

**Service Users' Views
of Collaborative Care:
A descriptive exploratory study**

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Abstract

There is a belief that service users have an essential role to play in collaborative care. Surprisingly, there appear to be minimal opportunities for service user's opinions, experiences and requirements to be heard when organising the plan of care. This lack of inclusion is significant in an increasingly consumer-conscious health care context, where service users expect to have a voice about their care.

The aim of this research was to explore service user's experiences, expectations and understanding of the care received at an Integrated Health Clinic. The design was qualitative descriptive. Fifteen service users were interviewed. Data were analysed thematically.

The major themes identified from the service user's that influenced service delivery were: User Expectations, User Perceptions and User Observations. Findings indicate that while service users did not receive collaborative care at the Clinic, unequivocally, they would have liked to be recipients of that model of care. However, service users spoke highly of receiving patient-centred care, of uni-professional communication, and noted that teamwork occurred in some professional groups. It was especially interesting to note that service users continued to attend the Clinic, so that they might contribute to student's learning. In becoming involved with students they engaged in two-way learning. It

seems that service users not only benefit from these practice learning situations, but contribute to the collaboration as well.

This suggests that the service user's view is a critical aspect for the ongoing development of service delivery and practice in this integrated healthcare environment. Recommendations include: Developing learning packages for service users to support student learning; marketing of the Clinic; clarifying the model of care is important; the Clinic's common purpose needs to be reviewed; interprofessional faculty development could be strengthened; and increasing Clinic availability to service users right across the year needs to be considered. Overall, service users have much to contribute to collaborative practice, and it seems that their input so far might be very much under-estimated.

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I dedicate this work to Nancy Lewis-Parker, a friend and colleague, who constantly reminded me to FOCUS and complete this thesis. Nancy had a belief in, and role modeled collaborative working in her professional practice. Her passion for nursing in particular has inspired many.

"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 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."

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Glossary

The following terms are defined for the purpose of this study:

Service Users: people who receive and are consumers of health care services that are usually delivered on a long term basis.

Collaborative Care

According to the World Health Organization (2010) collaborative practice occurs: "When multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings" (p. 13).

Integrated care: health services work collaboratively with each other, and with patients and their families and carers, to provide person centred optimal care" (National Health Priority Action Council (NHPAC), 2006, p. 11).

Interprofessional Learning: when two or more professions learn from and about each other to improve collaboration and the quality of care (CAIPE, 2002).

Uniprofessional Learning: where professionals learn in isolation from one another. Reeves, Zwarenstein, Goldman, Barr, Freeth, Hammick, & Koppel 2007

Chapter One

Introduction

The role and importance of the service user input into the planning and implementation of care has been the focus of long standing discussion.

This is based on a belief that the views of the service users are pivotal in health service delivery (Stewart, 2009). The service user's perspective is a critical aspect of evaluating care. Yet there are few studies on service user's perspectives and the longer term impact of collaborative care on the delivery of safe and effective care (Haddad, Potvin, Roberge, Pineault, & Remondin, 2000; MacDonald, Herman, Hinds, Crowe, & MacDonald, 2002; Reeves 2010; Shaw, 2008).

It is perhaps disappointing that, time after time, service users report that they are completely perplexed and overwhelmed by the number of different professionals involved in their care. Part of the problem is that service users suggest that user involvement in shared decision-making continues to be limited (Smith et al., 2008; Stewart, 2009; Stringer, Van Meijel, de Vree, & Van Der Bijl, 2008). It is not uncommon to hear service user's state that care is uncoordinated, completed in isolation of each discipline/profession, with no thought given to the needs of the service user. For example:

On receiving information from my cardiologist that they were unable to successfully convert my heart rhythm to a normal

beat, I was enquiring how this would affect the treatment I was due to receive for the prostate. I was told I would need to talk with my urologist. While I had concerns with both heart and prostate, along with ongoing stabilised asthma, specialists were determined to keep my health issues separated, dealing only with their speciality. I always left their consultations with little information I could readily apply to my overall health ... it was like I had to become this medical expert trying to piece together the disjointed medical information in order to make an informed decision as to ongoing treatment and what I was meant to do for the best ... I felt confused and frustrated ... (Consumer feedback, 2011).

This statement summarises a service user's experience within a public health system. While it is but one experience, it seems to reflect the experiences of other service users within the health services (Johnson, Wistow, Schulz, & Hardy, 2003; Shaw, 2008). Problems with poorly co-ordinated, fragmented care are apparently on-going. For example, over a decade ago, Hall and Weaver (2001) noted that those with complex health needs were required to communicate with a wide variety of health professionals and interpret discussions, despite the fact that many of the professionals struggled to establish effective communication between each other. Part of the problem was that often different professionals can be assessing the same issue and not observe the same thing. This communication appears to become even more difficult, as health services are accessed within primary health care settings that are frequently in different geographical areas. This can create a challenging situation for the service user who may not

understand the advice given. At the same time, receiving conflicting advice may hinder effective and efficient health care (Sterrett, 2010).

Surprisingly, considering that the service user should be an important part of collaborative care, in a day and age that is supposedly patient centered (Pelzang, 2010), there appear to be minimal opportunities for the service user's opinions, experiences, and requirements to be included in the plan of care. Litaker et al. (2003) suggest that this lack of inclusion is critical in an increasingly consumer-conscious health care market, where the service user's voice needs to be heard.

The specific purpose of this study is to: *Explore the service user's perspective of collaborative care received in an Integrated Health Clinic*. Due to the paucity of research in relation to service user's involvement in collaborative care, the approach selected for this study is qualitative. Burns and Grove (1999) suggest that "qualitative approaches are based on a worldview that assumes there is not a single reality, and what is known is situation or context specific" (p. 339). According to several other authors (Creswell, 1999; Smith, 2008; Willig, 2009), a qualitative design is appropriate when a new area is being explored and the aim is to gain further insight and knowledge in relation to a topic. Qualitative research generates systematic, comprehensive, subjective data. The researcher has the

responsibility to view what is happening in a situation through the eyes of the participants. In this study, a descriptive exploratory design was used to identify the service user's involvement in collaborative care. Description is useful when a researcher wants to identify what is significant for people having a certain experience. The qualitative design with thematic analysis followed an inductive process, in which themes provide rich descriptions of what is happening in a particular situation.

Background

To place the study into context, an overview is presented on why the term service user was chosen for this study. The models of health care that relate to the field of study are discussed. This is followed by a brief historic overview of the Integrated Health Clinic, and finally, changes to health service delivery in New Zealand in relation to integrated health care and collaborative care are outlined briefly.

Why Service Users?

In this study service users are defined as people who receive and are consumers of health care services that are usually delivered on a long term basis. The term service user encompasses the diversity of the makeup of the community and includes people who have a different

ethnicity, culture, religion, disability, and age.

Historically, many terms have been used to describe people who access health care services. Changes in social policies and government initiatives have meant that the emphasis has changed with the times. As McLaughlin (2009) states: "Whichever label we use - 'service user', 'consumer', 'customer', 'client', or 'expert by experience' - it is descriptive not of a person, but of a relationship" (p. 1114). Labels used by health professionals to describe their relationships with the public have included terms such as patients, clients, persons, customers, consumers, and service users (Mead & Bower, 2000; Pelzang, 2010; Slater, 2006). These labels are relevant, as they identify differing relationships and power dynamics that represent socio-cultural relationships that are typical of a particular time.

For instance, the historical biomedical model of care was such that the patient was seen and not heard and often had no idea of their own health status or treatments. Conversely, by the 1980s the label for the receivers of health services changed from patient to client. This was driven by the consumer movement in which service users "demanded greater accountability, better quality of service, and a more egalitarian relationship with their doctors" (Drew & Davis, 2005, p. xxii). Client centered care became popular, and in some instances clients were customers of health professionals (Slater, 2006).

The consumer movement however, altered expectations and responsibilities for care. Consumers had rights, were well informed, made their own choices, and were aware of the implications of the competitive market (Donaldson & Gerard, 1993; Smith et al., 2008). The market model of health was increasingly important. Service users were able to choose between public and private providers creating the discourse whereby health care became a commodity to be brought or sold. This positive relationship and involvement of service users assumed that the consumer or the customer (Harris, 1999; MacDonald, 2006) could access services in a marketplace leading to more efficient and effective services privately or publically. However, research also shows that even in this approach the partnership between service users and health professionals could be tokenistic and unproductive (McLaughlin, 2009). Stringer et al. (2008) add support to this by stating that service users have a right to be involved in their own health care. However, in many instances health professionals are reluctant to participate in this more egalitarian partnership. Furthermore, it is still unclear how the service users fit within this partnership (McLaughlin, 2009), although it is well documented that partnerships between service users and health care professionals apparently lead to more efficient and effective care (Hall, 2005; Shaw, 2008; Stewart, 2009).

The term service user is chosen for this study, as it best reflects the participants' independent choice to access care from senior undergraduate and postgraduate health students, working under the direction of clinical educators at an Integrated Health Clinic (thereafter known as the Clinic). Many of these service users present with complex health needs, which will require long term collaborative care.

Collaborative Care

The World Health Organization (WHO) (2010) states that collaboration occurs when “multiple health workers provide comprehensive services by working together synergistically along with patients, their families, carers and communities to deliver the highest quality of care across settings” (as cited in Mickan, Hoffman, & Nasmith, 2010, p. 494). This collaborative approach supports a key strategy identified by the Primary Health Care Advisory Council (PHCAC) (2009) that recognises the needs of service users as being pivotal to their received care. Because the collaborative model of care is relatively new, research is needed to understand what it means for the service user.

Some authors (Bodenheimer, 2005; Johnson et al., 2003; Shaw, 2008) suggest that people who are engaged in collaborative care tend to participate in their own health care and are more likely to adopt improved health related behaviors. This position is supported by the

authors of the PHCAC (2009), who report that service users overall have enhanced health and social outcomes and respond more positively to a relationship with people rather than a place. Nonetheless, working collaboratively is challenging, because frequently health care is delivered in the traditional medical model of service delivery that tends to be poorly coordinated and fragmented (Johnson et al., 2003). The traditional approach tends to focus more on the professional delivering the care, rather than emphasizing the consumer of the service, the service user. Despite this, access to services, which are delivered using a collaborative model of care, is seen to be essential (WHO, 2010).

Furthermore, collaborative care is supposedly essential for workforce planning, because services must be provided for an ageing population many of whom have complex health needs and chronic illness. "Collaboration, however, is not only about agreement and communication, but about creation and synergy" (WHO, 2010, p. 36). To achieve this, it is essential to engage with the service user, families, and communities, to identify and understand better their needs and treatments for their own requirements (Boyd, 2001).

However, working collaboratively is complex. Collaboration is a dynamic process. To date, collaboration is not yet fully understood or operationalized (Gaboury, Bujold, Boon, & Moher, 2009). Although

documentation on collaboration in health care dates back prior to World War II, it is only in recent times that an increase of work on teamwork and collaborative practice has appeared. This interest in collaborative practice is partly explained by the increased complexity of service users' care, and increase of chronic illness, and rising healthcare costs. In turn, collaborative practice is seen as a strategy that will promote effective and efficient care and improve health outcomes for service users (Gaboury et al., 2009). Within practice, collaboration is promoted by health care teams that operate at various levels of interaction, which influence team members and how they manage responsibilities for their service users. These various levels are referred as the multidisciplinary team, interdisciplinary team, and the transdisciplinary team (McCallin, 2005).

The literature suggests collaboration underpins a number of service delivery terms that are used interchangeably. Hall and Weaver (2001) differentiate between multidisciplinary and interdisciplinary teams. They state that within a multidisciplinary team health professionals contribute independently to the service user's health needs, often working alongside professionals from other disciplines. Communication occurs between professionals of the same discipline, but is limited between the different disciplinary groups. Overall, the multidisciplinary team tends to function uni-professionally. In

contrast, an interdisciplinary team is a team where the members work closely and maintain clear and frequent communication to optimize the health care needs of the service users. The interdisciplinary team is based around solving a common set of problems, and meets frequently to confer findings. Each team member contributes his/her specialist knowledge and skill set to augment and support the contributions of other team members, to allow for holistic management of the service users' often complex health issues. Interdisciplinary team work is also referred to in the clinical setting as interprofessional health care (Hall & Weaver, 2001). Overall, it seems that the way that health professionals practice changes according to the context and the developments therein.

Context and Developments

This study was undertaken at the Clinic, which is situated on a University campus in a Faculty of Health and Environmental Sciences, in a large metropolitan area. While the Clinic offers integrated care to the local community, it is also part of the National Centre for Education and Collaborative Practice that is situated in the University. Due to this connection, the Clinic's services are assumed to be collaborative. For the purpose of this research collaborative care is seen to occur when at least three different health professionals work

together in the same location (Gaboury et al., 2009).

The Clinic is managed by health educators who are expert clinicians within their specific profession. Senior undergraduate and postgraduate students work in the Clinic, providing care for service users under the supervision and guidance of clinical educators. The health professionals come from a variety of professions including: Nursing, Occupational Therapy, Physiotherapy, Podiatry, and Oral Health.

The Clinic is situated in a locality where the population is diverse and has a multi-ethnic grouping including a growing Asian population, as well as Maori and Pacifica people. The area is part of the largest city in New Zealand, where overall the population is 1.2 million. Censuses have shown that the population in this region is consistently increasing and projected trends show that this will continue in the future. This includes a growing population of young and elderly people (Auckland Council, 2011). The community has a wide-ranging socio-economic base. Many people from the community and elsewhere are employed within this region in a variety of work settings, including skilled, unskilled, and professional work. Unemployed people live in the area too. This community also has a broad range of educational centres including two universities, as well as several state and private schools. There are various retirement communities in the surrounding

area. There is also a large public hospital, and an extensive range of health services are offered both privately and publically. The number of primary health care providers is increasing. Service users are encouraged to choose the health care provider that most suits their health needs and where this service is received.

The Clinic is accessible to the people in the area. Approximately 400-600 service users access the Clinic each month. Many of the service users tend to use more than one service. For example, it is not uncommon for a service user to make an appointment for podiatry, and have a physiotherapy referral (Actual data not available). The services on offer include Podiatry, Oral Health, Physiotherapy (neurology, musculoskeletal, cardiopulmonary), the Arthritis Clinic, and Psychotherapy. The Clinic and the specialist services available are offered at various times between Monday and Friday during the semesters of the academic year (generally from February until November).

Historic Overview of the Clinic

The Clinic has evolved over many years. It opened as a Multidisciplinary Health Centre in January 1993. At that time, the feasibility of establishing a Multidisciplinary Centre was examined. A working group was established and included representatives of the

health professions from the faculty, including the author of this study.

The group agreed that the clinic mission statement should fit with and add value to the Faculty of Health Mission Statement, which was “Excellence and equity in vocational and community education to serve the health needs of New Zealand” (Boyd, 2001, p. 9).

The vision for the clinic included:

In the year 2000 the University will be running a large and highly successful multidisciplinary clinic/health centre ... with satellite clinics and outreach services throughout the region. This will provide a service to the community, a focus for the development and evaluation of innovative practice and teaching. It will also help to foster multidisciplinary practise and team work amongst staff and students from different disciplines (Shadbolt, 1993, p. 10).

Initially, in 1993 when the clinic opened its doors it offered core services in physiotherapy, in particular the neurology clinic, occupational therapy, and psychotherapy. Treatments were funded by the Accident Compensation Corporation (ACC).

The goals of the vision statement have been realised over time and are reflected in the services currently offered at the Clinic, which emphasise innovative practice and teaching, and collaborative care.

Underpinning the aims of the Clinic are two main concepts:

- To provide a collaborative health care service with a multidisciplinary focus, which meets the health needs of identified individuals and groups within the community.
- To provide quality education for students of the Health

Studies Faculty.

In 2012 these aims are still relevant and reflect the vision of the Clinic. In 1995 a Health and Counselling Service was added and the Clinic was relocated to a special purpose built site. The Clinic still consisted of the three original professional groups. The professions predominantly worked separately. While specialty clinics were co-located under the same roof, in reality they co-existed beside each other. Students at this point were only able to observe the delivery of care.

Perhaps due to this limitation to student learning an external report was commissioned in 2001. The intent was to identify future developments to assist in the growth of the Clinic. The report noted that between 1992 and 2001 very little progress in inter-professional, collaborative working had been made and professionals still continued to work separately. Overall, service delivery was fragmented and followed an ad hoc approach. Despite the problems, the Clinic was seen to be an innovative initiative that was responsive to community needs (Boyd, 2001). This was in keeping with international trends that advocated for the development of "integrated service models and collaborative ways of working to better meet the needs of [service user's and families] who were vulnerable to poor health and social outcomes" (Schmied et al., 2010, p. 3517). Included in the

recommendations was the development of an Integrated Clinic. This Clinic was to become a teaching and learning centre for senior undergraduate students. Clearly, there was the potential to develop an interdisciplinary clinic, which would cultivate interprofessional, collaborative learning while based within an educational setting (Boyd, 2001).

The Boyd Report (2001) was significant, as a new direction was set. The Clinic management was restructured and gave those involved more autonomy to develop new services. For example, 2002 saw the transfer of the Bachelor Health Science, Podiatry to the University, which became the national provider of the programme. In 2005 the Bachelor Health Science, Oral Hygiene and Oral Therapy programmes commenced. Both these programmes required specialist clinical settings, which were established within the physical space of the Clinic. This added another dimension to the Clinic development. However, although more service users accessed the services of the Clinic, the professionals continued to work separately, rather than collaboratively. They followed a multidisciplinary model of care where the health professionals independently contribute to the service user's health needs often working alongside other professionals (Hall & Weaver, 2001).

Nonetheless, between 1993 and 2011, the Clinic has undergone

many changes. In February 2009 the Clinic was renamed and became the Integrated Health Clinic. It was officially opened by the Minister of Health, The Honourable Tony Ryall. Political support for the development was seen to be important. Government interest supposedly encouraged collaboration, which was seen as a means to develop a responsive, highly skilled workforce (McCallin, 2009). The opening of the Integrated Health Clinic for example, was important to highlight its place in the National Centre for Inter-professional Education and Collaborative Practice that was established in the University at the same time. This Centre is the first of its kind to focus of on inter-professional education, research, and practice in New Zealand. The opening of this Centre was timely, as the location of the Clinic under that umbrella supported the WHO (2010) recommendations to develop interprofessional education and collaborative practice. As stated in the Akoranga Integrated Health and Rehabilitation Brochure (2012), the Clinic aimed: “[to create] a health workforce that can collaborate across disciplines and across sectors to provide person and community centred care as opposed to traditional treatments where an individual typically sees only one health professional” (p. 2).

Today, in 2012, the Clinic is a clinical placement for students from Oral Health, Podiatry, Nursing, Occupational Therapy, and

Physiotherapy, which includes the neurology, cardio pulmonary, and musculoskeletal clinics. After a decade of development inroads have been made to offer collaborative care to service users at the Clinic. For instance, the Cardio-Pulmonary Clinic offers a collaborative service for service users who have been referred by the cardiac nurse specialist from the local public hospital. This service is supervised by expert clinical nursing and physiotherapy educators, who work with senior undergraduate students from both nursing and physiotherapy. This is a relatively new initiative established between nursing and physiotherapy. Currently, this specialist clinic is available one day per week.

Another initiative is a partnership that has developed between the New Zealand Arthritis Foundation and the Clinic to provide a collaborative health service for service users who have arthritis. This particular service includes a comprehensive wellness and health check from a nurse practitioner, who then leads the team meeting to discuss the support and services required for the service user. Next, a decision is made as to what service(s) is required first, and which health professional will lead the service user's plan of care. It is assumed that the care will be collaborative. Sometimes for example, other health professionals from the University campus e.g. psychology

or psychotherapy may be invited to join the collaborative team as required.

Overall, there is an ad-hoc approach to collaborative care at the Clinic. It occurs under the banner of "Integrated Care" (the Clinic name) and takes place intermittently. Collaboration occurs in an informal manner, in particular between the physiotherapy and podiatry services. However, most care delivered to the service user is managed by individual professions. This perhaps illustrates that collaboration challenges traditional professional boundaries, but if different health professionals can learn together, working collaboratively may develop over time (McCallin, 2009).

