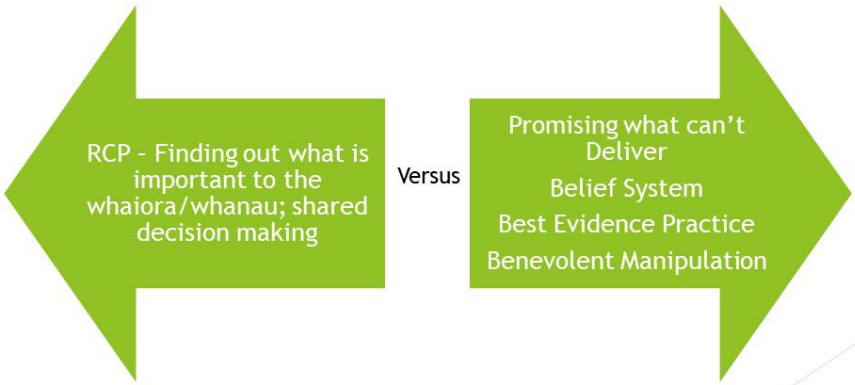
External Training Barriers

Early Observations

- Barriers and Enablers sometimes form different parts of a Continuum
- Only small differences when practicing RCP with the Community Context and the Acute Context
- Patient Activation and Decisional Matrix really important for Physios, OTs and Pharmacists

RCP Training Cohorts

An Internal Conflict for HPs



Community Versus Acute

- Perceived power balance changes
- Whaiora hugely vulnerable in an acute hospital environment
- Different Tikanga in community setting in whaiora own home - we are the Manuhiri

Comments

- 'Clients will need more visits/more therapy sessions if you do not use RCP'
- 'If you are in a health care professional role and want to help people why would you not embrace RCP - it's a no brainer'
- 'Understanding patients' reality is essential'

Future Ideas for Embedding RCP

- Make RCP Mandatory
- RCP Supervision Sessions
- RCP Key Enabler 1-2 hour sessions 6 months afterwards
- Application of principles to Case Studies
- RCP Pop Quiz
- Positive story about RCP in practice once a month
- Getting colleagues to teach
- Pertinent Professional Area Clinical Examples
- Being videoed and someone critiquing it

Key Informant Group

Appendix I: AUTEC Ethics Addressing Mitigating Factors

Ethics Application: **22/26 What impacts the implementation of Tikanga Ako Hono-Tangata/Relationship Centred Practice (RCP) by Allied Health Professionals (AHPs) within Hawkes Bay District Health Board (HBDHB)**

Thank you for considering and approving my Ethics application subject to addressing the conditions outlined in the email on 23 February 2022.

In response to the conditions raised by the committee:.

1. **Provision of further information about how the conflicts of interests and the associated power imbalances involved will be avoided, minimised, and managed. AUTEC noted the primary researcher's leadership and management role in relation to the participants as well as their involvement in the programme requires further consideration. It may be more appropriate for someone else to do the interviews and de-identify the transcripts.**

a) In my role as Director of Allied Health, I do not have any line management, performance management or budgetary responsibility for any of the Allied, Scientific and Technical workforce. None of the staff who would meet eligibility to take part in this research directly report to me. My role as Allied Health Director means that I am responsible for anticipating, highlighting, and addressing issues pertainent to the Allied, Scientific and Technical workforce in the Community and in the Older Person Allied Health area. The role is one of advocacy and support to ensure Allied Health practitioners are able to be as effective as possible in delivering high quality healthcare with equitable outcomes in their everyday work. In essence, I have a mandate to champion this workforce on matters affecting them and provide a balanced approach to the Group Leadership decision-making process.
(See Appendix A – Organisational Chart)

b) Regardless of the above, I acknowledge the potential for a perceived power imbalance by virtue of holding a leadership position. To further address this, I have:

- Amended the Participant Information Sheet as per the committee's suggestions below to be more transparent about any possible risk associated with my leadership role so that potential participants can consider that as part of their decision to take part.
- Ensured (potential) participants have a mechanism for addressing concerns about my conduct through the course of the research in relation to this dual role (DHB leader/researcher) by supplying details of a Senior Human Resources Advisor in the DHB, Suzanne Paul. Suzanne has agreed to be a point of contact for staff.
(See amended Participant Information Sheet attached changes highlighted in yellow).

c) With respect to the suggestion by AUTEC that someone else be engaged to do the interviews – I have considered this suggestion and would, respectfully, prefer to mitigate risk associated with perceived conflict and power imbalance rather than remove myself from that process for three reasons:

1. As above, I do not have direct line management responsibilities which lessens the potential risk associated with my role;
2. Methodologically, Interpretative Description (ID) positions the researcher as active in data construction, analysis and interpretation. Further, my professional knowledge and the insights I bring to the interviews may be formative to the direction of the interviews and are critical in developing the quality of the data. This also impacts on the ability of the research to generate insights for practice (a key purpose of Interpretive Description research). As such, having someone independant conduct the interviews is epistemologically problematic, and would impact the integrity of the project.

