The experienced, autonomous 'I': critical and discursive accounts of occupational therapists' professional identity

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Abstract

Changes in the economic and political landscape in the UK are leading to far reaching changes throughout the health and social care sectors and changing the established position and authority of health and social care professionals (Speed & Gabe, 2013). Professionals from the National Health Service and those traditionally delivering social care for Local Authorities are being asked to work more closely together to both commission and deliver services (Department of Health, 2007; HSMO, 2012). In addition, both sectors are feeling the strain of increased demand on services (Glendinning, Kirk, Guiffrida & Lawton, 2001) in conjunction with restriction on available budgets (Ferry & Eckersley, 2011). Against this backdrop, a review of a local children children's equipment service was commissioned and undertaken by the author as part of a funded Master by research. The findings from an analysis of data generated at focus groups with professionals to discuss potential changes to the service under review, showed that at this time of strain and change for the organisation and institutions, discourses of professional identity were brought to the fore.

Therefore this thesis seeks to contribute to the developing literature on professional identity construction (Mackay, 2007; Kaposi, 2011). It will discuss literature on professional identity and its construction by individuals through talk and language. Thirdly, it presents a critical and discursive analysis of focus group data which provides evidence of the key sites of professional identity construction; between the structures of their professional institution, employing organisations and within changing relationship between occupational therapist and service users This thesis will conclude that these varied constructions of identity serve to create local discourses of occupational therapy practice that focus simultaneously on themselves as autonomous individuals, and members of a social collective, whose practice is shaped by institutional and organisational discourses and the professional-service

user relationship. This thesis asserts that critical and discursive methods of analysis are useful tools when attempting to understand dynamic constructions of identity in organisational settings, particularly at a time of change within an organisation.

Introduction

National context: Changing services, health and social care in the UK and the role occupational therapy

Evidence has been globally reported that, through medical and technological advancements, many more children are surviving past birth and into adolescence with complex healthcare needs and are increasingly being cared for in the home and the community (Peter et al, 2011). The provision of care for this group of children in the home has been driven in part by Government policy (DfCSF 2009) and has significant cost implications for healthcare services (Glendinning, Kirk, Guiffrida & Lawton, 2001), requiring specialist commissioning and improvements in joint working arrangements between agencies involved in the provision of care, support and equipment for these families (Kirk & Glendinning, 2004; Robson & Beattle, 2004). In 2009, the Department for Children, Schools and Families estimated that there are approximately 500,000 children with disabilities in the United Kingdom (DfCSF, 2009). Figures reported by Glendinning *et al* (2001) suggest that amongst the UK population of children with disabilities, there may be 6000 children with complex healthcare needs, and that the total cost for their care to services could be as much as £150,000 per child per year, although this is identified as a potential maximum figure, dependant on their specific needs.

Against this backdrop of increased demand and cost to services, the NHS and Social Care is facing a period of financial uncertainty (Appleby et al, 2009) and potential increases in budgets which are only slightly above the rate of inflation (Ferry & Eckersley, 2011). In the past 5 years the NHS has made an allocation of "£340 million over the three years from 2008/09 to 2010/11 to improve services for disabled children" (NHS Confederation, 2009). The way in which specialist equipment services are provided to children and young people has come some way since 1997 when the House of Commons Health Committee (1997) described it as 'beset by difficulties' and recommended that there be improvement in the way the services were co-ordinated and managed by health, education, social care and the voluntary sector'. Reading and Marpole (2000) reviewed the establishment of an interagency

equipment fund in East Norfolk, which comprised funding from health, social care and education agencies. They found that, although problematic at times, this interagency working for the provision of equipment was popular with parents due to the removal of organisational barriers to obtaining the equipment for their children.

Key to this interagency working in the provision of adult and children's equipment is the work of occupational therapists. Occupational therapy is a profession now regulated and overseen by the Health and Care Professionals Council (2012) and the College of Occupational Therapists. Much of what occupational therapists and other health and social care professionals do is determined by both their professional institutional training and the policies of the organisations who employ them. In essence, it was the introduction of the Chronically Sick and Disabled Persons Act in 1970, which created the need for a workforce who could ensure that the statutory requirements of this act were met by local governments (Tucker *et al*, 2012). Local authority and health organisations employ occupational therapists to assess what is needed by identified individuals and to ensure adequate provision for them. This activity is based around the Chronically Sick and Disabled Persons Act (1970) which underpins the work of occupational therapists today (Mountain, 2000; Department of Health & College of Occupational Therapists, 2008).