While collaboration at the Clinic has been slow in the past 18 years, progress has been made and the number of service users accessing the Clinic has increased consistently, with the need now to book appointments well in advance. At the same time, many more undergraduate and post graduate health professional students have learning experiences at the Clinic. Overall, the developments support wider social change that has impacted the delivery of community services.

Changes to Health Service Delivery

The establishment of the Clinic is in line with the New Zealand Health Strategies (2000, 2001) particularly in relation to primary health care and collaborative care (Primary Health Care Strategy, 2001). These strategies support collaboration. For example, the past 30 years has seen the reorientation of the health systems towards primary health care and health promotion. A key principle that influences this is the promotion of collaborative care in practice. This has come about as a result of recognition of inequities in health and social development throughout the world. Primary health care is a philosophy of care that aims to address these issues by reorganising and integrating services around people's needs. In this philosophy of care it is expected that services should be more socially relevant for people and responsive to the changing world, and at the same time, produce better health and social outcomes for service users. Features in primary health care that differ from traditional models of health care are "person-centeredness, comprehensiveness and integration, effectiveness and safety, and continuity of care" (WHO, 2010, p. 8). The primary health care movement in New Zealand has been influenced by various health charters and strategies.

For example, The Declaration of Alma-Ata (1978) identified equity as a core value in health. This value underpins comprehensive

primary health care. Also important are community participation and action, as are the determinants of health, which are central for achieving health equity and reducing inequalities in health (WHO, 1978). This Declaration marked the beginning in the global development of primary health care, and is also seen as being foundational to the development of collaboration.

Another key primary health care development which indirectly impacted interest in collaboration was the Ottawa Charter. The aim of the Ottawa Charter (1986) was to set out the actions required to achieve “Health for All” by the year 2000 and beyond. Part of the Health Promotion Action included the sharing of resources, and power sharing across sectors, and between professions and service users. It also acknowledged that people were a significant health resource. As a result, governments, organizations, and professions were expected to support people and enable them to keep healthy (WHO, 1986). Although collaboration was not explicit, the partnership-type model could not occur without collaboration.

Collaboration is a concept that has been both implicit and explicit in national and international policy development. The Ottawa Charter (1986) formed the momentum for the development of The New Zealand Health Strategy (2000). This strategy signaled that primary health care was central to improving the health of all New Zealanders.

The key principles include reducing inequalities in health, improving access to healthcare, collaboration by all sectors, acknowledging the special relationship between Maori and the Crown, and active involvement with consumers. Primary health care aims to bring health care services as close as possible to where people live and work. It is service user centered, is the first line of contact for the service user in the health system, and offers continuity of care (WHO, 2010). This shift of focus emphasizes service user involvement. It is quite different to the previous government arrangements that aimed to improve the accessibility, acceptability, availability, and affordability of health care.

The new emphasis is clear in the WHO Framework for Action on Interprofessional Education and Collaborative Practice (WHO, 2010). This technical report recognises that many health care systems around the world are fragmented and struggling to meet the health needs of the communities. The framework focuses on interprofessional collaboration in education and practice as strategies which will strengthen health systems and improve health outcomes for clients, carers, and communities. This suggests that there is an interprofessional learning opportunity for the health students working in the Clinic. Some of the benefits for students include a real world experience of working collaboratively with different professions. Students also have an opportunity to work with service users from a

variety of backgrounds (WHO, 2008).

Aim of the Study

The aim of this study is to explore service user's perspectives of collaborative care received in a University Integrated Health Clinic.

Research Significance

Underpinning primary health care is the belief that the care should be person-centered, comprehensive, and integrated. To begin to move towards a more effective and efficient integrated model of health care it is essential to incorporate the perspective of the service users. This allows for their opinions to be heard and these can be used towards improving routine care and outcome evaluation. This opens up communication and creates a platform for the service user and health professionals to begin to understand each other's perspective (Stewart, 2009). Nevertheless, despite the belief that service users are central to integrated health care, there is a paucity of research directly related to the role of the service user within this model of health care. This research is significant, as it will provide knowledge about the topic and go some way to reduce the knowledge gap.

The Researcher's Interest

The researcher's interest in collaborative care has developed over many years of working in health care and health professional education settings. Membership of the original working group for the development of the Clinic was particularly significant. In more recent times the researcher was involved as a practice coordinator at the Clinic from 2009-2010. That role provided an opportunity to work with different students in the Clinic. It was useful to observe the various health professionals working alongside each other and the challenges they faced in delivering collaborative care (Ateah et al., 2011; Hall, 2005; Reeves et al., 2008). Further reading in the topic area suggested that collaborative practice is increasingly important, as the complexity of care is far greater, and more people need medical support. When this is considered along with a shrinking health care workforce, it is clear that health professionals must work collaboratively. It is also important that undergraduate students are exposed to collaborative care and understand what it means for the service user.

While many writers in the field (Litaker et al., 2003; Mikan, 2005; Sheehan, Robertson, & Ormond, 2007) highlight the importance of patient-centeredness, much less is known about the service user experience of collaborative care. We need to know more about the

service user's involvement in collaborative care. In this situation involvement is defined as:

A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decision about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change (The Health Boards Executive, 2002, p. 6).

It appears that health professionals discuss the importance of involving the service user in care planning, and the service user is keen to be involved, but care providers are slow to develop the collaboration further (Stringer et al., 2008). As noted, it is challenging for health professionals who believe they 'know best' to work differently. There are several studies both nationally and internationally (Gaboury et al., 2009; Sheehan et al., 2007; Shaw, 2008) that comment on the importance of collaborative care, and suggest that the service user is pivotal to planning of the care. Yet interestingly, there is little literature that invites the service user to share their experiences of collaborative care, hence the importance of this study.

Structure of the Thesis

In this chapter the thesis topic has been introduced. A background has provided a brief overview of the primary health care charters and strategies, which have had an impact on service delivery in New

Zealand over the past 30 years. The context has been outlined. The aim and significance of the study, and the researcher's interest in the topic, have also been identified. A discussion and critique of relevant literature is presented in Chapter Two. The research method is described in Chapter Three, and rationale for the choice of research method is offered. The findings are presented in Chapter Four. This chapter includes the themes that emerged from the data analysis. Chapter Five presents a discussion of the findings that are linked with current literature. Chapter Five also addresses the limitations of the study, the implications and recommendations that are made as a result of the findings.

Chapter Two

Literature Review

As has been seen in Chapter One there has been extensive health care restructuring in recent years which has increased the emphasis on primary health care and health promotion in communities. A key component has been the introduction of integrated health care, which offers health services that are more socially relevant, accessible and inclusive, tailored to the service user's needs. Integrated health care aims to produce better health outcomes and is usually facilitated by teamwork (Centre for the Advancement of Interprofessional Education (CAIPE), 2002; Gaboury et al., 2009; Reeves et al., 2008; World Health Organization, 2010). Primary health care involving interprofessional team-based care is a global phenomenon and, is something that has been promoted since 1978 (WHO, 1978, 1986). For example, the introduction of the World Health Organization (WHO) Technical Report, Framework for Interprofessional Education and Collaborative Care (2010) outlines the emergence of interprofessional concepts and collaborative decision making in the care of service users, and argues that collaborative practice is a means to achieve affordable, efficient, and equitable care to reduce health inequalities, and to improve the health of communities. According to Gilbert (2010), interprofessional collaboration is an innovative approach that

has potential to bring together community health in relation to primary health care, chronic disease management, and workforce shortages. With these trends in mind, the purpose of this chapter is to review the literature on the research topic. Firstly, the literature review process is discussed briefly. Then, the rest of the chapter discusses literature related to service user involvement, models of care, health professional roles, and interprofessional learning.

Literature Review Process

The literature review sets the scene for research, as it allows the researcher to begin to understand what is known about the topic and to provide a basis on which to construct new knowledge on the subject (Polit & Hungler, 1999). In this instance it not only defines the parameters of the topic, but clarifies existing knowledge on the service user's perspective of collaborative care at an integrated health clinic.

A major problem when reviewing the literature is that position papers and research studies may not refer to the specific topic. That was evident in this research, where literature on the service user is sparse. Although a plethora of literature exists around collaboration and integrated health care, it is generally from the stance of the health professionals, or focuses on interprofessional learning. This has made the task of reviewing literature specifically about service users

challenging. For this reason an integrative review was considered necessary. According to Whittemore (2005), an integrative review is an approach to combine data from a broad category of research designs that encompasses both empirical and theoretical literature. Empirical literature is based on observed and measured phenomena, often peer reviewed, and includes primary research. Theoretical literature identifies key issues that impact the topic of study. Due to the limited research published on the topic, it was necessary to include seminal authors and seminal works to support the literature review. In particular, this included articles and authors associated with The World Health Organisation, editorials, chapters in books, and literature reviews. This chapter includes an overview of recent literature, as well as the analysis of the most relevant literature (Polit & Beck, 2008; Holloway & Wheeler, 2010).

The literature was gathered by a systematic search using electronic data bases such as Scopus, CINAHL, Pub Med, and the Cochrane Library that included the key words: health service users, collaborative care, and integrated health care. Due to the limited literature identified, the search was expanded to include related terms such as teamwork, communication, patient centered care, clients, primary health care, and interprofessional learning. The literature search was restricted to literature published from 1999.

The following themes identified in the literature review that commonly reoccur have been used as a broad framework to present the literature review in a seamless manner. These themes tend to interlink in this study. These are: service user involvement; models of care, namely collaborative care and integrated health care; health professional roles; and interprofessional learning.

Service User Involvement

Understanding the service user's perspective is a critical aspect of assessing the effectiveness of integrated care. It is essential that service providers engage with the service user, families and communities to identify and better understand the service user's health requirements. Providers need to know about the longer term impact integrated care has on the delivery of safe, effective care, particularly for those with long term chronic health needs (Haddad et al., 2000; MacDonald et al., 2002; Reeves, 2010; Shaw, 2008).

Not surprisingly, service user involvement improves when health professionals spend more time with service users, particularly when the emphasis is on service user education and self-management. For example, Litaker et al. (2003) investigated effective care for common chronic diseases such as hypertension and type II diabetes mellitus in the United States. One hundred and fifty seven patients with

hypertension and diabetes mellitus were randomly assigned to their primary care physician and a nurse practitioner, or their primary health care physician for the year-long study. The researchers report that those receiving care from both the nurse practitioner and the medical doctor identified greater improvement and satisfaction with care and health-related quality of life. This was directly linked to the increased time spent with the service user, and an emphasis on service user-centered education and self- management. These findings were supported several years later. Mills et al. (2010) for instance argue that rural communities who received collaborative care from interprofessional health teams received a more holistic approach to care, especially if service users had complex health needs.

Zwarenstein, Reeves and Perrier (2005) report there is mounting evidence that collaborative practice improves service user's outcomes. Collaborative practice to enhance patient care outcomes highlights the service user as central to collaborative processes forming an interdependent relationship. This reflects changes in service delivery, as today it is more common to organise care delivery around the needs of service users and families. This is different to traditional models of care, which were organized according to health professional needs (Hall, 2005; Hendry, 2010; Law et al., 2010; Litaker et al.,

2003; McLaughlin, 2009; Nisbet, Lee, Kumar, Thistlethwaite, & Dunston, 2011; Smith et al., 2008).

Although service users have an increasing importance in collaboration, little is known about their experiences. Shaw (2008) undertook a qualitative study to explore the complexities of patient's experiences of interprofessional care received at a family health centre in Canada. All patients received care from at least two health professionals. Three key findings were: the affability, accessibility, and ability of the health professionals was important; family physicians were effective interprofessional health team leaders; and providing patient-centered care was significant. Limitations to this study were the small purposeful sample group of seven service users and three health professionals. Unintentionally, service users who may have had a negative view of collaborative care may have been excluded from the study. Nevertheless, Shaw's (2008) study is significant to provide baseline data on the service user, and has been replicated for the current study (Tucker, 2012) five years later.

Hopkins, Loeb and Fick (2009) reviewed international literature about service user's non-medical expectations of care within the mental health services. The aim of the review was to identify the importance of including service users in the planning and provision of health services. Hopkins et al. report that service users hoped for and valued trusting,

empathic interpersonal relationships with staff. Service users expected to be respected as individuals, and wanted to be involved in decision making, working collaboratively with health professionals, particularly in relation to discharge planning. This review highlights what is important for service users. Limitations to the review include the small number of studies (10) analysed, and the largely descriptive nature of the studies, both of which limit generalizability.

Another study examined the service user perspective of an entirely different process – the selection of health professionals. Rhodes and Nyawata (2011) report that service users appreciated the opportunity to be part of a selection panel for prospective health students. They believed that service user involvement would enable prospective students to see firstly a person, rather than a patient. Once again service users emphasised the importance of feeling valued. Although this was a small scale study, the research findings highlight that service users are responsive to working collaboratively, and as receivers of care, are prepared to be involved in health workforce development.

Models of Care

As has been discussed earlier there are many different models of healthcare today. Traditionally, the biomedical model is the most recognized model of care. However, the increasing emphasis on primary

health care requires new models of care, which encompass the policies and services that reflect the New Zealand perspective (Boyd, 2009). The two models of care that will be discussed next are collaborative care and integrated care.

Collaborative Care

According to the World Health Organization (2010) collaborative practice occurs: "When multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings" (p. 13).

The delivery of collaborative care is seen as essential to workforce planning to address the needs of the ageing population many of whom have complex health needs and chronic illness (Egan-Lee et al., 2008; WHO, 2008). This supports the New Zealand Primary Health Care Strategy (2001), which stresses the importance of collaborative team work. Collaborative care can: improve overall health and social outcomes for people with chronic illnesses; support access to and coordination of health services; decrease length of hospital stay; and produce greater staff satisfaction, decrease staff turnover, and reduce the cost of care (Funderburk et al., 2010; Holland et al., 2005; Lemieux-Charles & McGuire, 2006). This approach to care recognises the needs of the

service users as being central to the delivery of care (PHCAC, 2009).

Because this collaborative model of care is relatively new, it is not surprising that we do not understand what it means for the service user (McDonald & McCallin, 2010).

There is increasing evidence though that working together collaboratively is challenging, possibly because ideas are quite vague (McCallin, 2003). For example, collaboration has been defined as being “not only about agreement and communication, but about creation and synergy” (WHO, 2010, p. 13). It is not unreasonable to assume that this collaborative creation and synergy work more effectively when health professionals and service users work together. Oandasan et al. (2004) support this view and identify that interprofessional collaboration creates more efficient and effective care for service users, with obvious benefits for those receiving the care, and for the health professionals, as well as the health organization.

It is also evident that if collaborative care is to be successful shared leadership is required. In this approach the leadership role changes according to the needs of the service user. In reality, this means that all team members carry leadership responsibility for team processes and outcomes (McCallin, 2003). This observation supports earlier work by Wilson and Gleason (2001), who recognized that where interprofessional team members share equal participation and

responsibility, the leadership role constantly changes according to the expertise and knowledge required to deliver the care.

Despite the potential for understanding, as one might expect, collaborative practice works better when health professionals have clarified roles. Counsell, Kennedy, Swabo, Wadsworth, and Wohlgemuth (1999) noted individual health team members assume profession-specific roles yet, within an interprofessional team, they collectively problem solve to define goals and take shared responsibility to accomplish goals and outcomes for the service users. However, these goals must be compatible with all team members and, to be effective, the team members must be familiar with the roles of other professionals (Marino, 1999).

This view was supported by a British study (Meirs & Pollard, 2009) that explored professional views on collaborative abilities, the nature and effectiveness of inter and multiprofessional collaboration, and different professional roles. Thirty-four participants were interviewed including nurses, midwives, physiotherapists, social workers, occupational therapists, and a mental health nurse. All participants identified a wide range of abilities required for interprofessional collaboration. The researchers concluded that effective interprofessional communication is complex, and that communication is the core of collaboration. It was also noted that different skill sets are required for

different teams and services. Some require general flexibility while others demand specialist skill. Overall, it seems that the success of interprofessional collaboration is reliant on leadership and organizational factors. For instance, co-ordination requires an understanding of the macro and micro organizational structures, a specialist skill-set, professional role understanding, and communication skills to facilitate team cohesion and trust. This study, although small with 34 participants, demonstrates interprofessional collaboration is central to the delivery of patient-centered care. The findings are consistent with earlier work by Johnson et al. (2003) who suggest that flexibility, open communication, shared vision, and inclusion in decision-making are likely to provide positive outcomes for service users.

Involvement in collaborative care is not necessarily straightforward. Reeves et al. (2008) identify that health professionals do not always work well together in collaborative care, because many have been educated separately. McCallin (2005, 2006) for example, argues that health professionals must learn how to work together, to integrate their collective knowledge and expertise into an integrated health service that promotes health and self-management of chronic conditions for service users.

At the same time interprofessional collaboration requires professionals to share knowledge. Gao and Riley (2010) argue that the

process of knowledge transfer is not automatic, and may be influenced by issues surrounding knowledge ownership. The phenomenon known as 'stickiness', in which the sharing of knowledge in teamwork is impeded, can cause passivity and raise unintended barriers to collaboration. Loss of ownership of knowledge may cause a reluctance to share knowledge. Gao and Riley go on to argue that identity also affects an individual's willingness to share knowledge. The type of knowledge to be shared, and the level of organizational interaction also influence the process. This has implications for interprofessional learning and may account for the different profession's engagement, or otherwise, in shared learning. Despite these problems, Argote, Ingram, Levine, and Moreland, (2000); and Ibarra, Kilduff and Tsai (2005) suggest that the social processes of networking and nexus-forming are fundamental for knowledge sharing. Apparently, networking boosts collaborative working, encourages knowledge exchange, and collaborative learning.

Knowledge sharing of course relies on members of a team having a common language. A New Zealand study by Sheehan et al. (2007) identifies the importance of using a common language in collaborative health teams. Successful interprofessional team work is promoted by the use of inclusive language and consistent terminology between the team members. This is particularly important when sharing patient documentation and communicating with service users. This links with

Cohen's (2003) earlier work that recommends the use of a single, collaborative assessment tool that meets the needs of the patient. This approach moves beyond traditional professional assessment and encourages team members to value the different professional contributors. Nevertheless, Mitchell (2005) argues that while it is important to value team colleagues, everyone need not be fully conversant with the language, conceptual frameworks, and roles of the other team members.

Despite the complexities of issues related to collaborative care what is clear is that successful collaboration requires teamwork. For instance, Mitchell (2005) argues that labels are less important when ongoing learning and outcome success are considered. However, if the team have differing viewpoints and aims this will affect collaborative care and health outcomes for the service user. It seems that the complexity of different perspectives comes into play. The importance of working collaboratively has been exacerbated by the increase in knowledge and the specialisation associated with different health professionals. Conversely, this also means that no one health care provider can meet the complex health needs of the service user or family (Mariano, 1999; Smith et al., 2008).

A more recent study commissioned by The World Health Organization (Mickan et al., 2010) perhaps sums up the general issues

when the common themes of collaborative practice are examined. Data came from ten case studies from ten different countries. In all the studies collaborative practice took place with service users who had chronic illness, complex, and/or long term care needs. Mikan et al. argue that collaborative practice is essential when multiple health workers are involved in care. They report also that collaborative practice begins at team meetings, where common goals and health management are negotiated on behalf of the service user. They emphasise too that collaborative care encourages prompt, appropriate and affordable treatment for service users, avoiding unnecessary treatments typical of uni-professional care. Limitations to this study are the issue that ten case studies limits universal generalisability. The findings though support existing research in the area. This means that the knowledge creates a starting block for global recommendations for collaborative practice.

Integrated Health Care

Integrated care means “that health services work collaboratively with each other, and with patients and their families and carers, to provide person centred optimal care” (National Health Priority Action Council (NHPAC), 2006, p. 11).

Integrated health care aims to reduce barriers between health

disciplines, as health professional's work together in mutually supportive teams that are focused on the best interest of the service users (CAIPE, 2012; Talbot & Verrinder, 2010). This approach also enhances the efficiency of health teams by reducing service duplication and ensuring more efficient coordination of care and collaborative decision making (Mickan, 2005). This assumes that if service delivery is well coordinated, service users will receive improved integrated health care.