3. Finally, I am undertaking this research as part of the Doctor of Health Science. The nuances and insights gained from conducting these interviews in person will bring depth to the research. It will also contribute to my growth and development as a researcher and will increase the likelihood that my research can have a meaningful and positive impact on practice.

2. **Clarification about how the professional leads will be involved in the recruitment and selection of participants. AUTEC advises that it is inappropriate for those with line management responsibilities to be involved in the recruitment of those reporting to them.**
    - To clarify the Professional Leads position in the organisation – they are responsible for the professional standards and development of their respective disciplinary groups. They have no direct reports or line management responsibility. Therefore they are an appropriate independent party to distribute information about the study. (Refer Organisational Chart – Appendix A)
    - Offering health professionals a choice of submitting their interest either through the Social Work Professional Lead or linking directly with the Primary Researcher regarding their potential participation gives participants choice and control.
    - The Social Work Professional Lead will then provide me as Primary Researcher with their details.
    - As Primary Researcher, I will then undertake the purposive sampling and the consent processes. This will ensure no one, other than the primary researcher, knows who has ultimately agreed to take part, maintaining confidentiality.
    - These processes will ensure the other Professional Leads, their immediate Managers, or other DHB employees will not have any indication of who responded to the inviation and who has been selected (unless the participants themselves disclose this information to others).

3. **Provision of revised protocols for obtaining permission to undertake the research at work. AUTEC advises that it is the researcher's role to obtain access permission and to ensure that staff partcipation is confidential and not know to their managers. AUTEC recommends that consideration be given to staff being interviewed outside work hours.**
    - I have discussed my research project with Dr John Gommens who heads the Hawkes Bay DHB research committee and he has advised that it is acceptable to interview staff in their lunch hour in the workplace if the participants so wish.
    - I will give participants the choice on time and place of interview. To ensure flexibility and responsiveness I will offer the choice of either lunchtime interviews on the hospital site or after hours in the BNZ Rooms in Hastings.
    - This will ensure that the Allied Health Professionals are taking part in the research on their terms. Having this choice will also be important given some participants may have young children and childcare may be an issue out of work hours.

4. **AUTEC has advised that the Participant Information Sheet (PIS) be amended in three ways:**
    a. **To include advice about conflicts of interest and any perceived power imbalances and how these will be managed, along with strong assurances to potential partcipants about their voluntariness and safety.**
        - The level of confidentiality, the vountariness and participants safety and ways of redressing any concerns have now been addressed more comprehensively in the

Participant Information Sheet. Wording in the PIS has been amended to include the following:

As DAH, I have no line management responsibilities for you and see myself as an Allied Health colleague in the DHB. I am interested in your answers whether good, bad, or indifferent as it will help inform my research and future practice change initiatives here in Aotearoa New Zealand. I am looking for participants to be completely honest and open and direct with me, as this will provide the richness of information I require to get a holistic picture of the barriers and enablers you experienced when implementing RCP into your everyday work practice. This in no way has any bearing on the position you hold as an Allied Health Professional at this DHB. There is no compulsion for you to be part of this research. If you do decide to participate you are able to withdraw from the research up to the time that the data is being analysed. Being part of this research programme is completely voluntary and your safety and comfort will be paramount at all times.

(See amended Participant Information Sheet parts highlighted in yellow in Appendix B)

b. **To provide clear advice to participants about the level of confidentiality that can be given in this study.**

- The PIS has been amended to include the following:

There is a choice of submitting your interest in being involved in this research project through the Social Work Professional Lead or linking directly with me as the Primary Researcher regarding your potential participation which gives you an an option.

If you decide to submit your interest through the Social Work Professional Lead then she will provide me your details and your potential interest in participating so purposive sampling and the consent process can be operationalised. This will ensure no one, other than myself, knows who ultimately agrees to take part. This helps maintain your confidentiality.

Other Professional Leads, your immediate Managers, or other DHB employees will not have any indication that you may have responded or that you have been selected (unless you decide to disclose this information to others yourself).