Currently in the NHS there is a transition taking place where Clinical Commissioning Groups (CCG's) are replacing the organisational structures of the Primary Care Trusts (PCTs). This change stems from recommendations in the Health and Social Care Bill (2012). Alongside Local Authorities (LA's) PCTs have had responsibility for commissioning the services of occupational therapists for their crucial involvement in the provision of equipment. CCGs are likely to adopt these functions, with an increased emphasis on closer working between CCG's and LA in the joint commissioning of health and social care services. Occupational therapists employed in either health care or social care settings can expect changes in their practice stemming from these institutional changes. The way in which individual professionals reconceptualise their identities in this shifting landscape will certainly be of interest.

Local context

Locally in Cheshire there are similar concerns to those identified by Reading and Marpole (2000) about restrictions on funding from health and social care agencies. The restrictions of funding and increasing number of children being referred to the Cheshire Children's Equipment Service is a matter for concern for both Cheshire East Council and Central and Eastern Cheshire PCT (now CCG). In 2010 these local agencies produced a summary of the current provision of equipment to satisfy the requirements of the Strategic Health Authority and Aiming High for Disabled children. In addition, Cheshire East Council also put forward a proposal for a revised, combined model of delivery.

This research project arose from a request from both Cheshire East Local Authority and Central and Eastern and Cheshire Primary Care Trust, for academic assistance in reviewing their current children's equipment service to inform their proposal. The requirement was to complete a review of present practices and processes and to produce a consultation report with recommendations on how this service could be improved. This service provides specialist equipment to children with disabilities across Cheshire, spanning the boundaries of both Cheshire East and Cheshire West and Chester local authorities, and both Central and Eastern Cheshire and Western Cheshire Primary Care Trusts. As with Richard and Marpoles review (2000) funding for the service comes from all four organisations and the work force of professionals who deliver the service are employed by either the local authorities or the NHS through the PCT's.

The initial stage of this research was to gather data for a consultation report on the processes currently in place for the provision of specialist paediatric equipment in Eastern Cheshire. This involved detailing all elements of the current provision such as demand on the service, funding streams, figures for past and projected spending and the processes of referral, assessment for and the prescribing of equipment. Based on analyses of this data, the consultation report made recommendations for improvements to refine these processes. As part of the data collection, interviews were held with key stakeholders and employees from health and social care about their experience of working within the service and implementing the current processes. Two participatory events or focus groups were held specifically to engage

with a range of professionals and discuss what was working and where improvements might be made.

The consultation report was completed and delivered to the Children's Equipment Team in April 2012 and the key recommendations discussed with the Joint Commissioning Team. Following successful completion of this report, funding was agreed for the remainder of the MSc and the second phase of the research. The participatory events and interviews provided the data from which this thesis was created. At the outset, it was anticipated that within the data there would have been much discussion around disability and that more parents and children would have been able to participate and discuss their experiences of living with disabilities and the services they received. This was not the case.

Occupational therapists, their talk and this project

What began to happen was that the physiotherapists and occupational therapists that took part were talking about their professional selves through their discussion of practices within and about the processes of the children's equipment service. Thus, the story that became apparent was one of them creating professional identities and constructing their professional selves and their practices, both as individuals and as members of a group (their profession). Mackey (2007) suggests that the organisations employing occupational therapists can act to constrain and define the practice of these professionals. The dynamic changes that take place within these organisations can cause practitioners to question and seek for a new understanding of the self in relation to work and these wider organisations (Munro & Randall, 2007). It is at this point that individuals, through their practice, resist or accept new roles for themselves in the work place and where professionals can act within organisations to disrupt their employers policies and procedures in order to pursue their own professional practices (Daudigeos, 2013).