Hall (2005) argues that integrated health care is a response to fragmented health care practices. As a strategy it requires a process of reflection and developing methods of practice that provide an integrated and unified answer to the needs of the service user/whanau/ family/community. However, the delivery of integrated care is not straight forward, as each professional from the diverse health care disciplines has an interpretation of the service user's needs and the response required to address the often numerous and complex health conditions of these service users. Furthermore, each profession has its own scope of practice with different roles and responsibilities, which impacts on the delivery of services. However, this silo-like approach rarely meets the needs of the service user or that of the other professionals (McLaughlin, 2009; Pullon & Fry, 2005).

There is no doubt that uni-professional care is problematic when

working with service users who have complex health needs. Indeed, to address the issue of uni-professional care, consecutive United Kingdom governments since the early 1990's have specified that all individuals with ongoing health and social issues are assigned a care manager to plan integrated health care prior to discharge from hospital (Johnson et al., 2003). This initiative was a response to individual service user needs, and aimed to empower service users to be involved in decision making and take responsibility for their own care. Under this system, professionals making decisions in one service are expected to work collaboratively with other professionals for the benefit the service user.

Integrating care raises all sorts of issues, as boundaries blur. Johnson et al. (2003) studied the difficulties of cross boundary working. Twenty two senior health and social service managers were interviewed in two rural and two urban settings in England. Once again findings are similar to previous studies already mentioned. Johnson et al. highlight the importance of professional communication, the need to develop a shared understanding of roles, and emphasise the ability to work in a collaborative manner.

Litaker et al. (2003) suggest that partnerships might be a way of providing effective, efficient care. These authors observe that integrated care is inherent in partnerships. Apparently, integrated

partnerships create a more effective and efficient service by utilizing the skills and professional strengths of each health care provider, thereby increasing health care satisfaction and quality, both for the service user and the providers of care. This approach assumes that everyone involved in the partnership understands the requirements of collaboration and is willing to work together collaboratively.

While some authors promote partnership working to improve integration, others have focused on identifying the barriers to integrated care. Problems with uni-professional approaches to practice are well illustrated in a quantitative study about integrated care (Moore, West, Keen, Godfrey, & Townsend 2007), which evaluated intermediate care for older adults. The subjects for this study included a cohort of 258 service users across five localities in the United Kingdom. Data was collected and collated over a 12 month period. In addition, information was gained from 153 of the 258 service users identifying their experience six months post discharge. The main aim of the study was to establish the extent to which patterns of movement of individuals provided evidence of service integration and collaboration. Findings suggest that intermediate care is a distinct experience, and the advancement of collaboration depends on governance arrangements at management level. Moore et al. report that fragmentation led to inefficiencies and poor experiences for service users, especially when

multi-agency input was required. The weakness of this study concerned missed data and data inaccuracies. Therefore, the research findings need to be viewed with caution. Despite this, the research shows that teamed up government agencies need to move beyond partnership working, if integrated service networks are to be developed.

Interestingly, Hendry (2010) also agrees that different types of integration are suitable in diverse situations and settings, and suggests that successful collaboration requires effective and efficient leadership, and a shared commitment to collaborative working. This can be difficult, as communication challenges and role understanding issues mean that integrated teams are confronted by constant change in practice, change of staff, not to mention lack of resources driven by economic constraints. In these difficult times the individual health professionals tend to resort to uni-professional working and integrated care disappears. As a result service users are unlikely to receive integrated care consistently (Mitchell, 2005; Reeves et al., 2008; Sheehan et al., 2007).

Health Professional Roles

As has been seen already role understanding influences collaboration. It is well recognised that each health profession has their own culture which includes values, beliefs, attitudes, customs and behaviors. These

professional cultures have evolved over time reflecting changes in historic factors, social class, and gender issues (Hall, 2005). Professional culture is reinforced by each profession in the manner in which common values, problem solving, and the use of language/jargon are role modeled. As the culture of each professional remains vague to the other health professionals, this contributes to the challenges of effective integrated collaborative care (Arksey, Snape, & Watt, 2007; Hall, 2005; Pullon & Fry, 2005; Reeves et al., 2008; Sheehan et al., 2007).

According to Sheehan et al. (2007), professional roles overlap in interprofessional teamwork. This overlapping of roles often leads to role blurring with professional boundary confusion. Not surprisingly, some team members feel underutilized while others feel they are doing everything (Marinao, 1999; Reeves & Lewin, 2004). Role understanding though is complex. To work together in a collaborative and effective manner requires an understanding of one's own professional role, and the skills associated with the roles of colleagues. In reality each team member needs to develop an understanding of the unique values, culture, and problem solving styles of the other professions within the team (Ateah et al., 2011; McCallin & McCallin, 2009; Mitchell, 2005; Reeves et al., 2008; Wright & Lindqvist., 2008).

Closely aligned to role understanding is the issue of competence

and its influence on collaboration. McCallin and McCallin (2009) believe that role competence influences team competence that goes on to effect team communication. Communicating clearly with other professionals can be challenging when different health professionals have differing world views and use different language. For example, Zwarenstein et al. (2005) describe how learners enter health professional programmes with preconceived stereotyping of their chosen profession and other health professions (Ginsburg & Tregunno, 2005; Lindqvist, Duncan, Shepstone, Watts, & Pearce, 2005). This stereotyping may be reinforced by educators and mentors who act as role models, enculturating professional mores and beliefs. This professional socialisation can affect an individual's willingness to collaborate with other health professionals (Hall, 2005).

Ateah et al. (2011) support these views suggesting that stereotyping of health professionals can be both positive and negative. Nurses for instance are frequently reported positively as caring and trustworthy. Equally, nurses are stereotyped negatively as being hierarchical and bossy. This negative view can influence how other health professionals view the role of the nurse and this can have an effect on how the nurse may view their own professional role. Oandasan and Reeves (2005) recommend that exposing, confronting, and dispelling stereotypes is a key step to role understanding and promoting

collaborative work.

Another study set in rural Australia (Mills et al., 2010) identifies that while the context of practice may differ, best practice requires professional collaboration, communication, and partnership working. Once again though, successful collaboration depends on team members recognising their own role in the team. At the same time, team members need to understand and value the role and expertise of other team members and be willing to share leadership as appropriate. If this is possible it is predicted that collaboration will improve health outcomes for the service user.

Interprofessional Learning

Interprofessional learning has been robustly advocated internationally over the past four decades. It is seen as a way to improve the effectiveness and efficiency of service user care, for service users who have complex needs and require a team of health professionals to deliver collaborative care (Bilodeau et al., 2010; Egan-Lee et al., 2008; Freeth & Reeves, 2004; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005; WHO, 2008).

Interprofessional learning aims to advance collaborative practice by encouraging diverse groups of health professionals to learn together. Interprofessional education is “when students from two or more

professions learn with, from and about with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, p. 13).

Traditionally, health professionals have learned separately, as they have been educated and socialised within their respective profession (Hall, 2005). The opportunity for health professionals to learn together encourages awareness of other's professional roles, and promotes confidence to share knowledge about practice, which is foundational for interprofessional collaboration (MacIntosh & McCormick, 2001; Oandasan & Reeves, 2005; Sicotte, D'Amour, & Moreault, 2002).

One of the challenges of working collaboratively requires health professionals to have the skill base necessary to work within a collaborative model of health care. The importance of interprofessional learning between health professionals at undergraduate level for the success of team work and collaborative health care, has been well documented (Barr, Koppel, Reeves, Hammick, & Freeth, 2005; Pullon & Fry, 2005).

The progression of interprofessional learning depends on the development of interprofessional competencies. Internationally, health professional education has fallen behind changes in practice. In order to continue the quest of interprofessional learning, core competencies were

developed by the Interprofessional Education Collaborative Expert Panel (2011). The competencies are a general guideline for interprofessional education. Although it must be noted that at this time there is no internationally agreed upon set of interprofessional competencies. For instance, many authors in different parts of the world have put forward competency frameworks. (Banfield & Lackie, 2009; CAIPE, 2012; Interprofessional Care: A Blueprint for Action, 2007; Jungnickel, Kelley, Hammer, Haines, & Marlowe, 2009; Nisbet, Lee, Kumar, Thistlethwaite, & Dunston, 2011; ; Report of an Expert Panel, 2011; Walsh, Gordon, Marshall, Wilson, & Hunt, 2005; Wood, Flavell, Vanstolk, Bainbridge, & Nasmith, 2009). However, for the purpose of this study the definition for interprofessional competencies in health care has been included: "Integrated enactment of knowledge, skills, and values/attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate to improve health outcomes in specific care contexts" (Report of an Expert Panel, 2011, p. 2).

These competencies have been divided into the domains of:

- Domain 1 Values/Ethics for interprofessional Practice
- Domain 2 Roles/Responsibilities
- Domain 3 Interprofessional Communication
- Domain 4 Teams and Teamwork

Although identification of interprofessional competencies provides a framework for interprofessional learning, it does not necessarily help when promoting interprofessional learning in practice. For instance, a qualitative study by Derbyshire and Machin (2010) followed a group of newly qualified nurses working in a range of hospital settings. The nurses had had interprofessional learning (IPL) in their programme of study. Five key themes emerged from the findings: participants valued interprofessional learning; IPL content needs to be interactive, including problem based learning; IPL within the practice learning environment is essential to facilitate the transfer of knowledge and skills; IPL experiences change stereotypical views of other health professionals and communication with other professionals. The overall outcome of the study suggests that IPL should be practice focused to promote collaborative practice and support interprofessional learning.

Another study by Sterrett (2010) identifies the importance of informal learning and unconscious role modelling in collaborative care. The objective of the qualitative research was to understand the phenomenon of participating in interprofessional learning experiences. 12 interprofessional fellowship graduates, who came from a wide variety of professions representing the disciplines of medicine, public health, social work, nursing, dietetics, speech therapy, physical therapy, and education, were interviewed. Research findings indicate that

collaborative working promoted learning within a community of practice. In particular, newcomers to the interprofessional experience noted how important it was to be able to articulate their professional role, and establish their identity within the group. Informality and collegiality were perceived as empowering and encouraged open communication and mutual engagement in learning. This collegial culture in turn facilitated rapport and full participation in the learning experiences. As a result, participants report having to step up to the mark to participate in the interprofessional learning experience, rather than standing back as an observer. The participant's involvement in collaborative learning gave them a sense of being a valued team member, developing a perception that they were capable, contributing members of the team.

Conclusion

The literature reviewed for this research reveals that while service user involvement is viewed as pivotal to the models of care namely integrated health care and collaborative care, available literature on the service user is sparse. Although a plethora of literature exists around collaboration and integrated health care, it is generally from the position of the health professionals or interprofessional learning. For this reason an integrative review was considered necessary. Due to the limited published research on the topic it was necessary to include seminal authors and seminal works to support the literature review. Themes which commonly reoccur

in the literature review were used as a framework to present the literature reviewed. The themes in this study tend to interlink and in instances overlap. The key themes which were identified and discussed were: service user involvement; models of care namely collaborative care and integrated health care; health professional roles; and interprofessional learning.

This current study seeks to explore the experiences of collaborative care received by service users who access care from two or more of the services offered at the Clinic. The gaps in the literature indicate that there is an urgent need for further research in relation to service user's involvement and requirement of collaborative care.

In the following chapter the research method chosen for this study will be described and the use of one to one interviews as the data collection tool will be outlined and discussed.

Chapter Three

Research Method

Introduction

This chapter describes the research design. The first section provides a justification for using qualitative descriptive research methodology and the theoretical processes that underpin this study. The second section identifies the Design and Method including the study design, the study setting, ethical considerations, participant selection, the participants, researcher involvement, data collection and analysis. The third section concludes with a discussion about rigor in the study.

Qualitative Research

According to Smith (2008) and Willig (2009) qualitative research is essentially an investigative process that allows participant-generated meanings to be heard. Qualitative research is useful, as it is a means for a researcher to engage in exploring, describing, and interpreting the personal and social experiences of participants. A qualitative study aims to develop understanding of a social or human problem that occurs in a natural setting. It is an approach that uses words to build a complex, holistic picture that reports the detailed views of participants.

Generating knowledge in this way is consistent with the purpose of

research, which is to produce knowledge that can be utilised to improve and advance a discipline or profession. Knowledge generation is situated in a paradigm. Paradigms in the human and social sciences help to understand the phenomena under study (Breakwell, Hammond, Fife-Schaw, & Smith 2006; Creswell, 1999; Smith, 2008). A paradigm is a philosophical worldview that has an associated ontology and epistemology (Holloway, 1997), which influence research design. Holloway states that ontology is about the nature of being, and needs to be congruent with the researcher's beliefs about the social world. Epistemology explains the relationship between the researcher and the knowledge generated (Grant & Giddings, 2002). Epistemology and ontology influence the choice of methodology.

Qualitative research is a style of research that is flexible and suitable for study of a phenomena like collaborative care that occurs in a naturalistic setting such as the Clinic. De Poy and Gitlin (1998) suggest that the assumptions underpinning naturalistic inquiry are:

- "Human experience is complex and cannot be understood by reductionism ... only by identifying and examining its parts.
- Meaning in human experience is derived from an understanding of individuals in their social environments.
- Multiple realities exist, and [the view] of reality is determined by events viewed through individual lenses or biases.
- Those who have the experiences are the most knowledgeable about them" (p. 27).

These assumptions influence the choice of methodology. Indeed,

Lincoln and Guba (1985) maintain that choice of research methodology is based on the nature of the research question and the researcher's experience and philosophical orientation. In this case a descriptive, exploratory approach was seen as suitable, because interpretive description is useful to explore a phenomenon where little is known about the topic (Thomas & Hodges, 2010; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). The purpose of descriptive exploratory research is to identify patterns, themes, and perceptions, in order to generate knowledge that informs understanding. Indeed, Sandelowski (2000) suggests that the emphasis of a qualitative descriptive study is to provide a detailed "summary of events in the everyday terms of those events" (p. 334). Such studies tend to require small samples and use data collection methods such as interviews, participant observation, and documentary analysis.

Design and Method of the Present Study

Study Design

As has already been noted in earlier chapters, the aim of this study is to explore service user's perspectives of collaborative care received at the Clinic. The approach was qualitative interpretive. Qualitative inquiry is ideal for this type of project, as "interpretive description acknowledges the constructed and contextual nature of human experience that at the

same time allows for shared realities" (Thorne et al., 2004, p. 5).

Descriptive research is exploratory, focusing on identifying beliefs and experiences occurring in a particular situation. Qualitative research systematically documents the subjective nature of experiences and their meaning (Burns & Grove, 1999).

Qualitative descriptive design with an interpretative approach was selected for two main reasons. Firstly, as has been seen in previous chapters, although much has been written about collaborative care, there is a definite gap in the literature about the involvement of the service user in collaborative care. According to Roberts and Taylor (2002) and Streubert, Speziale and Carpenter (2007), qualitative research is particularly appropriate when a new area is being explored and the researcher seeks to gain further insight and understanding about a situation. Qualitative research focuses on the experiences and viewpoints of the individuals involved. It can provide rich, detailed descriptions of participant's commentaries about a new phenomena. That was appropriate in this research where the researcher set out to explore the service user's experiences of collaborative care.

As the realities and viewpoints of the participants were unknown at the onset of the study, the design is referred to as emergent (Polit & Hungler, 1999; Streubert et al., 2007). Polit and Beck (2008) observe that qualitative design is flexible in that it allows for some adjustment.

The direction of data collection is not necessarily prescribed specifically, although the overall focus of the study should be clear. An emergent design was suitable for this study.

The research is significant, as no previous work has been undertaken within this type of health care setting. By remaining open to the participant's views of the experience the researcher is well positioned to contribute to knowledge generation that may inform the on-going development of integrated service delivery at the Clinic.

The Study Setting

The setting for the study was the Clinic, which is situated within a University in a large New Zealand city (See Chapter One, p. 11). Access to the setting was gained by approaching the Director of Interprofessional Education, and the Director and the Manager of the Integrated Health Clinic, seeking support for the research. The research proposal was presented for their consideration. Consent to proceed was granted reliant upon confirmation that the research met ethical guidelines, as granted by the University and Ministry of Health Ethics Committees (See ethical considerations, p. 56).

The setting for qualitative research is known as the 'field', which is the natural setting where the participants experience the phenomena.

The location of the research is significant, as it allows participants to have more control over what is discussed and to decide on the information that will be shared (Streubert et al., 2007). This research setting was chosen for its uniqueness in offering health services to the local community while supporting student learning (See Chapter One, p. 8).

Ethical Considerations

As the research involved human subjects, ethical approval was sought and gained by submitting a detailed ethics application firstly to the Ministry of Health, Northern X Regional Ethics Committee (Appendix A). This committee granted ethical approval. This was followed by approval from the University Ethics Committee (Appendix B).

Ethical practice in research is critical, as over the past six decades various codes of ethics have been established internationally to protect participant's rights (Polit & Hungler, 1999). This is in response to human rights violations such as the Cartwright Inquiry (Coney, 1988). In this current study (Tucker, 2012) the ethical principles governing research involving healthy participants have been adhered to by following the Auckland University of Technology Ethical Guidelines (based on the Institutional Review Board Guidebook, 1993). Several key principles shape research design. These include: informed and voluntary

consent; respect for rights of privacy and confidentiality; minimisation of risk; limitation of deception; social and cultural sensitivity; research adequacy; and avoidance of conflict of interest. These principles effect researcher behaviour.

When considering ethics, researchers are obliged to ensure that research participants have the right to self determination and are capable of making the decision freely to consent to join the research.

Researchers must ensure that potential participants have the ability to understand information about a project before they get involved in informed consent procedures. Initially, many service users heard about the research from the receptionists at the Clinic, who drew attention to the fact that the research was happening. Prospective participants activated the initial phone contact with the researcher. As this contact was made without coercion the telephone approach was assumed to be a preliminary verbal consent. Nonetheless, the telephone conversation about possible research involvement did not imply an obligation to join the study. Service users still had freedom of choice to ask questions and to decide what they wanted to do. This process enabled them to consent voluntarily to participate in the research, or to decline the invitation (Polit & Beck, 2008).

Obtaining informed consent is fundamental to the research process. Written consent (Appendix C) was obtained after participants

had been given information about the study both verbally and in writing (See Appendix D). Participants were clearly informed that they could stop the interview process at any point, or withdraw from the research at any stage without penalty. The participants were also informed that the data would be audio taped. Participants were assured that they were free to decline from answering any questions, and that the audio tape would be turned off at any time during the interview at their request.

Another key ethical issue is confidentiality. According to Polit and Beck (2007) confidentiality is a guarantee that any information participants provide will not be publicly conveyed in a way that identifies who they are. In other words the data collected will not be made accessible to others. Participants have a right to privacy, and can expect that their rights to anonymity and confidentiality will be respected. All participants were given the opportunity to choose a pseudonym to identify their data. They did not see this as necessary. However, the researcher was careful during the interviews not to refer to participants by name. At the completion of each interview data was de-identified using an assigned number. Any identifying data was removed.

In spite of this, total anonymity at all stages of the study was unavoidable, simply because the participants attended the Clinic as patients. Many spoke openly to other patients and the receptionists about being in the study, and most participants chose to be interviewed

at the Clinic. Along the same lines, the use of rich text can lead to issues with confidentiality. This means that the researcher needs to be sensitive to confidentiality issues at all times (Streubert, Speziale & Carpenter, 2007). While participants were not concerned about being identified in the research, they were assured that the data would be coded for reporting and would be unable to be linked directly to an individual.

Confidentiality was further protected by asking the transcriber to sign a confidentiality agreement prior to the commencement of scribing (Appendix E). During the project the tapes and transcriptions were stored safely at the researcher's workplace. Interview tapes, transcripts, and working data will be destroyed after a six year period.

The researcher was aware of her ethical responsibility to minimize participant's risk, and to protect them from harm and discomfort. Any harm or discomfort was likely to be minimal in this study. As a precaution though, strategies to manage psychological risk were included in the design. The plan was that, if a participant required/asked for further support, they would be advised to contact an approved service such as the Patient Advocacy Service (0800 555050), or their General Practitioner/Practice Nurse. The researcher had also arranged for support from the University Counseling Service, which offers three free sessions of counseling for research participants if they need it. A card with the contact details for these services (Appendix F) was given

to each participant. Alternatively, a phone call may have been initiated on their behalf if they so wished. None of these services were requested by the participants.