(See amended Participant Information Sheet parts highlighted in yellow in Appendix B)

c. **To include counselling services' contact details.**

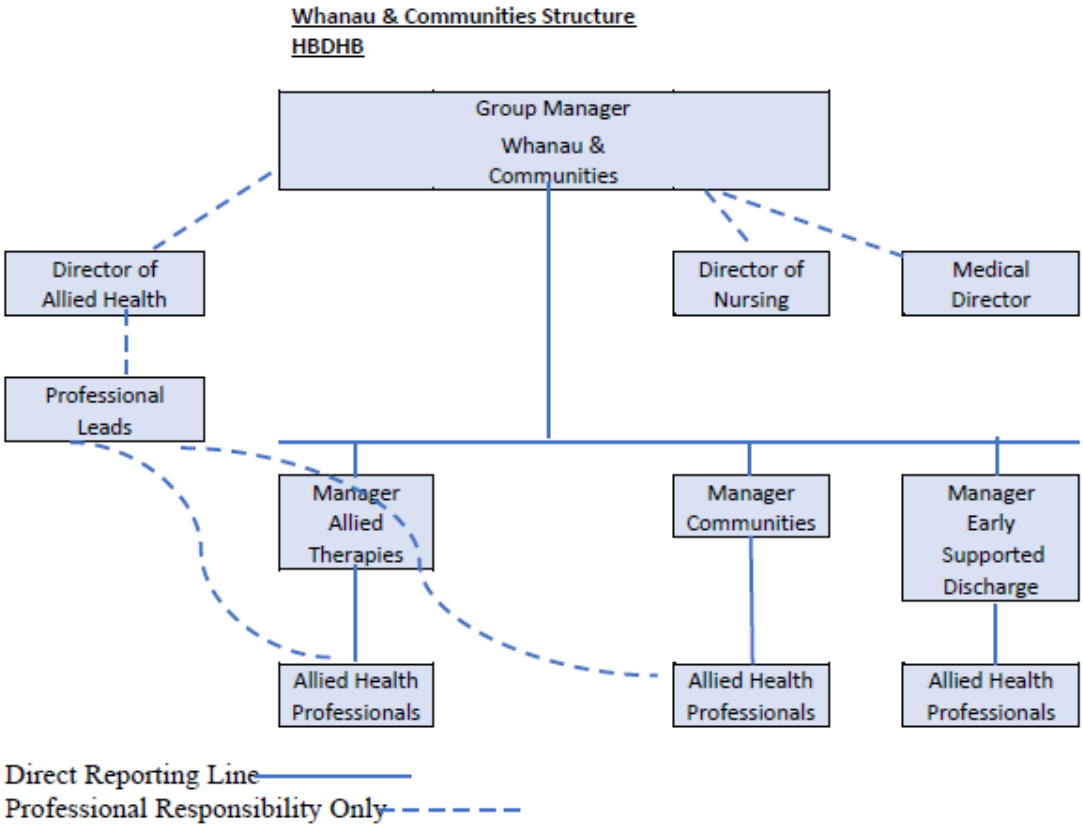
- The PIS has been amended to include the following:

If you have any concerns about the research or my conduct as a DHB leader/researcher at any time then you can contact Suzanne Paul, Senior Human Resources Advisor, at Hawkes Bay DHB on 027 5556429. She will listen to your concerns and provide guidance in dealing with these concerns in an appropriate way.

If you feel any distress or wish to discuss anything that comes up from telling me your story, there is other support available. You are able to contact the Employee Assistance Programme on 0800 327 669. This is a free and confidential service funded by the DHB offering up to three sessions.

(See amended Participant Information Sheet parts highlighted in yellow in Appendix B)

APPENDIX A – Whānau and Communities Directorate Organisationa Chart



APPENDIX B

Participant Information Sheet for staff

This information sheet is provided for staff who may be able to assist in this research about 'Relationship Centred Practice.
Date Information Sheet Produced: 9 March 2022

Project Title
What helps or hinders the implementation of Relationship Centred Practice?

An Invitation
My name is Anne McLeod. I am the Allied Health Director for Whānau & Communities. I am also a student at Auckland University of Technology (AUT) carrying out research into the implementation of Relationship Centred Practice as part of my Doctor of Health Science qualification.

My research is aimed at understanding the experience of Allied Health Professionals attempting to implement the Relationship Centred Practice (RCP) skills learnt through the RCP Training Programme at Hawkes Bay DHB. I hope the findings of this research will build on the knowledge we already have, to inform a refresh of the Relationship Centred Programme at Hawkes Bay DHB and inform future health practice change initiatives in Aotearoa.