The occupational therapists who took part in this research may share a professional label, but their working background and resultant practices are different. For instance, they differ in who employs them. Some participants were employed by the local authority and worked with both adults and children. Other participants were employed by the Primary Care Trust and worked exclusively with children. All were considered community therapists and used the same organisational structure to request and fund the equipment when they identified needs in their clients.

This thesis aims to investigate how between the structures of their professional institution and their employing organisations, these occupational therapists construct their professional identities. In addition, it seeks to understand whether these differing constructions affect the practices of these professionals and if so in what ways.

As such the main contribution of this thesis will be to the understanding of the construction of professional identities in the field of occupational therapy. However, it will also add to the literature on the changing nature of work within and across health and social care environments and around the service received by patients in the face of the health and social care reforms, with the continued implementation of evidence based practice and increased pressure on budgets in the NHS.

Literature Review

This literature review will provide discussion of 'professional identity', beginning with a broad definition of these terms and more specifically what is meant by professional identity in the context of this project. It shall examine what past research has contributed to an understanding of professional identities generally, with an explicit focus on how professional identities are developed or constructed by individuals. Following this, there will be an examination of the identities of professionals within the organisational settings of health and social care and the factors particular to those settings which the literature suggests have an effect on the identities of these professionals. In reviewing the research base in this way this thesis will attend to the processes of negotiating professional identity within health or social care settings, with specific attention to the identities of occupational therapists.

Professional identity – investigating definitions, origins and constructions

Elliot Friedson (1994) in a summary of work on the sociology of professions, discussed the difficulty that has arisen in the social sciences of defining what a profession is. For Friedson, the troubles with definition arise because "a profession may be described as a "folk concept" He abandons attempts at an "absolute" definition and favoured examination of specific social concepts: such as who is considered to be a professional, and the way in which professional practice builds that identity. Crucially, in terms of understanding professional identity he also proposed an investigation of "what the consequences are for the way professionals see themselves and perform their work" (Friedson, 1994: 20).

Freidson's term, 'folk concept', implies a variety of people in different occupational contexts negotiating their own meaning of what a profession is and how it is practiced. In the context of this thesis, the term 'occupation' refers to categories of paid employment. It could be argued that rather than a folk concept, a profession could be better described and understood as a social construction, produced through talk between and within particular occupational groups. Social constructionism (Berger and Luckman, 1966; Shotter & Gergen, 1989) is certainly an epistemological approach through which many researchers have also examined the concept of

identity in such terms (see Wetherell & Moharty, 2010 for a review of constructionist literature in the domain of identity). This body of research continues to grapple with issues of how people see themselves in relation to their social world and create multiple understandings of themselves in these social environments, of which occupations are a part. Social constructionist theory on professional identity and the approach to knowledge in this domain that it offers will be discussed later.

A satisfactory definition of 'professional identity' remains elusive, with perspectives from a wide range of disciplines offering various foci. Initially, and despite the aforementioned issues, it is necessary to define the constituent parts of the term 'professional identity' in the context of this piece of work, focusing on each in turn. To neglect to do this would be to adopt a non-analytical stance and say that professional identity is no different to the concept of self-identity.

The term professional is grounded in the notion of a profession, which as has already been explained may be problematic. However, there has to be a position from which an examination must proceed so using the definition laid down in an English dictionary may suffice for the present, as the professionals involved with this research are English. A profession is defined as "an occupation that requires highly specialised skills or training and qualifications" (OED, 2012). Hence, a professional may be regarded as a person who possesses particular requisite skills, training and qualifications and is potentially eligible for membership of that profession. So an understanding of a professional occupational therapist assumes that these individuals have been trained in a range of skills and been awarded qualifications which allow them membership to the profession of Occupational Therapy. But where does the concept of a profession such as 'Occupational Therapy' come from?