When the research was designed the researcher considered social and cultural issues. The researcher sought support and guidance from a Whakaruruhau Committee representative¹. This was important to check that the research design was culturally sensitive for potential participants from other cultures (e.g. Maori or Pacifica), who might have wanted to join the study. As participants self-selected to join the study no particular ethnic grouping was excluded from the research.

The only identifiable cost to the participant was their time. All participants received a koha² in appreciation of their commitment and time for their support of this study. Participants were unaware that they would be receiving a koha until the completion of the interview, therefore this could not be seen as coercion to participate in the study.

Participant Selection

All service users who had accessed two or more services from the Clinic were eligible to take part in the study. To protect initial anonymity the

¹ Whakaruruhau describes cultural safety. A New Zealand experience of working with people whose experience and cultures differ from those of the practitioner. (Junersen 2002).

receptionists agreed to be the conduit between the researcher and the participants. Potential participants were identified and approached by the receptionists. The informal invitation was undertaken in a non-persuasive manner, and the voluntary nature of participation was emphasised at the time. It was seen as appropriate that the receptionists were involved in this process, as they had no ownership of the research. They were though privy to knowing which service users had received care from two or more of the health services offered at the Clinic.

Prospective participants who showed an interest in the study were given a copy of the information sheet (Appendix D) which informed them about the research, their rights as a participant, and the reasons for the study. Researcher details were included for contact should a potential participant consider the invitation to be part of this study.

In addition, information advertising the study (Appendix G) was displayed on notice boards and situated in the reception area at the Clinic. This was consistent with guidelines from Ministry of Health Ethics Committee, which recommends that healthy participants should be recruited through general advertisements rather than an individual approach. It seems that this lessens the likelihood of influencing the voluntariness of the participation, which may occur due to an existing

² Koha: giving of a gift. Koha is an example of reciprocity a common feature of Maori tradition. <http://www.maoridictionary.comnz/index.cfm>.dictionary keywords.

relationship between the recruiter and the prospective participant.

Once contact was initiated with the researcher, a verbal description of the study and reasons for the study were outlined. Any other issues were clarified. Throughout the process the researcher was mindful of her ethical responsibility to ensure that the participants were free from coercion or undue persuasion. Language was used carefully and information was passed on to participants in a non-persuasive manner. All participants who contacted the researcher agreed to take part in the study.

The Participants

A purposive sampling strategy was employed to recruit participants. Purposive sampling was seen as being useful, because the topic area was new. It was assumed that participants who volunteered for the study would have the knowledge required to answer the research questions (Polit & Hungler 1999; Thorne et al., 2004). There are many benefits associated with volunteer samples, although it needs to be remembered that they are biased in that interested people self-select. A set of selection criteria was used to ensure that the selected participants would represent the phenomenon under study.

As the researcher was aware of the services accessed by the service users she was able to purposely select the widest possible variety of

participants who were likely to be knowledgeable about the topic. These people were typical to some degree of those attending the Clinic. On the one hand, there were some similarities in who attended the Clinic. There were differences too. This perhaps illustrates problems underlying qualitative sampling, which is subjective. This has implications, as it means that it will be more difficult to generalise findings to other health care settings (Thorne et al., 2004).

The fifteen participants (service users) who self-selected for the study included two males and thirteen females. Ages ranged from thirty two-eighty years. Eight participants worked in various roles within the University (excluding the Clinic). The remaining seven stated they had retired or were not working.

A set of selection criteria was used to ensure that the potential participants would be appropriate for the study. The inclusion criteria required the participant to have received care from two or more of the health providers at the Clinic. The clinics attended include Nursing, Occupational Therapy, Physiotherapy, Oral Health, or Podiatry. The study was not limited to age, gender, or ethnicity. Exclusion criteria included any potential participant who was unable to converse freely in English, or any potential participant who had cognitive impairment owing to a physical or mental cause such as dementia. No prospective participant fitted within this category.

The participants were invited to bring a support person to the interview if they desired. No participants took up this offer.

Researcher Involvement

In qualitative research the researcher is strongly involved in the process. Qualitative research is interpretative. Therefore, the researcher must acknowledge her values, biases, and judgements at the outset of the study (Breakwell et al., 2006; Creswell, 1999; Smith, 2008; Willig, 2008). The researcher was conscious of her theoretical readings of relevant literature, and how her professional and personal experience could influence the research process.

For example, the researcher was aware that her previous experience as the Interprofessional Practice Co-ordinator had some effect on how she perceived the Clinic. That role involved facilitating learning for small groups of students on placement at the Clinic. Interestingly, at no time had the researcher had any involvement with service users when she was in the role. She did though have some understanding of the context, as she was always free to observe patients and students working in the Clinic. The researcher believes that this understanding of the context and roles enhanced her awareness and sensitivity to the service user's responses to the questions during the interview process.

Another issue that influenced the data collected was that the participants were unknown to the researcher prior to interview; no personal biases had been formed. According to Streubert et al. (2007), this is of particular importance, as qualitative research and the information gained is subjective and could be ideologically driven, especially if the researcher dominates research questioning. It means that in qualitative research the researcher needs appropriate interpersonal skills to establish trustworthiness. The interviewer is responsible to help the participant feel comfortable, so that he or she will share information, which reflects their experience without fear of being judged (Polit & Hungler, 1999). The researcher was aware of the importance of these requirements, and focused on developing a professional rapport with the participant during the interview.

As described in Chapter One the researcher had had a long involvement with the development of the Clinic and the introduction of collaborative learning. Although this historic involvement may bring certain biases and some sensitivity to various issues such as the health professionals working in silos (Hall, 2005), every effort was made to be as objective as possible during the data collection and interpretation. Thinking critically about the analysis and interpretations was supported by discussion and critical reflection with the thesis supervisor. While this goes some way to keep thinking open, the

participants were not included in any of the analytical interpretations at any stage.

Data Collection

Data were collected using one on one, in-person interviews. Several researchers (Breakwell et al., 2006; Creswell, 1999; Smith, 2008; Willig, 2008) report the advantages of one on one interviews, suggesting that they create a situation whereby the participant has an opportunity to provide historical information about their experiences. This is useful if participants cannot be directly observed in the course of their treatments, as occurs in collaborative care, when questioning might interfere with what is going on. Interviews assisted the researcher who had some control over the line of questioning that was to be followed.

Interviews were semi-structured. As discussed in Chapter One (p. 3) the questions followed Shaw's (2008) study, although the term collaboration replaced interprofessional. The use of collaboration was chosen to reflect the model of care at the Clinic. The questions were designed to promote exploration of collaborative care and elicit responses that would increase knowledge about the topic. The questions guided the interview, rather than dictating the flow of responses. Questions provided some boundaries for the study. At the

same time though, participants had the opportunity to add rich data, as they talked about their experiences of visiting the Clinic (Smith, 2008).

To enhance rigor in the study the interviewer worked to engage participants in the interview process, so that they responded to all questions. In reality, this was a challenge, as participants did not always discuss their experiences in a logical way. Sometimes, they spoke of other issues that were important to them. This illustrates that the way the researcher manages the situation is important. Smith (2008) for instance states that the importance of the interviewer in semi structured interviews is that: "There is an attempt to establish rapport with the respondent. The ordering of questions is less important. The interviewer is freer to probe interesting areas that arise. The interview can follow the respondent's interests and concerns" (p. 58).

The questions which were used to guide this study were:

- ☐ What is your understanding of collaborative care?
- ☐ What are your expectations of collaborative care?
- ☐ What were some helpful experiences of collaborative care?
- ☐ Unhelpful experiences of collaborative care?

- ☐ Hoped for experiences of collaborative care?
- ☐ Why did you choose to use this Integrated Health Clinic?

(Shaw, 2008, p. 231).

These questions were seen as prompts that would promote discussion and identify dimensions and variations about collaborative care. Each participant was asked the same questions to ensure consistency across the collection of data. During the interviews participants were encouraged to share spontaneous responses about their experiences at the Clinic. This type of in-depth interview is advantageous because it tends to provide a more holistic view of what is happening and data can be collected from a smaller number of participants (Thorne et al., 2004).

The interviews were held at a time and place which was most suitable for the participant. Twelve of the participants chose to be interviewed at the Clinic. Meetings were organised for two people who wanted to have an interview in their offices. One participant had issues with the time commitment and asked to be interviewed in their home.

Interviews were conducted by the researcher. The length of interviews ranged from fifty to sixty minutes. The participants agreed to be contacted to clarify any information once the data analysis commenced if necessary. This was not required. The interviews of the

fifteen participants occurred over an eight week period.

Data Analysis

Data analysis included clustering of data which was arranged for similarities, differences, and thematic significance. These clustered ideas are known as themes. Data organized in this manner is known as thematic analysis (Braun & Clark, 2006; Holland, 1997; Thomas, 2006). Thematic analysis was seen to be appropriate for the research because it provides flexibility to explore and develop interpretations in an area where there is little knowledge.

Themes became apparent when listening to the tapes, reading the transcripts (transcribed verbatim), and thinking about the data collected. Braun and Clarke (2006) recommend that the researcher look across the entire data for themes, rather than concentrating too much on an individual interview. This enabled the researcher to focus on the meaning of the service user's experiences and their reality (Braun & Clarke, 2006; Streubert, Speziale, & Carpenter, 2007).

Themes were identified by an inductive approach. In induction, analysis moves from the specific to the general. In other words, data provided by an individual is melded with data from other participants, and generated into a general interpretation of participants' experiences. Themes were not specific to each question and were organized more

generally around the key topics that came up in the interviews.

According to Braun and Clarke (2006): "Inductive analysis is ... a process of coding data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions ... this form of thematic analysis is data-driven" (p. 83).

Braun and Clarke (2006) outline six phases of thematic analysis which were followed in this study. In phase one the researcher immerses herself in the data and becomes familiar with the content. This involves reading and rereading of the interviews, looking for patterns and meaning. This is also the stage when the audio-taped interviews are transcribed into a written form. Bird (2005) has argued that all verbal utterances should be transcribed verbatim. This is a key phase of data analysis and is seen as an interpretive act, as meanings are created. During this phase the researcher identified and highlighted key words and statements which consistently emerged, as the 15 transcripts were read and reread. Examples of these words included: communication, supporting students, accessing appointments, professional, helping, and siloed care.

Phase two involves the coding of data from the initial list of ideas gained from the data into meaningful lists (Braun & Clarke, 2006). It is imperative to work through all the data sets identifying interesting aspects and points that may form the basis of repeated patterns. At this

point it became apparent to the researcher that, although common ideas and themes were evident, the initial coding was very broad. Participants did not talk about their experiences in a neat and tidy way. They spoke about some things that answered a question, or part of a question, then moved on to talk about something quite different that they thought was relevant to the study. This meant that some codes could be linked to the research questions. Other codes took the data in a direction that had not been anticipated at all. For example, new information included topics such as two-way learning, the opportunity to be part of the students learning, making a difference, and being valued by offering their time and experiences.

In phase three of data analysis all data is coded and themes are established by sorting codes into a broader level of themes (Braun & Clarke, 2006). Braun and Clarke suggest that, at this point, some of the original codes will become main themes, while others will form sub themes, and others may not be included. During this phase the researcher identified the most obvious reoccurring data and began to label the sub themes. For example, two-way learning, service model of care, clinic access, and student support. Labels served a purpose in that they drew many broad descriptions into a more coherent whole.

Phase four involves reviewing of themes, to create a meaningful, cohesive set of data, which has clear and identifiable distinctions

between themes (Braun & Clarke, 2006). At this stage the data set is reread to check that the themes relate to the data set and any additional data missed in the initial coding is added. "The need for re-coding is to be expected as coding is an ongoing organic process" (Braun & Clarke, 2006, p. 91). This phase was more complex and required time. It was a messy stage of data analysis, as the researcher deliberated over the titles of some themes and sub themes. Trying to fit content and context of the study into themes was frustrating at times. For example, the theme that was labelled as "models of care" was originally called "collaboration - not at this Clinic". Eventually, after much reflection, this sub-theme was called models of care. That code was broad enough to encompass participant's perceptions. While that was lower-level description of the participants' views on what they saw happening, the theme was too descriptive. It was then changed to collaboration-teamwork, which was more concise. But, it was also confusing, as there are fine distinctions in the literature between those two concepts, as has been seen in Chapters One and Two. This theme retained its confusing label for some time, until it was finally refined in the next phase of data analysis.

During phase five themes are defined and refined. The researcher checks the essence of meaning, to ensure the theme conveys an accurate description (Braun & Clarke, 2006). At this stage it is

expected that each theme will have a detailed analysis, which categorizes the story that depicts the theme. For example, the theme "user expectations" had clear sub-themes that were labelled as "accessing services", "practical issues", and "sense of security". That particular theme came together well, because the data were organized appropriately, and the theme titles were straightforward. However, once again the collaboration-teamwork theme came under scrutiny. It did not quite capture what was happening in the data. After discussion with the supervisor it was decided to label the theme as "service models of care". That was an improvement, but still did not capture the sub-themes sufficiently. Finally, the theme was labelled as "user perceptions", which was seen as being a broader descriptor of the data. At this point the researcher checked that the themes related to the title of study and the research questions. All was in order.

Phase six of the data analysis is the final phase of the analytical process and involves the presentation of the findings (Braun & Clarke, 2006). This phase includes an analysis of the findings and the final write-up. Braun and Clarke (2006) state that "this needs to be a concise, coherent, logical, non-repetitive and interesting account of the story the data tells" (p. 93). Extracts from the data need to be embedded within the themes to capture the essence of the point that is demonstrated. The integrated findings and interpretations are presented in Chapters

Four and Five.

Braun and Clarke's (2006) descriptions of the phases of the data analysis are supported by the work of Thorne et al. (2004). These researchers recognize the importance of developing a coherent and meaningful description of the themes and patterns that emerge from the process of inductive reasoning. Thorne et al. suggest that this process highlights the importance of making a "tentative truth claim" in reporting. This is consistent with the qualitative approach to knowledge generation in which it is recognised that there are multiple realities and knowledge is contextual.

Rigorousness of the Study

In any research the truth value of the findings is critical. Rigor is a term that refers to the overall trustworthiness of the research findings.

According to Burns and Grove (1999) "rigour concerns the openness, scrupulous adherence to a philosophical perspective, thoroughness in checking data, and consideration of all the data in the overall interpretation" (p. 372). In naturalistic inquiry the truth value is judged according to "the accuracy of the interpretation or how closely the analytical scheme reflects the natural context under study" (De Poy & Gitlin, 1998, p. 314). Truth value is known also as credibility; readers of research findings need to know the research is believable and

trustworthy (Creswell, 1999; Thorne et al., 2004).

Lincoln and Guba (1985) identify four criteria for establishing trustworthiness of qualitative research. These are credibility, dependability, confirmability, and transferability. In this study the following strategies were utilized. Credibility relates to the truthfulness and value of the findings. In this instance, prolonged engagement with the participants at interview provided an in-depth understanding of the topic. The researcher had multiple opportunities to listen to the views of participants and consider their experiences of receiving collaborative care in the Clinic. Credibility was enhanced because the researcher used the set of research questions, which meant that she focused on the topic of study. Credibility was further developed once the researcher identified her personal and professional connections to the participants. Being transparent promotes credibility.

Similarly, triangulation improves the credibility of qualitative findings. This is achieved by using multiple sources of data, such as interviews, reading the literature, and discussing the topic with colleagues, experts in the field, and a critical friend. Exposure to other points of view assists the researcher to reflect on the wide-ranging sources of data before she draws conclusions about the findings. All these techniques went some way to enhance truthfulness of the findings.

Dependability of the findings is developed as the thesis has been scrutinized by a supervisor and an external critical friend, both of which offered feedback on the analysis. Critical analysis of the findings and the process is useful to enable the researcher to consider different points of view that may shape interpretation. Once again, these strategies go some way to promoting trustworthiness of the findings.

Finally, it is hoped that the generalizability of the findings are such that they can be transferred to another similar setting or group. Potential for transferability is promoted when there is a clear audit trail and the researcher provides a thorough description of what has occurred in the study design, explaining how decisions were made and followed through.

Conclusion

In this chapter the researcher's rationale for the use of a qualitative descriptive methodology and the theoretical processes that underpin the study were outlined. Ethical issues, participant selection, the interview process, the data collection and analysis were discussed. Finally, strategies to enhance rigor were outlined. In the next chapter the research findings will be presented.

Chapter Four

Research Findings

Introduction

The aim of this study was to explore service user's perspectives of collaborative care received at a University Integrated Health Clinic. The focus was on learning if a collaborative model of care had any influence on why the service users chose to continue to attend the Clinic. As discussed in the previous chapter, the research findings are presented in themes with sub-themes. Three main themes stood out:

(Table 1).

- User expectations
- User perceptions
- User observations

Table 1 Themes and Sub Themes.

User Expectations	User Perceptions	User Observations
Accessing services	Models of care	Student Support
Sense of Security	Uni-professional working	Two Way Learning
Practical Issues	User involvement	Communication

The first theme, User Expectations, outlines service user's reasons for attending the Clinic and encompasses: accessing services, sense of

security, and practical issues. User Perceptions, the second theme, refers to the impressions of care that the participants had when they went to the Clinic. Sub-themes include: models of care, uni-professional working, and user involvement. The third theme, User Observations revolves around the benefits of supporting student learning. The sub-themes are: student support, two way learning, and communication. The chapter opens with an overview of participant's responses to the research questions. Then, each of the themes and sub-themes are presented.

Responses to the Research Questions

- Question One: *What is your understanding of collaborative care?*

It was evident that all participants had different understandings of collaborative care. What was clear though was that care was delivered separately from students who were attached to disciplines. Overall, it was noted that participants did not understand what was meant by the term collaborative care at all. It was a new concept for most, and for some it was difficult to answer the question at all.

- Question Two: *What are your expectations of collaborative care?*

According to the participants, service delivery did not meet their expectations of how collaboration might occur. Once the participants realised that they were attending a clinic that was labelled as an Integrated Health Clinic, they expected that

students would be involved with delivering integrated care. Even though they did not realise that the service model was supposed to be collaborative, they thought an integrated clinic that offered a collaborative model of care, it should have been evident. Clearly, there was a gap between participant's expectations of care and what they thought the Clinic was offering. Participants also thought that collaboration would involve being referred on to health professionals as required, but this was not evident.

- Question Three: *What were some helpful experiences of collaborative care?*

While participants could not discuss collaboration, they unanimously reported that their visits to the Clinic were positive. They noted particularly that communication was excellent and invaluable to ensure that they got access to the care they sought. Even though the care was non-collaborative, the participants felt that the model of care available benefited them individually.

- Question Four: *What were any unhelpful experiences in accessing care at the Integrated Health Clinic?*

On the whole, participants did not have unhelpful experiences at the Clinic. Two participants however, identified having issues with the students looking after them. Problems appeared to be related to the student/participant personality mix and were managed by the clinical educators supervising the students at the time. Participants did though identify a potential problem that might make Clinic attendance more difficult in the future. They reported that if the Clinic were to become even more popular in the local community, access

would likely be more difficult, and it would be challenging to obtain appointments within a desired time.

- Question Five: *Hoped for experiences at the Integrated Health Clinic?*

Overall, participants hoped to receive the service where they had an appointment. Participants attended the Clinic for a particular service for example, oral health or podiatry; they expected to have a dental check-up or a foot assessment. While the Clinic name implied more services were on offer, participants simply wanted to access the service of their choice.

- Question Six: *Why did you choose to use this Integrated Health Clinic?*

All participants spoke favourably about the accessibility, affordability, and availability of the Clinic. These factors were significant in choosing the Clinic. Another key consideration was that without question, participants believed that by going to the Clinic they might support student learning.

In this next section the key themes from the research are presented and where possible, linked to the questions asked. Although the themes are presented as distinct units, findings overlap and themes or sub-themes do not occur as separate entities.