I plan to interview Allied Health Professionals working in the acute secondary and community settings about their experiences of implementing Relationship Centred Practice.

I would like to invite you to participate in this study if you have previously participated in the Relationship Centred Practice Training Programme. Whether or not you decide to take part will not have any influence on your current position. You are free to join the study or not take part, it is up to you.

What is the purpose of this research?
The reason I am doing this research is to better understand the experience of Allied Health Professionals in the acute and community settings trying to implement a practice change programme into their everyday work. When this research is finished, I hope it will help inform the way health practice change initiatives are delivered in the health care arena in Aotearoa. My results will be published as a thesis, in journal articles and presented at conferences. I am carrying out this study as part of my Doctor of Health Science qualification at AUT.

How was I identified and why am I being invited to participate in this research?
You have been invited to take part in this study because you are an Allied Health Professional working at Hawkes Bay DHB. You are eligible to take part if you have previously participated in the Relationship Centred Practice Training Programme. Your experience of implementing RCP into practice having taken part in that programme will add to the information that is collated. I hope to talk to a diversity of people like you as a range of perspectives will add depth and richness to the study findings.

How do I agree to participate in this research?
You can indicate your interest in taking part by emailing the social work professional lead Stephanie Mackay, stephanie.mackay@hbdhb.govt.nz. She will forward me a selection of prospective participants so I can follow up with you to discuss your participation further. Or you can directly email your interest to me as

the Primary Researcher anne.mcleod@hbdhb.govt.nz. Or if you have questions about the research, you are welcome to contact be directly by email.

If, after having all your questions answered, you decide you would like to take part, you will be asked to complete, sign and return a consent form. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Taking part in this research will involve taking part in an interview and talking to me about your experience of implementing relationship centred practice in the acute or community setting. I will ask a few questions to explore your experience and perspectives with you. I will audio-record our conversation and it will be transcribed. The transcript of your interview will be provided to you for checking. We will meet at the hospital in a meeting room, off site at the BNZ Rooms in Hastings, or by zoom - depending on your preference and what is most logistically viable. The interview will be held on a day and time that is convenient to you. I anticipate that the interview could take up to one hour of your time.

Once I have analysed the information provided to me from a range of interviews with Allied Health Professionals, I will invite you to come together in with the other participants from the acute setting or the community setting in a 'focus group'. If you choose to take part in this focus group, you will be invited to complete a separate consent form for this purpose. In this focus group, I will share my preliminary findings with you and explore how much they resonate for you, clarify understanding and ensure no assumptions have been made. Participation in this this 'focus group' is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. Taking part in this focus group will take a further one hour of your time. Like the individual interview, the focus group will be held either a Meeting Room at the Hospital or the Napier Health Centre, or by zoom. I will aim to hold the focus group at a time that suits the majority of participants who wish to take part.

What are the discomforts and risks?

I am hoping that if you agree to participate that you will be willing to tell me your experience of implementing relationship centred practice. Reflecting on this might invoke some feelings related to this experience, good, bad or indifferent. Therefore, some participants may experience some discomfort in sharing their perspectives.

It is possible you may feel uncomfortable taking part given my role as Director of Allied Health (DAH) for Whānau and Communities.

How will these discomforts and risks be alleviated?

As DAH, I have no line management responsibilities for you and see myself as an Allied Health Colleague in the DHB. I am interested in your answers whether good, bad, or indifferent as it will help inform my research and future practice change initiatives here in Aotearoa New Zealand. I am looking for participants to be completely honest and open and direct with me, as this will provide the richness of information I require to get a holistic picture of the barriers and enablers you experienced when implementing RCP into your everyday work practice. This in no way has any bearing on the position you hold as an Allied Health Professional at this DHB. There is no compulsion for you to be part of this research. If you do decide to participate you are able to withdraw from the research up to the time that the data is being analysed. Being

part of this research programme is completely voluntary and your safety and comfort will be paramount at all times.

If you have any concerns about the research or my conduct as DHB leader/researcher at any time then you can contact Suzanne Paul, Senior Human Resources Advisor, at Hawkes Bay DHB on 027 5556429. She will listen to your concerns and provide guidance in dealing with these concerns in an appropriate way.

If you feel any distress or wish to discuss anything that comes up from telling me your story, there is other support available. You are able to contact the Employee Assistance Programme on 0800 327 669. This is a free and confidential service funded by the DHB offering up to three sessions.

How will my privacy be protected?

All information that you provide will be kept confidential so that you cannot be recognised in any publications or presentations about the experience of implementing relationship centred practice.