According to Pratt, Rockmann and Kaufmann (2006) professions arise from particular groups' claims to specialist knowledge which have "economic value when applied to specific social problems" (Pratt et al, 2006: 235). Of course, more broadly the term 'professions' may extend to occupations in the private or corporate sector too, such a bankers or lawyers, which may not traditionally be classed as dealing with 'social problems' per se. However, in terms of this thesis, the profession of occupational therapy is directly concerned with the alleviation of a social need, that of the functional needs of specific members of society. In the UK, the College of Occupational Therapists states that occupational therapy helps people engage as

independently as possible in the activities (occupations) that enhance their health and wellbeing. Here the term 'occupations' refers holistically to activities which allow the individual to function in their everyday lives. So with reference to Pratt et al (2006) occupational therapy is a profession which claims specialist skills and knowledge about enabling ill, injured or elderly people carry out their daily activities. Therefore, occupational therapists can reasonably be defined as workers who possess the skills, training and qualifications required to meet people's occupational functional needs, and have consequently been granted permission to practice those skills as members of that profession.

Identity itself is harder to define. Dictionary entries for identity state that it is "the fact of being who or what a person or thing is" or as "a sense of self, providing sameness and continuity in personality over time" (OED, 2012; dictionary reference.com, 2012). These definitions imply a static and objective, observable state of mind. Research within the social sciences, particularly psychological research suggests that identity is far more complex and subjective. There is a plethora of historical theorising in the domain of identity, from philosophers such as Kant and Satre, psycho-social discussions of identity from Ericson (1975) and Mead's (1984) distinction of the individual and social self. This multidisciplinary project of understanding identity is ongoing and certainly more than this thesis can hope to review. The following is an attempt to highlight work which is salient to the understanding of identity in a professional context.

As a starting point, this literature review will begin to examine research which addresses 'social' identity. Through the work of social psychologists such as Tajfel & Turner and their Social Identity Theory (SIT: 1979) a subjective concept of a 'social' identity was developed, influenced heavily by relations with others, both within and between social groups. For these psychologists, social identity indicates a person's sense of who they are, based on their group membership, which provides an individual with self-esteem and self-worth (Mcleod, 2008). Tajfel and Turner's SIT (1979) highlights the key role of social categories in the formation of one's social identity. For example, membership of an organisation, or other social grouping such as class, race, gender or age cohort are used by the individual to classify themselves and others as either belonging (in group) or not belonging to (out group). Using this

framework a profession can be considered as a social group to which one belongs or does not belong.

Hogg & Terry (2001) suggest that since SIT was applied to organisational psychology, the field has used SIT to investigate the processes by which individuals identify with the organisations for whom they work. The adoption of a social identity approach within organisational psychology has incorporated both the original SIT and the more recent idea of self- categorisation theory (Hogg, 2001) when investigating the social processes around the individual within organisations. SIT would seek to explain how an individual's maintenance of in-group comparisons with a particular group (a profession within this context) and through self- categorising (adopting that professions norms, values and stereotypes) help individuals make sense of themselves as members of a profession (Hogg & Terry, 2001). But precisely how these norms, values and stereotypes are maintained is not truly addressed by SIT and indeed some seek to draw a distinction between simply identifying with an organisation and professional identity (Pratt, Rockmann and Kauffmann, 2006).

In order to clarify further, a profession and an organisation are different, if similar categories. A definition for what constitutes a profession has already been provided, and is particularly concerned with a groups claim to specialist knowledge and the training of individuals in the skills and practices associated with that knowledge. An organisation is defined as 'an organised group of people with a particular purpose' (OED, 2012). In the context of this thesis the organisations that are of key importance are the National Health Service (NHS) and Local Government (LG), specifically the NHS Primary Care Trust (PCT) and the LG social care department. PCT's were established for the purpose of exercising their duty under the Health Act (2009) within the NHS to provide and commission local health services such as hospital and community health services for their local populations. LG social care departments are organisations whose purpose is the delivery of social care services and facilities designed to 'support people to maintain their independence, enable them to play a fuller part in society and protect them in vulnerable situations…' (DoH, 2006:18).