It needs to be noted at this point that while the emphasis of the study was collaborative care, as has been stated 80% of the participants were unsure of what the term collaborative care meant. Nor did they

believe that they had witnessed collaborative care. Nonetheless, they were willing to 'have a go' at describing what they thought it might be. On a more positive note all had observed uni-professionals working together, and working in teams. For this reason working together is discussed in the findings. These issues will be addressed in the following chapter.

User Expectations

The theme user expectations refers to accessing services, sense of security, and practical issues that influenced what happened to service user/participants when they visited the Clinic.

Accessing Services

All of the 15 participants interviewed were absolutely clear as to why they had accessed the health services from the Clinic. Overwhelmingly, it was evident that the participants expected to attend a Clinic where the services were affordable, accessible, and available. Interestingly, the findings support the principle guidelines of the New Zealand Primary Health Care Strategy (2001), which state that primary health care should be accessible to people in their communities, involve community participation, and be a first level of service for certain health needs such as podiatry, oral health, physiotherapy, all of which are offered at the Clinic.

Participants spoke about the cost of accessing health care from the Clinic. Cost was a huge benefit and a major reason why participants went to this Clinic when it was compared in cost to other practices in the community. Examples of responses included:

Cost effective for a start. 8 (2)³

Financially it's affordable for me. 10 (3)

Prices were absolutely wonderful. 12 (2)

It is reasonably priced compared with private practice. 15 (3)

Even though participants had perhaps not expected time to be an issue that influenced access, one participant noticed that students took a longer time to deliver treatments. Appointment times were significantly longer. But, apparently overall treatment timing was comparable to the private sector, although extra time was spent with student assessment and treatment, as opposed to sitting in a waiting room:

Reasonable rates but you will have a student, [and] supervisor treating you at any one time. ... It may appear to take longer but in actual fact I find that the treatments and findings ... are a lot quicker than you would probably have in the private sector. 4 (7)

³ The use of the service user's quotes is accompanied by a code which denotes a number for each of the 15 service users interviewed and the page where the quote occurred on the transcription. For example 7(12) indicates the quote came from the service user who was the seventh interviewed and is on page 12 of that transcription.

Several participants worked in the University and expected accessibility to be easier. They expected that the Clinic would be convenient and appointments could be fitted around work without too much disruption. They thought by accessing the Clinic they were exercising their responsibility to support students. Again, accessibility has been identified within the New Zealand Primary Health Care Strategy (2001) that recommends providing services within workplace settings, or where they are easily accessed. Examples of responses included:

It's very close in proximity to work. It means I can literally have appointments during the day and just nip out of my office for an hour. That is extraordinarily convenient. 4 (2)

Convenient to me to use the facilities here. 9 (2)

Because it is here at my workplace. ... It is accessible, easy for me to access and it's convenient. 15 (3)

Those participants who lived in the community and travelled to the Clinic for care noted a key feature was the easy access. Indeed, they expected to use the reserved parking which was available. Free parking was seen as an advantage and contributed to the positiveness of the overall Clinic experience:

Parking is great because of the clinics parks [there is] just about always one is available. 2 (3)

[Parking] It's brilliant ... one of the ... ladies on the desk has given me a slip to put on the [car], ... so I don't get towed away. 3 (12)

The convenience of location [of the car parks] ... [when I come to the clinic] I've got a mobility park. 9 (8)

Participants expected that access would be improved because appointments would be readily available at the Clinic. Availability combined with low-cost care certainly provided a positive experience:

The appointments are pretty good as far as availability [goes] ... [it] made [coming to the Clinic] an option for me, where as [if I had to pay more] I may not have got the treatment financially. 2 (2)

The convenience of location basically, and being able to get the appointments more or less as I feel I need them, has been worthwhile. 9 (8)

However, some participant's expectation of accessing an appointment within a certain time frame was not as they had anticipated. As the services of the Clinic are accessed by more people, and availability of appointments is limited due to inter semester breaks, this creates a longer interval between appointments. Nevertheless the participants had an expectation that this was acceptable, as it meant the Clinic was well patronized:

Usually [I can get in] but they are fairly booked up and I'll often be asked to return the next week and can't get another appointment till the following fortnight, so it is a bit tricky, but that's acceptable. It shows me that the Clinic itself is well used and has high attendance. 4 (3)

I think sometimes people, if they recognize it's got the limitations of the time factor and also the students' holidays, it becomes slightly more difficult to arrange an appointment there. But basically I think it's a useful service. 9(4)

Most participants spoke about the receptionist's welcoming and friendly attitude when booking follow-up appointments. The warm

welcome went a long way to enhance visits to the Clinic. While they did not expect it, the offer of a card or text message for an appointment reminder was seen as a useful tool to encourage them to keep their appointment:

They wanted to know if I [would] like a card ... reminder or ... a text [message] as ... [a] reminder of when my appointment was ... I found that really helpful ... for me that's a great way of communication. 15 (2)

The receptionists are always good to you. ... [they attempt to organize] the appointment [around my needs] "we'll try and work this one for you". They fit you in. The appointments are always on time. 1 (5)

As the Clinic was based within the University some participants expected that the treatment they received would be the latest. They hoped they were not going to receive the same old solution for their problem:

There is a sort of expectation that you are going through a University where they are trialling different things, so you're expecting not the same old solution that you'd probably get out there [in the community]. 7 (9)

Comparison was made to treatment that would be received in private practice. Participants expected that students working with clinical educators would deliver care that was on a par with private practice. Whether this expectation was realistic or not, did not seem to matter:

I know that the care that I am going to receive from this Clinic is as good as what I would be getting out in private practice

because of the kind of lecturer supervisor role with the students.
15 (3)

Sense of Security

As service users, the participants had an expectation that the care they received from the Clinic would be inclusive, and that they would be acknowledged in a caring manner. Overwhelmingly, all participants had had a positive experience with their health care received at the Clinic. The positivity of the experience was important in developing a sense of security about care at the Clinic. Although two participants had experienced communication issues with students, and did not feel secure being looked after by particular personalities, they were assigned new students who they were more trusting of. The overall result was that the participants felt welcomed, listened to, and had trust in the students who managed their care. Part of the sense of security developed because they felt that the students were interested in them as a person. Being included in the planning of their care was very important. The sincere student interest went a long way to establish a sense of security.

Examples included:

I have always found them courteous. I'm very impressed with the professional manner of both ... students and their supervisors. 11 (2)

Student's [are] really friendly and interested in me as a person.
2(8)

They [the students] were genuine; I felt that they wanted to do their best. 12 (5)

[The students are] professional but friendly, courteous, prompt at times. They try and make it personal within reason. 13 (2)

Furthermore, the participants had an expectation that they would have a sense of security with the delivery of care that they received at the Clinic. This occurred because students focused solely on the participant/service user who was central to the learning process. Trust in the manner in which the treatment was delivered and communicated was especially important for participants. In particular, participants spoke about feeling comfortable throughout the experience:

I find [the way I am treated by students is] very professional ... they are always insuring that I'm comfortable. If there are any problems I am to let them know. ... [they make] me feel kind of quite at ease in that different situation. 15 (5)

I find the way they treat [me] now [I am] more relaxed and I feel that because [I am] more relaxed I think that health improves much quicker. ... Like people recognise [me]. It's a trust thing and gives [me] a lot more confidence, because [I] don't have to keep repeating what's wrong with [me]. They know. 3 (10)

Although the clinic was a student learning environment the participants had an expectation that students would work in a professional way. It was seen as important that the service user/participant was central to their care and developed trust with the student managing the care, as they believed many people were involved in the decision making of the care. This added to the participant's sense of security:

People have different ways of how they like to be treated ... I think it's ... important... [to make] the person feel secure and confident ... making them quite centric in that process. Because you've got so many different people [health professionals] involved and you're putting your trust in a lot of different people to come up with one answer. 7 (12)

Other participants had expectations that their individuality and special requirements would be taken into consideration. Respect for individuality went a long way to establish trust. For them, this demonstrated sensitivity to their situation and enhanced their sense of security:

... and also ... age [matters] and definitely if the person was hard of hearing and all those kind of individual things, so age and just being that sensitive and listening and being responsive to the person [is important]. 13 (4)

In addition, it was noted that some participants expected that the students would work with service users of all ages rather than just practicing on each other. This gave the participants a sense of security when accessing the Clinic, simply because the students were confident in working with people of all age groups:

I would imagine the practical work of meeting people in different age groups [is important] because if they were ... only practicing on other students they are not getting a cross section ... it's probably beneficial to ... [students to have] having a wider age group ... [to] work on. 10 (10)

Encouraging a sense of security was not confined solely to students, but included other staff members as well. Participants stated

that the receptionist's recognition and acknowledgement of them as a person was important. It added to the participant's positive experiences:

They [the receptionist's] recognize me straight away when I walk through the door. It's nice ... that you [have] the same staff there which is really good. 3 (9)

Practical Issues

It was clear that various practical issues influenced user expectations. For instance, information sharing and how it was done was an important issue for participants. The participants spoke about the significance of being given information about the expectations of care they would receive. Interestingly, they also expected to be informed on how they might support student learning. According to the participants, this information needed to be shared before the commencement of the initial treatment. Not having this information available created the practical issues about the unknown for service users:

I guess ... each area has different times that the students are in the Clinic, I think... [not] having that information readily available for the consumers [is an issue] and definitely [service users need to know] the distinction between second and third year [students]. 13(8)

Advertising, or the lack of it, was a practical issue for participants as well. Overwhelmingly, the participants had learnt about the services provided at the Clinic by word of mouth. Most knew only about one service offered by a specific group such as oral health. This

was of issue. Many times information was gained about alternative services while waiting in the reception area, where it became apparent that there were other co-located clinics in the same building. Participants also noticed that there was not any advertising material informing them of the services available at the Clinic:

I haven't seen any advertising for this clinic. Anywhere... . It's more word of mouth, but never advertising. 8 (9)

I had no idea that those [Clinics] ... existed. I was just standing around in the Clinic waiting ... just looking at different things and I kept thinking, "Why are these shoes kept here?" I read the brochure but it still didn't strike me [that there were other Clinics in the area]. 12 (12)

Several participants noted that students did not seem to know about the other services available at the Clinic either. This was seen as a critical issue. Participants expected to be referred on to other services if they needed other treatment:

I think [the services] could definitely be ... more advertised. ... More students knowing what's available within the [Clinics] ... as well. Also [service users need] more information when [they] first [attend the Clinic]. 13 (9)

The students need to be educated about [the services] ... It would be very good for patients to have the information when they enrol, to [know]... what the student's [learning expectations are] and [for] the students ... to read [the information] ... 5 (6)

Appointment bookings were mentioned as another issue.

Participants noted that as the Clinic had become increasingly popular and was accessed by more and more people booking of appointments was

difficult. In spite of this, the participants had an expectation that appointments would be available to meet their health care requirements:

It was quite hard to get appointments and not necessarily when I wanted them, if I got told to come back in a week ... it wasn't as easy as that. It was a compromise and maybe 2 weeks out. 7 (10)

A two week wait for the next appointment was part of the problem. So the waiting times are a bit of an issue when you really want to get in. ... "Oh I can't get you in for two weeks." "But I need to be seen this week." 8 (9)

Another key issue was waiting times, which caused some frustration for participants. Part of the problem was the lack of services during the semester breaks and exam times. When the Clinic closed for several weeks this caused problems and interrupted participant access to care:

The waiting times are very long and I can understand that to a point. With holidays, the clinics aren't always running, or exams or things like that. But it can take a week or two to get in ... if you need to be seen urgently, or within a week, you can't always get that. It is a bit frustrating. 8 (6)

I can't always get an appointment when I want it because they close down when they're doing exams or holidays, and especially in the long holiday time. There's usually quite a waiting list. 10 (3)

Yet another issue involved expectations about the continuity of student follow through. Although participants were aware that they would have different students attending to their care, some hoped to have the same student, particularly if they had formed a rapport with them. However, they soon realized that students were placed in the

Clinic for a limited time, and their focus was on clinical learning, not on providing continuity of care for the service user/participant. While some accepted that, it was somewhat disconcerting:

Some [students] do a very good job, I'd like to have them the next time ... the students move around, ... so I guess that's one of the things you can't have, but I wouldn't mind sometimes if I could stick with one [student]. I know that they are learning. It's a learning environment. It's just part of the deal really. I accept that. 10 (5)

I think the majority of the time I have [the same student delivering the care] ... I probably should go back but there is that sort of "I don't really want to go back and see another person." But 99% of the time it has been with the same student. 7 (3)

While participants were keen to attend the Clinic, the constant change of staff was an issue. Five (32%) found it rather bewildering to have different students each time they attended the Clinic. Nevertheless, they responded by looking for the positive and noted that it was helpful to have another student's opinion about their health issue. Despite participant's positive attitudes, service delivery was in fact compromised, as the length of an appointment time increased whilst a new student became familiar with the situation:

Sometimes it's a bit disconcerting, especially if the student seems to be making some progress. But I've been attending the ... Clinic long enough that they do have fairly good hand over - they ... tend to read the notes and ... ask you more questions. Sometimes it's actually helpful as a ... patient ... not to just repeat the story but then to reflect on whether or not you have improved etc. ... it's also nice to be given a different approach. 4 (2)

It definitely does [slow down the treatment] because it's reiterating the same old same old and although having said that, sometimes things can come out of it that You know, you get a different perspective on it, so it's also quite good in the sense that you get a varied opinion and a varied treatment. ... one treatment doesn't necessarily work for all. 5 (2)

Two participants had expected to have the same student for their treatment. However, there was a practical issue with attending the clinic and having the same student assigned to a service user on an ongoing basis. The issue revolved around finding a time suitable for both the participant and the student. These participants understood that they needed a certain level of expertise or experience from a student who would treat them:

Accessing appointments is not easy ... you do have to be careful if you want the same person. It has to be when they are available which has to link in with when I'm available.

11 (7)

User Perceptions

The theme of User Perceptions refers to the models of care, uni-professional working, and user involvement that influenced Clinic visits. User perceptions reflect the participant's understandings of the care provided in an integrated health environment. Overall, it was an environment that was full of new terminology. Importantly, this section

conveys how little relevance terminology has when the service user's point of view is taken into account.

Models of Care

The sub-theme models of care refers to the type of care that was discussed in the study. As noted earlier in the chapter, most participants had not heard of the term collaborative care before they joined the research. Therefore, they had no preconceived notion of the care they might receive at the Clinic. This suggests that the model of care is not particularly important when a service user seeks a health service.

Participants did not attend the Clinic because it was advertised as an Integrated Health Clinic that apparently offered collaborative care. They went to the Clinic because it was available in the local community, parking was free, and the service was cheap. Nevertheless, all were able to describe the type of care received and were well aware of what happened at the Clinic. In reality, the label applied to the model of care, did not seem to matter.

Perhaps not surprisingly, participants who were employed by the University had a perception that they might receive some form of collaborative care at the Clinic. Their understanding of the type of care was that it would have a philosophy of collaboration:

... looking at the website about the clinic [I see] that it's housed under the National Centre for Inter-professional Education and

Collaborative Practice [I thought] that [collaborative] ... services should be readily available. ... I haven't been referred on to the other services. 7 (7)

Although participants certainly did not understand the significance of collaboration as the health professionals did, they actually had a very clear perception of what collaboration might look like:

I'm not sure that I can tell you I have an understanding, I have an expectation of collaborative care [which] is when I meet one professional and not only can I identify their own expertise, what they might be able to do to assist my condition, ... [and to] make a referral [as needed]. The understanding is difficult because I haven't actually encountered it. 4 (6)

[Collaboration is] disciplines working together to treat that patient. A patient would receive multi care from the different practitioners ... to give you a ... treatment plan which worked with other [disciplines] ... your notes ... [would be] shared. 7 (8)

Several participants acknowledged that they thought a collaborative model of care would include a holistic approach to their care. According to participants this model, would have involved other health disciplines as required, if the best care was to be offered. This suggested that the model of care was open:

[Collaboration is] holistic, working together with all facets of the different levels of care. 13 (5)

[The model includes] ... the whole person. ... I would certainly use 3 plus services in one building. 3 (8)

[Collaboration] I see it being a ... central point where different services are offered. 15 (6)

In contrast, others had no perception of the collaborative model of care and stated they had not heard of the term prior to this study. Not

surprisingly, they had not given the concept any thought, although they were able to give an explanation of what they thought a collaborative model should be. However, definitions were vague:

Different people from different disciplines ... collaborating together. 6 (7)

[Collaboration is] different care, all combined kind of. 10 (8)

Others assumed a collaborative model would invite their input so that care was patient-centred. The introduction of yet another model of care, the patient centred model, suggests that the model of care was unclear:

Collaboration between the patient and the care giver ... this is an important aspect to get the maximum benefit from whatever treatment is going to be provided. 9 (7)

Once collaboration was mentioned by the researcher, who raised it as a point of discussion, participants suggested that it was important that collaborative care be role modelled at the Clinic, and that it should include service users. They believed that the students learning in the Clinic should be able to convey an understanding of the concepts of the collaborative model of care that was supposed to be offered at a clinic that went under the name of the Integrated Health Clinic:

I have not seen ... the ... students from different disciplines ... working together ... seeing that students are doing collaborative work ... that would be great ... to see ...[the] interaction between them ... at the moment you go into [one] clinic and you just see

[those health professionals]. So there's not that hub and excitement between the different teams. From a customer's point of view [it would be good if] you can actually start to ... ask or know about it. 7 (10/11)

Understanding of the model of care on offer became even more confusing when participants were asked about integrated care. Because they had not experienced it, they had no response. One participant was able to suggest what an integrated clinic might do. This included reference to quality care and role understanding:

An integrated clinic ... where ideally the people who are doing the treatment, be they students or qualified people ... would be aware of the other professions and how they contribute to the patient's recovery. 5(6)

Despite its name, some participants did not realise the Clinic flew under the banner of the Integrated Health Clinic. Overall, they were not sure what that meant:

I didn't know it was an integrated clinic it didn't strike me until you mentioned it now. 12 (2)

Well these are new words in the [health world]. Integrated, I'm not quite certain what that is. 14 (6)

There was a perception that had collaborative care or integrated care been offered, the participants would have appreciated the opportunity to receive either model of care:

I wish it was more collaborative I didn't know that it was meant to be integrative or collaborative, but I would have liked that. 12 (9)

Collaboration amongst the various disciplines ... I could understand that as being a good proposal. But in my case, it really hadn't applied. 9 (7)

Several participants who worked at the University remarked that they knew about the Clinic. Their perception however, was that had they not been working within the University, they would be unaware of the services offered at the Clinic:

Because I work inside [the University] I have ... the knowledge ...but ... as an outside patient coming in, I don't think that there is anything that tells me to say, "Oh, by the way mention to the physio about your knee, perhaps I could talk to a podiatrist or something like that". 5 (5)

Had I not worked here [at the University] I would be none the wiser probably of some of the other services that were available. 7 (8)

While the model of care was clearly non-collaborative, some cooperation and coordination was evident in certain situations where service users had chronic conditions and notes were shared (as at the Arthritis Clinic). Participants believed that the sharing of notes and using the collective information as a learning tool for case studies was a positive move to promote learning about collaboration:

It's a good thing if they are ... sharing information and going over ... problem areas or case studies, ... that they could share information and hopefully it might kind of come out with a positive result. 15 (4)

Uni-professional Working

The majority of participants perceived that they had received care from students working together from the same health discipline, usually in pairs, with one student the main care giver. Uni-professional working gave participants the confidence that the student would seek advice or discuss care if they needed to:

... the student exhibits confidence while at the same time reserving judgment and allowing others to assist them. ... with [either] the peers or their supervisors. If they don't know something they will go and find out. 4 (4)

One person is the chief carer or worker ... they do learn from each other and if there is anything interesting that comes up, they do work with the lecturer. 11 (4)

Participants had a perception that disciplines were working together in the uni-professional clinics, nevertheless, teamwork across the disciplines was variable:

There appeared to be teamwork within the ... individual clinics but inter clinic teamwork... I haven't seen anything when I've used the services. 7(2)

I don't know about teams but I see them being very collegial and helping each other out as necessary [within the uni-professional clinic.] 11(3)