If you agree to participate in the 'focus group' then you will be meeting the other research participants in either the acute or community group. All participants will have signed the informed consent form including agreeing to keep participants identities and contributions confidential. However, we cannot guarantee that all participants will respect this.

There is a choice of submitting your interest in being involved in this research project through the Social Work Professional Lead or linking directly with me as the Primary Researcher regarding your potential participation which gives you an an option.

If you decide to submit your interest through the Social Work Professional Lead then she will provide me your details and your potential interest in participating so purposive sampling and the consent process can be operationalised. This will ensure no one, other than myself, knows who ultimately agrees to take part. This helps maintain your confidentiality.

Other Professional Leads, your immediate Managers, or other DHB employees will not have any indication that you may have responded or that you have been selected (unless you decide to disclose this information to others yourself).

What are the costs of participating in this research?

The only cost to you is your time. I estimate that the interview of you telling me about your experience of implementing RCP will be approximately one hour. If you agree to participate in the Focus Group this will be another one hour session. There should be no other financial costs involved in taking part in the study. This study has the support of the DHB so time for the interview can be negotiated with your manager, I am happy to assist you with gaining permission to arrange this.

What opportunity do I have to consider this invitation?

You have two weeks to consider this invitation. If you would like to be part of this study, please email your interest to **stephanie.mackay@hbdhb.govt.nz** within the next two weeks and I will make contact with you.

Will I receive feedback on the results of this research?

When the study is finished, the thesis will be available in the Hawkes Bay DHB library, and online via the AUT library. I will also provide you with a short summary of the main findings of the study for your information.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Nicola Kayes who can be contacted at nicola.kayes@aut.ac.nz or by phone on +64 9 921 9999 ext. 7309

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz 0800 288 864

Whom do I contact for further information about this research?
Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the researcher as follows:

Researcher Contact Details
Anne McLeod: anne.mcleod@hbdhb.govt.nz or +64 27 636 8592
Project Supervisor Contact Details
Nicola Kayes: nicola.kayes@aut.ac.nz or +64 9 921 9999 ext. 7309

Approved by the Auckland University of Technology Ethics Committee on type the date final ethics approval was granted, AUTEC Reference number type the reference number.

Appendix J: AUTEC Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

29 March 2022
Nicola Kayes
Faculty of Health and Environmental Sciences

Dear Nicola

Re Ethics Application: **22/26 What impacts the implementation of Tikanga Ako Hono-Tangata/RCP (RCP) by AHPs (AHPs) within Hawkes Bay District Health Board (HBDHB)**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 29 March 2025.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: anne@directionscareers.co.nz; felicity.bright@aut.ac.nz

Appendix K: Hawkes Bay District Health Board Ethics Approval

HAWKE'S BAY District Health Board Whakawātea

CHECK LIST FOR RESEARCH LOCALITY AUTHORISATION SIGN OFF

Received: 06 April 2022

Name of Principal Investigator: Anne McLeod

Full Project Title: What impacts the implementation oTikanga Ako Hono-Tangata/Relationship Centred Practice by Allied Health Professionals within HBDHB.

DOCUMENTATION	COMMENTS / DOCUMENTS CITED	DATE	SIGNED
Statement of maintaining Patient Confidentiality	**Stated in PISICF**	**06 Apr 22**	**M Spooner**
Summary of Protocol/Proposal	Cited in application	**06 Apr 22**	**M Spooner**
Participant Information & Consent Forms	Cited	06 Apr 22	M Spooner
Evidence of Cultural Consultation	Attached in Key Informant Group Information and with Laurie te Nahu Pou Whakaruahau Matua, ongoing involvement in this research project – No formal maori approval required.	06 Apr 22	M Spooner
Evidence of approval from student supervisor (for academic research)	Professor Nicola Kaye Signed 05 Apr 22	06 Apr 22	M Spooner
Evidence of academic institutional review & approval (for academic research)	N/A		
Service Manager / Clinical Director / Nurse Director approval	Dr Andy Phillips Signed 22 Mar 22	06 Apr 22	M Spooner
Contract or Agreement	N/A		
Request for data from IS	N/A		
HDEC Ethical review undertaken	N/A AUTEC approval 22 Mar 22	06 Apr 22	M Spooner
Research spreadsheet updated	Completed	06 Apr 22	M Spooner

HBDHB Research Review

The research project has been reviewed with the following prior to approval:

Name: JOHN GOMMANS Signature:

Date: 6 April 2022 Designation: Chair HBCRAG

REF: 2022/04/352

Academic Research Checklist