In order to perform and achieve their purposes, these organisations need workers with the required level of knowledge, skills and training to satisfactorily deliver the

services they are required to provide. Professionals such as nurses, social workers, physiotherapists and occupational therapists are generally employed by these organisations to carry out the organisation's functions or purpose (Friedson, 1994, cited in Evans, 2012). It is at this interface where organisational rules, policies and procedures and the professional's training, knowledge and skills meet. The individual professional's organisational practice is complex (Evans, 2012) made up of their personal professional knowledge and judgement of what is needed and their interpretation of the organisation's policies and guidance. Professionals can find themselves robbed of autonomy by organisational policies, which may be challenging given that autonomy or discretion, has for a long time been a key feature of professional's role and identity (Evans, 2012). Evetts (2002) emphasises the importance of distinguishing between autonomy and discretion, viewing the two as distinct and suggests that evaluation of such should be mindful of this distinction, and as such this research will attempt to do so.

Pratt et al (2006) seek to make an important distinction between employee conceptions of organizational membership and their professional identities, the former being defined by where people work and the latter by what people do. Their investigation of the formation of professional identities by medical residents stemmed from what they saw as gaps within the literature. They assert that prior research had failed to explore the mechanism for changes in professional identity, but rather simply implied that there were such mechanisms . Their qualitative investigations of physicians at the first stage of their professional careers, led them to conclude that the formation of professional identities was triggered by a mismatch by what they describe as work-identity integrity violations (Pratt, Rockmann and Kaufmann, 2006). In other words there was a dissonance between what they thought about who they were and what they were doing in their job role as physicians. These researchers are suggesting that in order to counter this dissonance, medical residents construct a professional identity which can marry the two together.

Like their paper, it is not the aim of this research to look at how a particular profession seeks to gain authenticity, status or legitimacy, but at how individuals *form and reshape* their own identities within the context of their professional lives. In this respect it is a departure from other literature which has addressed questions of how authenticity and status are gained.

Pratt, Rockmann and Kaufmann's (2006) review of the literature appears to find three prior theories or perspectives on professional identity; career or role transition, socialisation and identity work. The first of these, career or role transition, suggests that an individual's professional identity changes through the process of change in their job role and professional advancement or career progression. They cite studies by Hall (1968, 1995) and Nicholson with various contributors (Nicholson, 1984; West, Nicholson & Arnold, 1987) who have shown that at times when individuals transition from one role to another there is a shift in how they view themselves in relation to that work. This is characterised by shaping their identity to conform with their expectations of that role. Nicholson also touches on a change in identity at times of career progression or job role changes. However, as pointed out by Pratt et al (2006) this work does not shed light on the processes behind these identity changes but addresses when it might take place.

The second, socialisation, places emphasis on the process of how newcomers to an organisation learn or assimilate information about the new organisation that they have joined and how mastery of their new role and tasks is important in organisational socialisation (Ostroff & Kowslowski, 1992). This literature's focus on 'newcomer' socialisation means that it does not attend to professional identity formation directly, although it may be that information acquired by newcomers may contribute to this. It also does little to discuss how identities of established professionals change over time.

The third of these, identity work, is more focussed on the process of forming identities. Svenningsson and Alvesson (2003) subscribe to the idea put forward by Ashforth in 1996 that individuals and organisations are better understood in term of 'becoming rather than being' (Ashforth, 1996: as cited in Svenningsson & Alvesson, 2003). However, as they themselves point out they are more concerned with stressing the dynamic, resistive and transitory nature of the 'identity work' done by individuals than previous research which has adopted a more stable, functionalist approach, citing Dutton, Dukerich and Harquail (1994) as adopting the approach of SIT and looking at organisational identification.

Identity work is defined by Svenningsson and Alvesson as "people being engaged in forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness" (2003: 1165). This definition

suggests professionals are actively engaged in producing their own sense of their identity as distinct professionals. It also implies that this work is accomplished through changing how they form or construct their identity. Here it becomes necessary to explain what is meant in this context by 'construction' of identity.