Several participants observed students supporting each other and working as a team within the uni-professional setting. This was seen as a valuable learning opportunity that promoted openness to other ideas:

Within their groups they work together as a team – oral health ... physiotherapy ... I don't know that they talk to each other. 5(2)

It was my first appointment ... [the] student asked for another student to ... record the findings when I was being tested. That was one area of working together as a team. 15(4)

There [have been] two students, one sort of helping the other one or just observing. 10(5)

Knowing that the [students] are helping each other, and learning from each other ... being open to other ideas and other things. 8(11)

Unfortunately, it was quite clear that generally interaction between the different disciplines was limited, mostly non-existent. One participant stated that she had not observed any interaction of staff or students between the different services operating at the Clinic. She was unsure what might happen if staff, students and service users were to work with colleagues from other professions. Some other participants also had a perception that sometimes working separately was necessary due to the speciality:

It would be nice [to work more closely]. I think they try to but it's very difficult because ... [the professions] are all different. 13 (6)

[Health professions work together] slightly maybe with podiatry and physio, but then it kind of gets all muddled up as well. 13 (6)

I haven't seen them [students from different professions] interacting in any way. 3 (13)

Several other participants questioned the need to work collaboratively at all. They were not sure that integrated or collaborative care was warranted, as they perceived the students had different roles

and learning requirements from other professions. They were satisfied with uni-professional working:

I don't know if that's actually warranted because [students] have got different roles and they are training for different professions ... I kind of don't think that they should be [working with other professions]. 15 (4)

Although participants believed the different professional groups worked in a uni-professional model, as has been noted previously, they hoped that they would be directed to another service if they needed it. There seemed to be some overlap between uni-professional working, and teamwork, and working together which all seemed to be lumped together under the one umbrella. Interestingly, some stated that working together was a model that was part of quality care:

I would always hope that ... while you may go intentionally for one particular discipline, ... if they saw a need that required one of the other services available ... they would refer you ... as a customer it would be very seamless and would be integrated into your treatment plan. 7 (7)

Furthermore, it was noted that the participant had an expectation to receive care whereby the health professionals were working for the service user. If this was to happen, no one discipline would take ownership of care:

My expectation would be a very efficient patient treatment service where everyone is working together for the benefit of the patient. [It is] not one person saying this is my discipline and my

discipline is better than yours. ... [It would be] like a holistic approach. 8 (6)

Another participant believed that apart from the sharing of notes mentioned in the previous theme, that the disciplines worked separately. Even though participants liked the idea of integrated care they did not perceive that a philosophy of integration influenced the care provided:

Sounds wonderful, from what I have seen... [each discipline] works on their own, the only integration that I am aware of here is that they share the notes. I probably wouldn't be thinking of it as an interdisciplinary clinic as such, more as [providing] what the person needs. 11 (2)

Another participant, although clearly able to define the integrated model of care, perceived that care at the Clinic was delivered separately:

... health, ongoing care or whatever it may be, but very often they don't [understand the] philosophy ... behind the integration and what you are trying to achieve for the patient. The care is siloed and it could be improved for the students. 5 (6)

Overall, it would appear that the participants had a perception that each clinic was a speciality in its own right and that the professional groups operated separately.

User Involvement

User perceptions about the importance of being involved in the planning of their care were wide-ranging. This may have been due to the fact that this was the focus of the research questions and participant's perceptions of collaborative care or integrated health care were so limited:

I think the biggest hurdle ... [that New Zealander's] Kiwi's ... have ... You want a generalist [for your health needs] ... this one person is going to hopefully know all the answers to all my problems ...and I think ... that some people might not know what a physiotherapist or a podiatrist does so it's that whole explanation as well as to why I need it and this is the reasoning. 7 (11)

Other participants understood that the health care system had changed over the past decade and believed that service users or clients were no longer viewed as a number, but had become a person. Furthermore, service users are now included in the planning of care, and no longer passively accept recommendations for care. As a result, participants believed that they would have some involvement in their care planning:

The health care system has changed ... very much in the last ten years. ... You've become like a human [being] and not just a number. ... I find now the [professionals] actually ask you ... and interact with you. 3 (9)

It was noted that participant involvement in their care was seen to be essential for optimum health. In particular, involvement meant that the patient would be central to the planning of the care:

Collaboration between the patient and the care giver ... this is an important aspect to get the maximum benefit from whatever treatment is going to be provided. 9 (7)

Several participants wanted to be actively involved in the planning of care. Students recognised this and used questions to facilitate participation by identifying mutual goals in the care plan. Participants thought this improved their commitment to care:

Right from the ... [start] she asked me what my goals were and ... every second [visit] it was a review of them. [The student] also asked me the question "do I feel like I'm getting there?" so I did sort of feel part of it that way ... I did feel like there was a two way street. 7 (5)

Indeed, there was an element of partnership working when service user/participants were involved in care:

I have found that they [the student health professionals] adapt any type of programmes, exercise programmes or plans so that it suits me. ... We often talk about either my work situation or home situation, to make sure that anything that they are planning... can be adapted to work or my home situation. 15 (5)

One participant stated that they felt very involved in their planning of care, and identified the importance of clear communication and explanations. User involvement seemed to be a dynamic process that was subject to change, as new students reviewed the plan of care. Having different students attend to their care was perceived as beneficial as service user/participants appreciated the different approach of each student:

It has been interesting to see the various different approaches ... from a patient's perspective it's very interesting ... [I am] involved in my care. [Students are] very good at getting you to understand what is the problem and the reason for it, so that is good. 5(5)

One particular participant assumed from the start that he/she would be involved in their care. This person believed in an open approach and felt obligated to understand and follow the suggested treatments:

I'm the kind of patient who insists on being talked to in front of [everyone] ... I like the approach where basically ... I'm being asked questions [about my treatment] as they are discussing the issue and then being recommended certain ways in which I can do things outside of the Clinic [ready] for the next appointment. 4(9)

Others though believed that the level of involvement in the planning of care did not achieve the desired results for them. Service user expectations about involvement were certainly wide-ranging. Surprisingly, the participants either saw the level of their involvement in their care was either over prescriptive, or not involving them to the extent expected:

I could understand that [being involved] is a good proposal, but in my case it really hadn't applied. 9 (7)

Part of the problem seemed to be due to the student's stage of learning. Third year students for instance were likely to manage service user involvement differently to a fourth year student who had had more experience:

To some extent ... I don't think they've got the right balance yet. I feel that they are either ... too prescriptive or not prescriptive at all. They are unable to gauge the level of the client and therefore accordingly suggest [the] correct involvement. 12 (8)

However, some other participants had not given any thought to the idea of user involvement and what that would mean when making decisions about their health requirements. Indeed, one participant felt

daunted at the idea of having any input to any discussion at all. Their perception was that they attended the Clinic for a specific health issue such as an oral health check up. They did not want to have a holistic health review:

This sounds quite scary. ... I probably came in for one particular thing and to hear these people all ... [discussing] about what's wrong and what they could do... and who should do it ... 7 (12)

User Observations

Unequivocally, a significant theme in the study was user observations that referred to the learning environment which supported student's learning. Although participants primarily attended the Clinic because they had some medical problem, or wanted a health check-up, they soon realized that the Clinic was set up to facilitate student learning. Once that was understood participant's realized that their clinic visit was an opportunity to contribute to student learning. Those that continued to go to the Clinic deliberately did so because they wanted to support students, to value their uniqueness, and contribute to individual development. This is well supported by Smith and Ross (2007), and Hall and Weaver (2001), who suggest that service users are pivotal in health service delivery and provide valuable input to support student learning. For the ease of reading, this section has been divided into the sub-themes of student support, two way learning, and communication.

Student Support

In support of student learning most participants were aware that the appointment would take longer, and it was common that they required additional appointments. Nevertheless, this extra time was not seen as an issue, and the participants felt they had an obligation to be part of this process:

I'm prepared for an appointment to be longer because of the student involvement and the learning aspect of it from their point of view. ... I feel well, that's something I can contribute to. 9 (3)

Participants observed that student's interactions with service user/participants of all age groups, people who had a wide range of health issues, was beneficial to the students' long-term learning. By attending the Clinic, they were supporting students and providing learning opportunities:

I think because I have [a chronic health issue] and I have problems associated with it, I think ... they can learn from me, so therefore when they get out into the workforce they are going to be able to have that experience and knowledge of how to go about dealing with the kind of problems that arise with people that have [this chronic health issue]. 15 (7)

The participants were aware that the students only had a limited time at the Clinic for their learning. Most participants were not concerned by this, as they felt it gave another perspective to their treatments. However, some element of reciprocity about needs was expected. As has been stated earlier, consistency of care was identified as important from

the participant's point of view and they believed consistent follow-through with a student added to student support:

I see quite a few. That doesn't matter at all. You just think, "Well he's got a better idea than the other one." That's the beauty about it. Different ways of doing things. 1(9)

Part of the student support required that participants simply accepted what was on offer from the student:

You see the difference of capability [of the students] ... they ... [are different] but that doesn't worry me. 9 (4)

For some, student support was very much in the background and receiving dependable, on-going care was the critical issue:

It doesn't bother me as long as the consistency of treatment is there. 8 (2)

It was evident too that the participants felt confident and valued the knowledge and guidance that students shared with them in relation to their care. Student support was indeed multifaceted and involved the service user/participants, the clinical educators, and also other students. Participants were especially pleased if a clinical educator was present in the learning environment to oversee the treatment plan:

It's a learning environment ... the supervisor... is really good at explaining why and what is going on.The students are good too actually ... they chat away and explain things. 2 (5)

[Students are] very closely supported. ... they talk to the supervisor, ...[who will] confirm that the student is on the right track and then they'll sort out a treatment plan. 8 (3)

I see them helping. ... Each student I've got has been good. ... You have a tutor right alongside you after that too. 1 (7)

No I don't mind at all [having different students undertaking the care] ... if they are not sure they go and ask somebody and they check. ... I'm confident in the service. 3 (6)

Furthermore, it was noted that the participants felt secure when working with the students, as they would always seek support from a clinical educator. The learning environment was observed to be comfortable, ultimately enhancing student's learning:

In all clinics that I have been in, they have been always working closely with the clinical educators and they refer to them at all times and if unsure they will again ask them questions. It's a very comfortable kind of learning situation. The students feel that they are able to ask them questions. 15 (5)

Another participant observed that as long as the student delivering the care referred to the clinical notes, they saw no issue in having different students work with them. This flexibility with which students deliver care was viewed by the participants as supporting student learning:

I don't see any problem as long as they [different students] ... read the notes and ... consult with the supervisor lecturer. 15 (4)

Two participants commented when a student did not appear confident completing their treatment they felt in safe hands when the clinical educator increased student support by being present throughout

the treatment process. Guiding the students and assisting with the learning process improved student support:

The student didn't have a lot of confidence but luckily the support of the pairing of another student helped ... and also the Clinic Manager stepping in and providing that ... I suppose authoritative approach. 7 (3)

Two Way Learning

Overwhelmingly all 15 participants spoke about the importance of supporting student learning. What they had not realised though, was the learning would be two-way: they would learn from students, as students learned from them. In this instance participants were learning with the students, about the student, and from the student. This is foundational to collaborative learning (CAIPE, 2012). The participants believed that their intention of contributing to student learning was to better prepare the students who were to become the health professionals of the future. Involvement with the student's learning had a spin-off effect for participants, who also gained personally from the experience. Being active in the student learning process and learning more about themselves and their condition was important for the participants. The term 'helping' was identified by participants and consistently linked to two way learning:

I think initially I was worried about the setting ... but after that it was a learning experience for me as well. ... Helping them to

learn. 13 (2)

A benefit is that it helps students progress in their area of discipline. 7 (3)

I feel that it's helping students, which ultimately helps other people because they will be added to the workforce wherever they may end up, so it is a two way thing. It is giving to the students as well as for myself. 5 (1)

Other participants observed that supporting student learning had a positive spin-off. They felt that their life experiences added to the student learning, and in return the participants perceived that they received appropriate care, as students were supported:

Very positive [learning]. ... They learn a lot from the patients. 3 (3)

I am very happy to be a person that students learn on ... I know that they are supervised. 11 (2)

The participants believed that there was nothing like learning on the 'real person '. They thought learning was more likely to be meaningful if it was to be compared to learning from a mannequin or practise on fellow students. The participants observed that their input was important and a necessary part of student learning:

[Working with a real person who has a health issue] gives an experience to the students ... if they haven't got anyone to work on then they're just working on a dummy, or one of the other students. It's still not the same as a patient. ... It's alright to have it in a book, but they do [need to work with people]. 1(11/6)

1 ()

They're learning and so that contributes towards their education, future education ... it's best that they learn on examples rather

than trying to read it all in a book, because every person is different. 8 (2)

As has been stated, although the focus at the Clinic was the clinical experience for the students and the delivery of health care to service users, nevertheless, participants became aware that they learned from the students at the same time. Learning became a two-way experience that served both students and the participants:

I think I've learned something and that's another reason why we come here because people are learning and what better than to learn on the real thing. 3(3)

Participants referred to the two way partnership that enabled them to access the services at the Clinic in return for supporting student learning:

It is a great idea that [the Clinic] provides a service for the public that also benefits the students because they are getting to practice on real people. [The students] teach me as well – they educate me ... 2 (10)

For some, the opportunity to receive treatment at the Clinic was seen to be a way of supporting the students. In particular, participants became involved by questioning the students and noting the response. Participants saw the investment of their time as a two way exchange, as they perceived students were more eager to share knowledge. Working with the students in this way was very clearly a learning experience for the participants:

I'm a huge supporter of student professional development. I

find that being treated by students with their supervisors a lot more informative, a lot more inter active. And the students try very, very hard. ... So for me it feels a little bit more of an exchange rather than me just accessing and paying for something that's there. 4(1)

It was a learning experience for me as well. Helping them to learn. Asking them questions definitely, but also seeing how they respond. 14(3)

One participant was aware that because students were learning, they may not be as proficient in skills and time management.

Nevertheless, the disadvantages were put to one side because in return the participant perceived their care to be more interactive and informative:

I find that being treated by students with their supervisors a lot more informative, a lot more inter active and the students try very, very hard. So it takes a lot longer. Sometimes you're not always sure you are getting the best treatment, at least the most steady hands etc, but it is certainly something I support. 4(1)

Another participant recognised the importance of having the opportunity to contribute to student learning through participation in research. This was observed as a positive outcome for both the students and participant:

It's great as a patient to be able to give back to that sort [working with students in the Clinic] of research. 5 (1)

Communication

Communication, including active listening and the recognition of the service user as an individual, was important for participants.

Communication also included the health professional's use of appropriate language, and their explanation of the treatment to be provided.

However, the communication was seen to be confined to the individual disciplines (uni-professional). In other words, communication may have been effective, but it was discipline specific.

Most participants observed that the students worked hard to communicate at an appropriate level with service users. Students focused on explaining medical terminology in a manner that service user/participants could understand:

They use terminology and make you feel at ease ... the communication is quite easily understood and welcoming. 7 (5)

They ... explain things in ordinary everyday language right from the medical things... 10 (7)

I think they make the best effort not to use as much jargon, but then they are taught to be specific and so I think while being specific, they do have to use terminology, but I think they will often explain what they think are the terms that are difficult for new users to know. 4 (4)

They always use jargon because they're learning, but it's nice when they translate that into layman's terms for the patient. 8 (8)

Participants valued the student's explanations of what was happening throughout the delivery of care and the manner in which the communication was delivered. In turn, the participant felt respected and valued as a person:

If it's a medical term, they ... explain it to you. ... as they are [carrying out a treatment] they are ... talking to you and telling you what they are doing. They always ask your permission if they are doing something. 3 (13)

Other participants reported that they felt confident to ask for clarification of what was discussed, if they did not understand the medical terminology used. The participants also believed that by seeking clarification they were drawing attention to student communication and showing students that they must clarify and explain what they were doing. Asking questions to improve communication and understanding acted as a form of coaching. In other words, service user/participants indirectly coached students how to communicate better:

They use jargon...[I say] " I can't understand what you are saying. I understand what you are saying but I don't know what you mean". I think the student needs to be able to clearly show the different parts on the chart so it's more understandable. ... it should not be something out of the ordinary for them. 12 (8)

They communicate ... at a level that I can understand. If there's anything that I have come across ... that I don't know, I always ask. 15 (5)

One participant observed that when attending the Clinic the communication used to explain terminology and to communicate about health issues was conveyed in a non-intimidating manner. Mostly, the language was observed to be orientated towards the general public. This was important, particularly when communication was compared to what happened with other health providers:

I don't think [the Clinic] is an intimidating area where as sometimes when you go into ...GP's ... you can sort of be intimidated with regards to the presence and ... when they start talking with regards to terminology and what's wrong with you and the different solutions ... you almost need to get out a translation booklet. ...I think [the Clinic] is very orientated towards the general public. 7(5)

Three participants observed that good communication was based on valuing of the participant's individuality. This added to the sense of inclusion that enhanced communication:

You have become like a human and not just a number. They actually ask you and interact with you. They listen which I think is really, really good. 3 (9)

As well as you're talking about a person, not a complaint, and that person is present. 8 (7)

Even if communication was not always clear, it seemed that students tried to convey their genuine efforts to interact with the service users.

Well I don't know if a patient would be able to fully comprehend everything that they are saying, but it's making sure that the patient feels like they are still in the room. So if they are talking, even eye contact or just making sure that the patient feels like they're still present. 8 (7)

Several participants remarked that good communication skills are an essential part of health care delivery. It was observed that until students gained confidence in their communication skills some students struggled with communication. Another participant suggested that communication is a learned skill for some and believed their input into the student's learning was of importance. For instance:

I think it's part of ... [the student] experience to have to learn how to communicate with a patient but I think sometimes that may be a difficulty for them. They're a bit shy or a bit uncertain. 9 (9)

Maybe one or two are quieter, but that's just like people generally. 6 (13)

Two participants noted that they felt confident that communication could be developed, as the students would seek assistance if they were not clear with information in regards to the delivery of care. Another participant was particularly impressed by the student's recall of a lesson they had attended and the way the student was able to communicate and adapt the explanation to the participant's level of interpretation:

If they don't know something they will go and find out. If they do they will spend the time explaining it to you as best as they know how and sometimes you can tell they have just had a class on it, but it's brilliant because the recall is important for them as well as the ability to then explain it in a different way than they've been told to someone who may or may not have that background. 4 (4)

Yet another participant observed that the students had acquired the art of listening. This was appreciated and noted as an important skill for health professionals:

They listen which I think is really, really good. 3(13)

It appeared that all participants had thought about shared clinical histories, and case notes. However, overall the participants could not relate the usefulness of shared notes to the improvement in the

delivery of their health care. Written communication was only seen as useful if the notes could be interpreted by other health professionals:

If they [students] can understand each other's notes, [that is useful] ... but sometimes [communication] needs to be verbal. 4(8)

Because it's in the file ... each person adds their own perspective, ... It's a lot of reading for somebody else ... [to] absorb all that information before the consultation so that they don't have to ask the same questions again, but that can be beneficial too. 5 (3)

Conclusion

In summary all of the participants interviewed for this research were impressed by the care that they had received at the Clinic. As well they were very supportive of the students, finding both the students and clinical educators worked in a professional manner.

Overwhelmingly, all participants who attended the Clinic felt they had an obligation to support student learning and believed that they had knowledge and life experience to enhance student learning. From this experience of working with the students and supporting their learning the participants also gained knowledge in return.

Nevertheless, no participant experienced collaborative care or integrated care. Several participants noted that the individual disciplines worked in a siloed (uni-professional) manner, although the Clinic is part

of the National Centre of Interprofessional Education and Collaborative Care. Working together was observed between students and clinical educators within the uni-professional settings such as podiatry, physiotherapy, or oral health however no one noted collaboration between any other health disciplines that were co-located at the Clinic.

In the following chapter a discussion of the overall findings of the study is put forward and integrated with literature. Also included in the next chapter are the limitations of the study, the implications and recommendations for the development of collaborative care at the Clinic.

Chapter Five

Discussion

Introduction

The aim of this research was to explore service user's perspectives of collaborative care received in an Integrated Health Clinic. As has been seen in Chapters One and Two the role and importance of the service user input into the planning and implementation of collaborative care has been the centre of extensive dialogue for over a decade. This is based on the understanding that service users are pivotal in health service delivery (Stewart, 2009). In this final chapter, the overall findings are outlined; key issues are identified and patient-centered care, communication, and teamwork and integrated care will be explored and discussed in relation to the service user's place in collaborative care. In the last sections of the chapter the limitations, recommendations, and implications for further research are identified.

Research Findings

Specific responses to the research questions were presented in Chapter Four. Three themes were identified: user expectations, user perceptions, and user observations (Table 1).

Table 1 Themes and Sub Themes.

User Expectations	User Perceptions	User Observations
Accessing services	Models of care	Student Support
Sense of Security	Uni-professional working	Two Way Learning
Practical Issues	User involvement	Communication

The findings indicate that while the service user/participants did not receive collaborative care at the Clinic, unequivocally, they would have liked to have received collaborative care had they had the opportunity. The service users did however favourably comment on patient-centred care, communication, team work, and supporting student learning, which were all important reasons for them continuing to attend the Clinic. Although participants did not label care as collaborative, it is argued that the model of care experienced was in the initial stages of developing collaboration. This argument is put forward because communication, patient-centred care, and learning with, from, and about each other are foundational to collaboration. It seems that, regardless of the answers to the research questions and the mixed responses overall, participants had a positive experience of the model of care when attending the Clinic. The results from these findings are similar to previous writings of the topic (Furness et al., 2011; Shaw, 2008).

Several specific points are of interest in the research.

Patient Centred Care/ Supporting Students

The service user's identified that the partnership established with the students was a key reason for attending the Clinic. The participant/service users enjoyed being the receivers of patient-centred care and valued their involvement with the planning of their health care. Furthermore, the participant/service users appreciated that they were recognised, respected, and that the students were genuinely interested in whether the treatments had worked for them at follow-up appointments. However, it was clear that the model of care was uni-professional working, rather than an integrated collaborative care model. While it was not labelled as patient-centred care, participants certainly felt they were the centre of the student's attention.

The service user/participants commented on the fact that their individuality and special health requirements were taken into consideration when receiving care at the Clinic. This was of particular importance to them, as it demonstrated sensitivity to their individual requirements and enhanced a patient-centred approach. At the same time they believed that they were accessing innovative treatments, as the Clinic was situated in a University. All these factors ensured that visits to the Clinic were seen as positive experiences.

It was apparent that service user/participants enjoyed participating in student learning experiences. They were not phased to have a different student at each visit delivering care, providing there was consistency in the handover. Some service user/participants found it advantageous to work with different students, as this often meant they were exposed to another viewpoint, with new ideas that were often more successful. This change of students, also gave service user/participants a point to reflect on their treatment progress when clarifying the treatment plans with the new student. Nonetheless, there were those service user/participants that preferred to work with the same student, particularly if a professional rapport had been developed. They noticed that appointment times were longer while a the new student updated their knowledge with clinical notes and questioning. However, overall the time factor for most of the service user/participants was not an issue as they stated this was part of supporting student learning.

Communication Matters

The service user/participants did not believe they had witnessed the different health professionals either working together collaboratively, or communicating across the professions. Nonetheless, the communication observed between student, clinical educator, and the service user was seen as being effective. Although the interaction observed was consistent in uni-professional working, communication

was open and gave the service user/participants a sense of security, as the students would seek support from their clinical educators when required.

It was also clear that information sharing in a written form was important. The sharing of clinical notes had a variable response with some participants not seeing the need for this, and others trusting that the sharing of the information added value to their health care. This latter group hoped shared notes would prevent repeating information at each visit. In the same way service user/participants considered information which outlined the services and objectives of the Clinic should be clearly visible and available to each service user.

Service user/participants were impressed by the manner in which the students could describe the treatment and respond to their questions. Adapting the language and terminology to the appropriate level was especially important for participants, as they felt respected. Being recognised, listened to, and treated with respect, inspired a sense of being valued. From this experience the service user/participants believed that the trusting relationship established with the students and health professionals was a good basis from which to develop patient-centred care.

Why this Clinic?

Overwhelmingly, all participant/service users were quite clear as to why they choose to attend the Clinic. For many the affordability, availability, and accessibility of the services offered was critical. The presence of a clinical educator was perceived as a positive benefit as well. Similarly, the approachable, welcoming, and friendly manner of all staff was considered an asset. However, the popularity of the Clinic makes appointment access increasingly difficult. The lack of appointment time is not assisted by the waiting lists that develop during inter-semester breaks and at student examination times. This can cause a disruption to the treatment plan or require service users to find an alternative service.

Interestingly, the service user/participants initially learnt about the Clinic informally, through friends or fellow work colleagues. The lack of information about the Clinic is problematic. The service user/participants suggested that the Clinic and its services needed to be marketed, using a mix media approach.

The Learning Environment

One of the key aims of the Clinic is to offer clinical learning for students under the guidance of clinical educators. This learning environment impacted on the service user/participants, as they came for a treatment but in return became involved in the student's learning. There was an

overwhelming response from participants that they felt they had an obligation to support student learning. They believed that their experiences and range of medical issues were unique and added value to student's learning. Equally, working with students developed into a two-way learning experience, as the service user/participants learned from the students at the same time. As the students explained treatments, using the appropriate language and service users became involved in the process and worked with students to achieve their health goals.

The service user/participants noted that there was a need to provide information for both the service users and students prior to the commencement of the initial treatment. This information needs to outline what service users should expect from the service, and approaches as to how service users can best support student learning.

Discussion

Student learning about collaborative care has become increasingly important in recent years. As was noted in Chapter Two there has been a push to create a core competency or capability framework for interprofessional learning and collaborative practice. Various organisations and writers such as The Canadian Interprofessional Health Collaborative (Bainbridge et al., 2010), the World Health Organization (2010), Walsh et al. (2008), and Nisbet et al. (2011) have established a

recommended set of interprofessional collaborative competencies. Interpretations of what is a critical core competency are slightly different. To date, while there are commonalities, collective agreement on the core competencies varies. Part of the problem could be that current frameworks are based on “best guesses” of the competencies or capabilities that are important for interprofessional collaboration and practice. Nonetheless, it is apparent that there are common domains in the frameworks developed. Core competencies to date include: roles and responsibilities; patient-centred care; interprofessional leadership; interprofessional communication; team conflict management; teamwork; and ethical values.

In this next section the discussion focuses on several key factors in collaborative care that stand out from the service user’s point of view. These are patient-centred care, communication, and teamwork and integrated care. Teamwork and integrated care have been combined because the overlaps in the discussion made it too difficult to separate them into discrete sections. These areas have been chosen firstly because they are identified as core interprofessional competencies by some. Secondly, they were identified by the service user/participants as being important for service delivery. The discussion opens with a short analysis of patient-centred care and its relevance for collaboration. Some observations about communication and collaborative practice follow.

Finally, teamwork and integrated care and its place in interprofessional collaboration is reviewed briefly. That section incorporates critical reflections on collaborative learning, which seems to be underestimated as regards its influence on collaborative practice development.

Patient-Centred Care

As was illustrated in the early chapters of this thesis health care structures have been constantly re-evaluated internationally to keep pace with the rapid changes in health care. For many years for instance, there has been a greater emphasis on primary health care. In addition, the focus on patient-centred care has increased. Patient-centred care, combined with consumerism, has prompted service users to take a more active role in their health care by working collaboratively with health professionals. This involvement and its nature is clearly articulated in the Canadian Interprofessional Health Collaborative (Bainbridge et al., 2010). In that framework the Patient/Client/Family/ Community-Centred Competency statement is: "Learners/practitioners seek out, integrate, and value, as a partner, the input, and the engagement of patient/client/ family/ community in designing and implementing care/services" (p. 9).

This definition of patient-centred care encourages service users to be proactive in maintaining their health. It is consistent with previous writings by Solomon (2009) and Mickan et al. (2010), who argue that service user's health outcomes improve when they feel a sense of

involvement with their own health needs. Patient/service user involvement in collaborative care is not new. For example, Coulter (as cited in Pelzang, 2010) defined patient-centred care as: "Health care that meets and responds to patients' wants, needs and preferences and where patients are autonomous and able to decide for themselves" (p. 9). Wagner et al. extended the discussion further observing that "patient-centred ... care means different things to different people and disciplines. Regardless of perspective or definition, all represent reactions to the perceived inadequacies of traditional medicine" (2005, p. 9). Gilbert (2005) perhaps sums some issues up when he suggests that it is the patient who is the centre of attention in collaborative practice. Gilbert also argues strongly that the patient focus "goes beyond the skill and scope of any one profession" (p. 87).

These views about patient involvement were seen in this study in that participant/service users made an individual choice to attend the Clinic. They were all quite clear that they wanted to maintain or improve their personal health status, and believed in taking responsibility for their own care. This belief system is in line with one of the aims of the New Zealand Primary Health Care Strategy (2001), which recognises that individuals need to take responsibility for their health problems or concerns, to assist in maintaining independence, preventing the onset, and progression of disease and disability.

Taking an active responsibility for health goes some way to improving involvement in decision making. According to Goode et al. (2011) the service user is central to the decision making process when planning care. Consideration of the service user's individual preferences, values, and previous health care experiences need to be addressed to attain patient-centred care. This was certainly reinforced in this study. As has been seen, the participant/service users believed that the general patient-centred care focus gave them a sense of being valued, as their stories and experiences were listened to. The notion that service users want to be respected, recognised, and feel valued is well recognized in the literature (Furness, Armitage, & Pitt, 2011; Hopkins et al., 2009). It was evident also in practice at the Clinic as the service users spoke about being involved in their health care. Thus they were empowered to accept or not accept the health care offered by the students. The sense of control engendered by this approach has been reported elsewhere (Hopkins et al., 2009; Law et al., 2010; Wagner et al., 2005). This illustrates that many facets effect patient-centred care, and taking those issues into account has consequences. According to McCormack (2003), the idea of empowering service users to make decisions has changed the balance of power, subsequently changing the view on the role of the service user in health care decision making.

The changes have impacted health professionals–patient

relationships. It is now widely recognised that health professionals have a responsibility to support service users, to manage their own health care. Overall, there is agreement that the service user should be included in the decision making process about their care, and more importantly, be able to make choices about the health care they receive. (Dzur, 2008; Fischer, 2006; Sullivan, 2005). The patient-centred care model has the service user as central to the delivery of care, with the required services arranged as needed. Interestingly, Pelzang (2010) reports that this model of patient-centred care is likely to improve collaboration and service integration, as health professionals collaborate on behalf of the service users for the care required. This way of working encourages health professionals to plan, and implement practice that is largely receptive to service user's needs.

There is no doubt that service users expect to be part of the planning of their health care, and care needs to be appropriate and accessible (D'Armour & Oandasan, 2005; Mickan et al., 2010; Nisbet et al., 2011; Smith & Ross, 2007). Nonetheless, as was seen in this study, the service users differed in the amount of involvement they might have. For example, some were proactive and believed that it was crucial to be included in decision making around their care. In contrast, others found the idea of inclusion daunting, and chose to leave the decision making to the professionals. Pelzang (2010) acknowledges that shared decision

making in patient-centred care assumes that the service users are capable of making decisions and choices about what health care they require. This is further supported by Wagner et al. (2005), who argue that if service users are to make informed decisions, it is essential that they are educated and learn what it means to be involved in self-management. At the same time it needs to be acknowledged that educating people does not solve everything. Professionals need to be mindful that wellness means different things to different people. Therefore, service users bring an individual approach to the notion of their own well-being and for this reason no one treatment is best for all (McCormack, 2003).

Surprisingly, although the model of patient-centred care appears to be relatively straight forward, Pelzang (2010) reports implementation into practice has had its problems. One issue identified is the confusion over a definition and method of evaluation. This is further supported by McCormack et al. (2010), whose research identified that the patient-centred terminology "lacks common and shared meaning" (p. 621). Confusion arises when terms such as person-centred, people-centred, and patient-centred appear interchangeably or side by side in some literature and in professional discussions (Slater, 2006). If terminology is confusing, and there are mixed understandings about who is involved, and what is possible, collaboration is possibly undermined.

This illustrates that if we are to achieve a positive culture about patient-centred collaborative care, a new way of working will be required. It will be a way of working with patients/service users so that social and interpersonal factors are included. Including appropriate communication, learning how to talk and listen to patients, embracing new ways of delivering care, will all be crucial (Wagner et al., 2005; Pelzang, 2010).

Furthermore, if a model of patient-centred collaborative care is to be successful, its promotion will require the commitment and support of the service leadership team. Leaders will need to develop a clear vision and strategic plan on how patient-centred collaborative care will be delivered. This will also necessitate an on-going education programme for all health professionals and possibly induction workshops and training for service users (Barnes, Carpenter, & Bailey, 2000; Goode et al., 2011; Hobbs, 2009; Pelzang, 2010). Indeed, Wagner et al. (2005) argue that a successful team “requires role definition, co-ordination, and communication. These do not happen spontaneously and need to be planned” (p. 12). Without a supportive leadership team, the patient-centred care model is unlikely to develop as it needs to, to support collaborative practice. This could be due to a lack of commitment by all team members to work with this model of care, which could influence whether service users have access to interprofessional collaboration and

the innovative potential it offers (McCormack, 2003). At the same time, communication will be critical.

Communication

It is widely acknowledged that formal and informal communication are essential for patient-centred collaborative care (Gaboury et al., 2011; McCallin, 2006; Nisbet et al., 2011; Suter et al., 2009; Zwarensten et al., 2007). As discussed earlier in the chapter, The Canadian Interprofessional Competency Framework statement for the domain of Interprofessional Communication states that: "Learners/practitioners from varying professions communicate with each other in a collaborative, responsive, and responsible manner" (Bainbridge et al., 2010, p. 9).

Rice et al. (2010) view "collaborative communication as a two way exchange of information between professionals that is conducive to developing collaborative working relationships, in contrast to a top-down pattern of communication which has traditionally characterized interprofessional interactions in health care settings" (p. 351). This type of communication is dialogical in that those involved talk with each other, holding judgments and assumptions, all the while keeping open to ideas and listening for what is really meaningful for the service user/participant (McCallin, 2006). This is further supported by Zwarenstein et al. (2007),

who suggest effective communication between health professionals and service users is essential to cultivate a collaborative working rapport.

While communication with service users is of paramount importance, it seems that health professionals also need to communicate effectively with each other, if they are to work collaboratively. Gaboury et al. (2011) identify that the positivity or negativity associated with interprofessional collaboration depends on the trust, cooperation, and knowledge exchange that occurs with colleagues beforehand. This is further supported by McDonald, Vickers, Mohan, Wilkes and Jackson (2010), who suggest that health professionals are more likely to communicate, if they trust each other in the work environment.

According to Suter et al. (2009), the ability to work with other health professionals to deliver collaborative, patient-centred care requires a specific set of competencies, including communication of understanding other health professional's roles, mutual trust, and respect. Gaboury et al. (2011) and Sheehan et al. (2007) report that effective communication has a positive outcome in that it increases work satisfaction between health professionals. However, it was also clear that effective communication motivated health professionals to work together collaboratively. Furthermore, positive communication and supportive relationships between the health professionals lead to them feeling less stressed, more comfortable at work and able to enjoy work (MacDonald

et al. 2002). Communication overlaps with relationship building, and consequently, building team relationships is crucial in collaborative care. It seems that before effective teamwork and professional communication can occur, health professionals need to develop trusting and supportive interprofessional relationships (McCallin & McCallin, 2009; Report of an Expert Panel, 2011; San Martin-Rodriguez et al., 2005).

Not surprisingly, Rice et al. (2010) report that poor communication between professionals relates to poor service user outcomes. On-going communication is essential for service user's care. There is a belief that undergraduate students need to be taught communication skills, so they are well prepared to communicate effectively with colleagues, service users, and families. This goes some way to improve interprofessional collaboration and effective communication in the long term (Rice et al., 2010; The National Chronic Disease Strategy Report, 2006).

Communication though can be challenging. Communication is important for understanding other health professional's roles, for effectual team working, and demonstrates a willingness to work collaboratively (McCallin & McCallin, 2009; Suter et al., 2009). For example research has shown that interprofessional learning in a clinical setting such as the Clinic has a positive effect on influencing the interprofessional attitudes of students and opens up opportunities for communication. (CAIPE, 2012; Hayashi et al., 2012).

It was evident in this current study that service users thought students communicated well with their patients. Working in the Clinic required broader forms of communication, which were equally important. For instance, service users believed students ought to have an understanding of the other services offered, and the role of other health professionals co-located in the Clinic. This was seen as important, in the event that a service user might require the services of another professional within the Clinic, and need referral. These views are consistent with observations by earlier writers in the field. Suter et al. (2009) for example state that "recognition of other professionals for patient care is an important prerequisite for collaboration to occur" (p. 43.) This is further supported by Hall (2005) and San Martin-Rodriguez et al. (2005), who note that without common understanding of roles, effective communication and rapport with others, including service users, may be difficult to develop.

Communication that is effective also encompasses the process of information sharing. According to Smith and Ross (2007), accurate information creates a trusting relationship, developing open and honest communication between the health professional and the service user. Information must be provided in a meaningful manner that the service users can understand. This may need to be in several media forms such as written, verbal, or through advertisements. Furthermore, there is a

greater than before public expectation for openness and accountability in relation to health care (Smith & Ross, 2007).

It seems that if health professionals want to include service users in the collaborative process, the method of communication is crucial. As well, they will need to pay attention to inclusive participation. D'Amour and Oandasan (2005) report "care provided to the service user and the service user's willingness to participate are key factors in integrated health care" (p. 9). According to the Report of an Expert Panel (2011), listening actively and using respectful language supports a collaborative patient-centred approach. Indeed, Suter et al. (2009) suggest that adapting language and using terminology to an appropriate level for the service user is critical.

Furthermore, as stated in the Report of an Expert Panel (2011) and in writings by McCallin and McCallin (2009), the use of professional jargon creates a barrier to communication with service users. However, by adapting the language used to reach the target audience contributes to safe and effective collaborative care. Overall, participants felt that the trusting relationship that had developed with the student gave them the confidence to ask for further clarification. This is consistent with previous research in the area (Smith & Ross, 2007; Suter et al., 2009). This is further supported by the findings of Shaw (2008), where it was reported that the rapport and the relationships developed between the service

users and the health professionals instilled confidence in the treatment received by the service user.

Overall, it is clear that the evidence shows (The Report of the Expert Panel, 2011) that to begin to work collaboratively demands equipping health professionals with new skills and new ways of communicating with each other and the service users. Further to this, McCallin (2005) argues that self-development, team development and communication skills are crucial in order to acquire collaborative skills.

Teamwork and Integrated Care

For the purpose of this discussion integrated care is: “that health services work collaboratively with each other, and with patients and their families and carers to provide person centred optimal care” (National Health Priority Action Council (NHPAC), 2006, p. 11). The Report of an Expert Panel, (2011) in the Core competencies for Interprofessional Collaborative Practice state the domain for Teamwork as “relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-centred-/population-centred care that is safe, timely, efficient, effective and equitable” (p. 25).

As is clear, there has been a plethora of literature published about integrated collaborative care (Oandasan and Reeves, 2005; San-

Martin Rodriguez et al., 2005; WHO, 2010). However, confusion still exists over a definition and interpretation of integrated collaborative care which is very often used synonymously with teamwork. This is not helped by the use of a range of terminology, which further creates misunderstanding with the semantics in relation to integrated and collaborative models of care. Understanding is complicated when different prefixes to describe these models of care, for example, interprofessional, integrated, multiprofessional, uniprofessional, and collaborative are introduced (McCallin, 2006; Thylefors, Persson, & Hellstrom, 2005). Frequently, these terms are used interchangeably, adding to the confusion for service users, and some health professionals who do not have a well-defined understanding of the terms to start with. The terms integrated and collaborative care are dominant within international policy planning, such as the World Health Organization and seminal literature. Nevertheless, the terms collaborative and integrated models of care are confusing and add no value to the care received for the service user. Overwhelmingly, this has been reinforced by the findings of this study in which service users did not understand the term collaborative care.