Social constructionist epistemology rejects the notion of static or objective identities and replaces this notion with a more dynamic concept of contrasting identities negotiated actively through talk and discourse (Potter & Wetherell, 1987; Harre & Gillet, 1994: Gergen,1992). So, from a social constructionist viewpoint, what a professional *is* has no fixed meaning and cannot be objectively defined. Rather, what a profession is, or indeed professionals *are*, alters with changes in the historical, socio- political context and is shaped by the institutions and organisations that the professions function within and gain legitimacy as 'professions' from. For example, professionals working in state run organisations such as the NHS are subject to changes in governmental policies on health, administered through legislation. Often these legislative changes, for example the changes which were outlined earlier as part of the Health and Social care reform bill (2012) will have consequences for the daily practice of nurses or social workers. Therefore, the notion of what a profession is in any given context may be subject to change through shifts in these occupational demands, changes to contracts, working arrangements and "changes in the distribution of power between professionals and other groups" (Kelly, 1998: 78) as a result of political directives. The individual professional will need to either accept and take on board these changing notions, or may seek to resist and challenge them when deriving their own understanding of themselves as a professional.

As this project seeks to understand the processes by which professionals form their identities, the project adopts a broadly social constructionist framework when addressing the topic of professional identity. Thus, in a work setting, professional identity will be continually negotiated by and amongst those members of an organisation, with the organisational processes affecting and effecting the members' identities and the members' identities also affecting the organisation's processes to which they belong as part of a two-way dynamic (Watson, 1996).

Another view of the formation of professional identities has been offered by Beck and Young (2007). Using the writings of Basil Bernstein they argue that professional identities are created because of the way that individuals conceptualise their relationship to the knowledge that they possess – Bernstein..defines professions or disciplines "as socially constructed knowledge structures… whose creators have appropriated space to give themselves a unique name, a specified discrete discourse with its own intellectual field of text, practices, rules of entry, examinations and licences to practice" (Bernstein, 2000, p52 as cited in Beck and Young, 2007:185). If this is the case then professional identities should be heavily influenced by their relation to knowledge and any changes or challenges to that knowledge should have a profound effect on their identities as professionals. One such challenge may arise from the rise in prominence in both the training and everyday practice of professionals of Evidence Based Practice, which is strongly associated with application of new and supposedly gold standard research evidence to the daily discharge of their profession.

Characterising and assessing what we do in the workplace requires not only an examination of activities and practices, what is known and what we can do, but is 'a fundamental part of how we define who we are as people' (Munro & Randall, 2007:888). This idea is supported by Watson who states that "the work environment is one of the key locations where our private individuality (our personal identity) and the roles and characteristics attributed by others (our social identity) meet in the creation and recreation of our awareness and sense of self" (Watson, 1996: 245). The interactions of professionals in the workplace, through their language can be thought of as a site worthy of investigation if we are to understand the sense of self as professional. According to Potter & Wetherell (1987) talk and the discourses it creates are action. This means that what we say and what we do actively constructs our subjective realities. In the case of the therapists, their talk and interactions construct both their role and their everyday practice, which in turn may affect their interaction with their patients and service users. Similarly, these constructions are effected by the context in which these professionals find themselves. The organisations and the processes put into place by employers and regulatory bodies act to constrain and define the practice of professionals. The dynamic changes that take place within organisations can cause practitioners to question and seek for a

new understanding of the self in relation to work and these wider organisations (Munro & Randall, 2007; Pratt et al, 2006).

The main contribution of this thesis will be to the understanding of the construction of professional identities in the field of occupational therapy, the therapists who were primarily involved in the provision of equipment in the children's equipment service in eastern Cheshire. However, it will also add to the literature on the changing nature of work within and across health and social care environments and around the service received by patients in the face of the health and social care reforms.

Discourses and professions: the meaning of discourse for this project

A discourse can be either spoken or written utterances of language (McKinlay & McVittie, 2008; Wetherell *et al* 2006)) and discourse analysis can be considered as 'the close study of language in action' (Taylor, 2001: 5). Just as there are varying sources of discourse, the way in which discourse is analysed can also vary. Potter & Wetherell (1987; citied in Wetherell et al 2006) lay out a form of analysing discourse that goes beyond semiotics and the analysis of basic functions of speech, to uncover the constructive and active use of language to *act* within and *construct* our social world using varying accounts of particular events. McKinlay & McVittie (2008) emphasise the importance of the active use of talk for global self-presentation produced through variations in language, which in turn arise due to the context in which talk is produced. So for the discourse analyst, language is "not a neutral information-carrying vehicle… rather it [language] is constitutive: it is the site where meanings are created and changed" (Wetherell *et al* 2001: 6).