However, the participants understood and could relate to the term teamwork (Barr, Hammick, Koppel, & Reeves 1999). Although the service users observed teamwork in action between the individual health

disciplines, this did not appear to extend to a collaborative approach. Teamwork has been the most commonly discussed term in relation to collaboration. According to Barr, Koppel, Reeves, Hammick, and Freeth (2005) "collaboration is sometimes treated as being synonymous with teamwork. ... All teamwork is collaboration, but all collaboration is not teamwork" (p. 4). Indeed, this was reflective of the Clinic where collaboration is discussed 'as occurring.' In reality, service users witnessed teamwork.

There was an opinion amongst the participants that had collaborative care been offered, they would have appreciated the opportunity to be part of this. However, consistently the participants identified receiving uni-professional health care and referred to this as siloed care. Siloed care tends to occur in teams that are challenged by the constant change within health care systems. During these difficult times the individual health professionals tend to retreat into their professional groups where they work in a siloed manner rather than as a collaborative team. Service users therefore receive a minimised form of integrated care (Hall, 2005; Mitchell 2005; Reeves et al., 2008; Sheehan et al., 2007). Indeed, successful teamwork that supports integration requires a social competence. Therefore those professionals who lack the social skills to interact co-operatively with other team members may choose not to work collaboratively. Thylefors et al. (2005) argue that:

“An integrative teamwork also demands resources of another kind – social competence. Close co-operation tends to exclude professionals who lack ability or motivation for this social intimacy ...” (p. 111). This is further supported by Mickan and Rogers (2005) who identify that team members need to be socially competent and willing to share information.

This also highlights that service users in this study preferred to see the same clinician or student to complete their treatments and believed continuity of care was important. These findings are consistent with work by Smith and Ross (2007) whereby service users report feeling reassured to have continuity of care delivered by the same health professional or the same multi-professional team. This was identified as a key issue to address when developing integrated health care.

Team working and collaborative care have been an initiative in health care, especially within the primary health care sector, for at least the past three decades. This has been driven internationally by governmental future planning/workforce policies. The emphasis is designed to meet the needs of the increase in the population worldwide, the increasing complexity of health needs, the ageing population, and an ageing workforce (PHCAC, 2009; New Zealand Primary Health Care Strategy, 2001; WHO, 2010). Interestingly, although the Clinic has been established for 20 years the findings suggest that integrative collaborative care is still at the developmental stages. The team working

at the Clinic links to the findings of Schmied et al. (2010). These authors argue that there are components of collaboration that can exist on a continuum from co-existence, to collaboration. In co-existence services are offered independently, and maybe fragmented; cooperation is identified when ad hoc communication between professions occurs; coordination is evident when there is a degree of shared decision making between the health professionals, to "integration and co-ownership which are formal arrangements based on common values, where there is no differentiation between services' (p. 3518). It would seem that at the time of this study teams were co-located and co-existed, cooperating occasionally as required. This level of team working maybe sufficient for the Clinic, as the service users reported satisfaction with the care received, and the types of services offered make collaboration difficult. Service users seeking an oral health check do not necessarily want to have a foot assessment.

This goes some way to illustrate that "teams cannot and do not function effectively simply because a group of people is labeled as a team" (McCallin, 2006, p. 9). Thus, naming the Clinic as an Integrated Health Clinic does not guarantee that either teamwork or collaborative care will take place. To be successful, integrated health service delivery requires the health professionals are fully engaged in the idea of collaborative care and working with other health professionals, and that

they role model and reinforce collaborative care to students working within the environment (Atwal & Caldwell, 2002; CAIPE, 2012; Goode et al., 2011; McCallin, 2006).

Despite what is becoming a myriad of problems, teamwork is important, as is the partnership developed between the service user, students and health professionals. Surprisingly, service users felt they had an obligation to support student learning, as they believed they had a wealth of knowledge and their perspective added value to the student's learning. These findings have been reported elsewhere (Furness et al., 2011; Shaw, 2008; Smith, & Ross 2007). It seems that service users appreciate sharing their experiences and believe this experience is of value to students in their future careers. For example, Cooper and Spencer-Dawe (2006) report that the principles of teamwork break down barriers to communication between service users and health professionals. Importantly, the service user becomes the centre of the care process and shares an important role in the integrated and collaborative team (Interprofessional Health Education Australia, 2011). Added to this WHO (2010) highlights the stance of interprofessional learning in supporting the development of a collaborative practice-ready workforce where health professionals work collectively in delivering quality health care. It seems that service users want to be included in

teamwork. According to Mickan et al. (2010) service users expect to be part of the planning for their health care.

However, in this study teamwork occurred uni-professionally and collaboration not at all. The participants expected to observe the health professionals and students role model collaboration. In reality, this was not the case. Although collaboration may theoretically be an ideal model for present and future health care, it would appear that collaborative care depends on how this is supported by the health professionals. As McCallin and McCallin (2009) argue "today collaborative teamwork is no longer an option: it is a basic prerequisite for effective practice and quality care" (p. 61). This raises yet another issue that, although some students are exposed to interprofessional learning, are professionals in practice working in teams and modelling collaborative care.

In fact, Solomon (2009) and McCallin (2006) remind us that collaboration and teamwork are not recent concepts and what is required is a change in culture. In other words collaborative care needs to be the fundamental way of working, placing the service user at the centre, driven by patient safety principles. The participants from this study did not believe they were central to care planning, although some felt they were included in the care.

Despite this, it is some comfort to realise that Hayashi et al. (2012), and CAIPE (2012), report that interprofessional learning in a

clinical setting such as the Clinic has a positive effect on health students, influencing interprofessional attitudes and teamwork. Wright and Lindqvist (2008) observe that active involvement in teams goes some way to developing interprofessional learning opportunities. Health professional role modeling of professional and cultural beliefs and attitudes can affect their willingness to collaborate with other health professionals. For this reason educators can either support or impede student's opportunities to become involved in collaborative learning. This role modelling may influence student's perception of other health professionals and working collaboratively (D'Amour & Oandasan, 2005).

Therefore, it is argued that the findings from this study have highlight the importance of having an Integrated Health Clinic that has the unique purpose of offering collaborative care and interprofessional clinical learning for students. However, it is imperative that collaborative care is modelled for the students. D'Amour and Oandasan (2005) suggest that "[there is] a need to foster collaboration with the involvement of patients/clients and health care professionals, learners and educators and institutional leaders and policy makers" (p. 18). This suggests that interprofessional learning development is required.

Frenk et al. (2010) suggest that interprofessional learning is a process to improve service user's health care, both at an individual level, as well as at a community/population health care level. In this structure

interprofessional learning and health professionals learning are in a dynamic partnership with the health care organisations, which become more responsive to the changing health needs of the communities they serve.

The following section is the concluding section of this research report. Included are the limitations of the study. The recommendations and implications for research are outlined. The section closes with a concluding statement.

Limitations of the Study

While personal learning has been significant throughout the research process there are several limitations within the study.

As the service user/participants self-selected they are more likely to have positive view of the study. Consequently they are unlikely to be representative of all the service users who access these services. Therefore, they become but one small sample of people who were interested in talking about their experiences of collaborative care at the Clinic. It is possible, even likely, that others who attend the Clinic may have very different views. This could create a positive bias in the results (Braun & Clarke, 2006).

A further limitation to the study could be seen as the one on one interview process that presents indirect information through the eyes of

the interviewee. Not all people are as articulate and or perceptive in their responses (Smith, 2008). For that reason the same set of questions were used for consistency. There was a possibility of bias grounded on the manner in which the questions were asked, responses followed up, and data selected for presentation. Every effort was made to represent all views fairly and to avoid bias. The participants who volunteered for the study tended to be articulate and were keen to share their experiences at the Clinic. Not all people are as expressive and/or perceptive in this way. It is possible that the participants who worked in the University were accustomed to analyzing situations and putting forward their views (Thomas & Hodges, 2010). However, as the questions from the study have been replicated from a similar Canadian study, this increases the validity of the study and could be useful to others to develop for future studies (Creswell, 1999).

Data collection and analysis were conducted by the researcher who was independent of both the service users and the Clinic. Steps were taken to maximise objectivity: interview recordings were transcribed verbatim. The researcher met regularly with the thesis supervisor to discuss and compare findings minimising any bias (Smith, 2008).

As this study was completed in a unique setting, using a purposive sampling method decreases the transferability of the findings

when considering other integrated health care settings. Context does affect what happens and how it takes place, so the automatic application of these findings to another similar but different context cannot be assumed.

Implications and Recommendations

The findings of this study for research have implications for research and recommendations for the clinical practice. Firstly, to be successful this integrated collaborative care model of service delivery requires support and acceptance from all those involved. In particular, as the Clinic is a teaching and learning environment for students, therefore positive role modelling by staff (academics and clinical educators) is essential.

To achieve this, leadership is required to ensure that staff are given appropriate support so that they are prepared to work interprofessionally, and confident of their ability to facilitate collaborative care in a positive learning environment.

The findings clearly identify that faculty staff development and workshop induction should be a pre-requisite for all those working in the Clinic. This needs to include orientation, preparation, and coaching and mentoring of staff to support them develop interprofessional facilitation skills that are appropriate for clinical education in an integrated health care environment.

Further, it is suggested also that marketing of the Clinic is crucial. Services need to be advertised locally, and include some information about the student learning environment, and how community members might become involved in accessing services and supporting student learning at one and the same time. It is also recommended that this information is common information for both the students and service users, and is provided in a mixed media form. Ideally, information about the Clinic and the services it offers needs to be shared more actively with local community groups, and perhaps include involvement with the North Shore Times media. It would be worth considering electronic advertising via the University web-site as well.

It is recommended that clinic availability be reconsidered. Particular attention needs to be paid to the length of the academic year. Management are urged to consider developing a three semester year that would enable the local community supporters to access services throughout the year.

Debate is urgently required over the terminology used to describe the Clinic, to clarify the use of terms such as collaborative care and integrated health care. To date, this terminology is not well understood by the participants and is confusing. This debate needs to include clarification of the common purpose of the Clinic, so that everyone involved has a clear understanding of what is on offer, their

roles and responsibilities.

In addition, active service user involvement in student learning needs to be reappraised. At the moment, services users are passive contributors to the student learning process. It appears some would be prepared to have a more active role. These people could be encouraged if the university was to offer workshop inductions for interested service users. CAIPE (2012) and WHO (2010), add support to this and argue that a University has an obligation to support service users who support students learning. At the same time it is important that the service user does not lose their integrity and openness to offer support with what they see as learning for the students based on their own health history and health requirements. If service users are to make informed decisions, it is essential that they are educated and learn what it means to be involved in self-care.

It is recommended that study findings will be of interest to organizational leaders and managers involved with strategic planning. Therefore, research findings will be presented to the Director of the National Centre for Interprofessional Education and Collaborative Practice, and discussed with that Centre's Management Committee. It is hoped that the research results will stimulate dialogue and change that will ultimately improve collaborative care for service users, and develop interprofessional clinical learning opportunities for students.

Debate is also required to clarify the model of care at the Clinic. Currently, the Clinic offers co-located services that are directed by uni-professional models of practice. While the service users very much appreciated being the centre of student attention and patient-focused care, whether this is sufficient for students supposedly learning about collaborative care, is questionable. Dialogue between the different professionals at the Clinic is required to review professional priorities for collaborative practice development.

As regards future research, there is a need to repeat this study for a larger group of service users, and to include students, clinical educators, and service managers in data collection. It seems also that research about service users understanding of language is potentially important. It is hoped that this study will encourage other researchers to explore ways to develop service user interprofessional learning initiatives within health practice settings.

Concluding Statement

This qualitative exploratory study offers an insight into service user's perspective of collaborative care at an Integrated Health Clinic.

Although considerable research has been devoted to collaborative practice involving the health professionals and interprofessional learning, less attention has been paid to the viewpoint of the service

user. Fifteen service users who had received care from two or more of the services at the Clinic took part in the study. One on one interviews were used to collect data and this method proved beneficial for the participants to share their views and experiences of collaborative care. The interviews generated a wealth of valuable in-depth data which was particularly useful, as there is minimal research in the service user's perspective of collaborative care. The findings of this study have added to the existing body of knowledge around integrated collaborative care. The study is particularly relevant as collaborative practice has been internationally identified as a means to achieve better health care for an ageing population with complex health needs (WHO, 2010). The service users spoke particularly about their expectations, perceptions, and observations of the care offered. The findings of this study emphasise the strong influence that two-way learning has on service users attending the Clinic. It seems that the service user contribution to student learning, and possibly collaborative care, is vastly underestimated. Nonetheless, student input into patient centred care, communication, and teamwork and integrated care were all much appreciated from the service user point of view.

This study has highlight that health students working in the Clinic seldom interact collaboratively with students in the other health professions. However the service users were very positive about the care

received and spoke about the importance of team work within the uni-professional setting. Equally, the findings indicate that the service user felt valued and respected by being involved in their patient-centred care. For many it was an important reason for attending the clinic.

As a final point service users were very definite as to a main reason for attending the integrated health clinic which was to support student learning. As they believed they had experiences to share with students that would assist with their future professional practice. For any future planning in relation to collaborative practice or integrated health care particularly where students are involved it would seem imperative to include the voice of service users as they are motivated and the crucial link in health collaboration.

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Northern X Regional Ethics Committee
c/- Ministry of Health
650 Great South Rd
Penrose
Auckland
Phone: (09) 580 9105
Email: northernx_ethicscommittee@moh.govt.nz

20 October 2011

Ms Lynne Tucker
Auckland University of Technology
School of Health Care Practice
AUT University, North Shore Campus
Private Bag 92006
Auckland 1142

Dear Lynne

Ethics ref: **NTX/10/EXP/178** (please quote in all correspondence)
Study title: Service user's perspective of collaborative care in an Integrated Health Clinic
Principal investigator: Lynne Tucker

Thank you for your progress report, received 20 October 2011.

The study has received ongoing ethical approval for the next eleven months from the Deputy Chairperson of Northern X Regional Ethics Committee under delegated authority. The next progress report is due **17 September 2012**.

It should be noted that Ethics Committee ethical approval does not imply any resource commitment or administrative facilitation by any healthcare provider, within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please note that progress reports are the responsibility of the researcher and forms can be found on the website, www.ethicscommittees.health.govt.nz. Please complete promptly to ensure ethical approval is continued.

It would be appreciated if we were advised when the study is completed and also that an End of Study Report is sent promptly after completion in order to close and archive the file.

Yours sincerely

A handwritten signature in black ink, appearing to be 'S. Young'.

Sabrina Young
Temp Administrator
Northern X Regional Ethics Committee



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Antoinette McCallin
 From: **Madeline Banda** Executive Secretary, AUTEC
 Date: 26 November 2010
 Subject: Ethics Application Number 10/249 **Service user's perspective of collaborative care in an integrated health clinic.**

Dear Antoinette

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 8 November 2010. Your application is now approved for a period of three years until 8 November 2013.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 8 November 2013;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 8 November 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
 Executive Secretary
 Auckland University of Technology Ethics Committee

Cc: Lynne Tucker Lynne.tucker@aut.ac.nz

Consent Form

For use when interviews are involved.



Project title: **Service User's perspective of collaborative care in an Integrated Health Clinic**

Project Supervisor: **Dr Antoinette McCallin**

Researcher: **Lynne Tucker**

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 30th September 2010
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's

signature:

.....

Participant's

name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number*

Note: The Participant should retain a copy of this form.

Participant Information Sheet



Date Information Sheet Produced

2010

Project Title

Service Users Perspective of Collaborative Care received from an Integrated Health Clinic

Invitation

You are invited to take part in this study which evaluates your experiences of collaborative care. Your participation is voluntary. You can decide if you want to be part of the research or not, without consequence. The researcher, Lynne Tucker works in the Faculty of Health and Environmental Sciences.

What is the purpose of this research?

The researcher wants to collect information from service users like you who receive care from two or more health professionals based at the Integrated Health Clinic. The aim of the study is to find out about your attitudes and experiences of receiving collaborative care to provide information for ongoing development of service delivery and practice within an integrated health care environment. The findings of this research will be published as a master's thesis, and may be published in a journal article, or presented at a conference in the future.

How was I chosen for this invitation?

As you have received health care from two or more health professionals based at the Integrated Health Clinic.

What happens in the research?

The researcher will outline what the study is about at the beginning of the interview, including your ethical rights for example; that participation in the study is voluntary; your identity will remain anonymous. A consent form will be completed and signed by you and is taken as an agreement to participate in the research. The information obtained from the interview will remain confidential and is seen only by the researcher and study supervisor. There is nothing from the interview/data which will identify you as a service user of the Integrated Health Clinic. You are free to ask any questions. You will then be invited to undertake the interview which will be recorded and later transcribed for accuracy. The interview will take place in the Integrated Health Clinic or any other place convenient to you. The interview will take approximately 60 minutes to complete. You can choose to withdraw from the study any time up until the completion of data collection. If you prefer not to continue with the research/interview, this will have no influence with your ongoing treatments/care.

What are the discomforts and risks?

There is no apparent risk in the interview process.

What are the benefits?

There may be no immediate benefits for you from participating in this research. Sometimes, individuals enjoy having an opportunity to comment about something that they have been part of. Changes may be made in the health care received at the Integrated Health Clinic based on the information gathered. The research knowledge might be helpful for planning of service delivery in the future of the Integrated Health Clinic.

How will my privacy be protected?

The information collected remains confidential and the only people that have access to it are the research team. You cannot be identified by your responses. The data will be stored securely and destroyed after ten years.

What are the costs of participating in this research?

The only cost is time.

What opportunity do I have to consider this invitation?

Once the researcher gives you the information you will be asked to decide if you want to be in the research or not.

How do I agree to participate in this research?

By contacting the researcher and signing consent form will be taken as consent to join the research.

Will I receive feedback on the results of this research?

A summary of the findings will be available to participants after the completion of the study in mid 2012 from Lynne Tucker by email request lynne.tucker@aut.ac.nz

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

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUT Ethics Committee, Madeline Banda, madeline.banda@aut.ac.nz , 0064 9 921 9999 ext. 8044.

Whom do I contact for further information about the research?

Lynne Tucker
Nursing
School of Health Care Practice
Faculty of Health and Environmental Sciences

0064.9.921-9764
lynne.tucker@aut.ac.nz
z

Confidentiality Agreement



For someone transcribing data, e.g. audio-tapes of interviews.

Project title: Service user's perspective of collaborative Care in an Integrated Health Clinic

Project Supervisor: Dr Antoinette McCallin

Researcher: Lynne Tucker

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Transcriber's signature:

.....
.....

Transcriber's name:

.....
.....

Transcriber's Contact Details (if appropriate):

.....
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Date:

Project Supervisor's Contact Details (if appropriate):

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.....

*Approved by the Auckland University of Technology Ethics Committee on AUTEK Reference number **type the AUTEK reference number***

Note: The Transcriber should retain a copy of this form.



Support is required to undertake a study to find out

Service user's perspective of collaborative care in an Integrated Health Clinic

If you have:

- Attended the clinic for longer than 6 months
- Accessed 2 or more of the services such as Physiotherapy, Podiatry, Oral Health, Nursing or Occupational Therapy
- Have a clear understanding of the spoken English language
- Would like to or have time to share your experiences and stories which may lead to improved collaborative care

Your support and time would be greatly appreciated

It is anticipated that the interviews will:

- Take approximately one hour (one on one)
- Organised at a time which suits you
- Take place in July / August 2011
- You would be welcome to bring a support person

For further information please contact:

Lynne Tucker,

Nursing,

AUT University

Phone 921-9764/ Mobile 0274-454710



Service User's Perspective of Collaborative Care in an Integrated Health Clinic

Support Information:

If you feel you would like to talk to someone else about any issues we have raised in this interview please feel free to contact:

- **AUT Counselling Service**
(3 free sessions if required)
Ph 921-9999 ext 9998
- Your **General Practitioner or Practice Nurse**
- **Patient Advocacy Service** ph 0800-555050
- **Director of the AIH Clinic, Dr Duncan Reid**
ph 921-9999 ext 7806

I will be happy to initiate the contact for you.