As Wetherell and colleagues (2001) point out it is important to clarify whether the language is being harnessed by the analyst as a topic or as a resource to investigate another phenomena. In the case of this research, the discourse being analysed is the talk of the participants during both interviews and focus groups conducted as part of the wider research project. Rather than simply treating the talk of the participants as merely imparting their views about the service under discussion, this analysis will attend to the way in which the participants draw upon existing discursive formulations available to them and how they use these to construct themselves as professionals and negotiate their own professional identities within the wider discourse.

Therefore, discourse *can* and, within this project, *does* have an additional meaning. Rather than merely instances of spoken or written language, discourse can also refer to the wider concepts of 'disciplines' or 'bodies of knowledge' (generated through talk, writings and practices) as described by Michael Foucault (1972; cited in McHoul & Grace, 1993.) For Foucault, a discourse constitutes whatever limits or allows writing, speaking or thinking about an object of knowledge. These limits and constraints are necessarily determined by the socio-historical context of the time so things were true or meant something only in that specific historical period (Hall, 1997). Discourses for Foucault are not fixed but are subject to change as the disciplines which shape and create them alter and are a reflection of social and institutional practices (McKinlay & McVittie, 2008).

So how does Foucault's idea of the discourse relate to the present project? Firstly, the professionals interviewed are subject to the scholarly discipline in which they have trained. Their expertise as professional occupational therapists is acquired or made possible by exposure to discourses and texts (articles, policy documents, codes of practice etc.) and through their everyday practical experiences. Further to this, they have been subject to a process of accreditation through their professional institution, the British Association of Occupational Therapists and College of Occupational Therapists. Prospective occupational therapists are required to successfully complete a University degree through an academic institution itself accredited by this 'disciplinary institution', which 'continually tests their "fit" with the discourses, logics and ways of thinking of a particular discipline' (Danaher, Schirato & Webb, 2010: 22). Their professional practice is accredited and endorsed by satisfying the criteria for membership of this body and their practice defined by documents such as the Professional standards for occupational therapy practice (COT, 2010a).

Another institution that may help to generate the discursive formulations which create the 'professional occupational therapist' as an object of knowledge is the Health and Care Professional Council. This body, newly renamed to include the category of 'care' by legislative changes laid out in Health and Social Care Act (2012) is the professional regulatory body which oversees the professional regulation of Occupational Therapists, amongst many other professionals. The title of occupational therapist is protected by legislation (HCPC, 2012) and is therefore

enshringed in law. These layers of regulation and legislation surrounding professional titles and professional conduct have created the professionals that they register as objects of knowledge.

Foucault's work, The History of Sexuality (1986; 1988) investigated the way in which specific historical conditions create and govern what 'the subject' is through available techniques and discursive formulations (McHoul and Grace, 1993) and the subject is produced within the discourse (Hall, 1997). Therefore the disciplinary institutions and the scholarly discipline of occupational therapy are instrumental in creating the objects of knowledge and discursive formulations around what it means to be a professional, which in turn effectively create the subject position of 'professional' for individuals (McKinlay & McVittie, 2008). But it is important to emphasise that individuals also have an active role to play in creating discursive formulations. MacKay (2007) applies Foucauldian thinking to her account of occupational therapists identities – 'Don't ask me to remain the same'. In this paper she argues that traditional approaches limit the identities that therapists can occupy. She goes on to suggest that through an excavation of the discourses of the history in occupational therapy, Foucauldian approachs can be helpful to OT's and allow them freedom to construct identities for themselves.

Kaposi (2011) argues that with 'the crooked timber of identity' it may be advantageous to put aside some of the methodological disagreements evident in previous research (Wetherell and Moharty, 2010) about the level at which discourses of identity are analysed. His paper shows that a combination of local discursive, wider critical and psycho-social approaches can all be applied as analytic stances when examining texts of identity. The aims of this project to investigate the local construction of occupational therapist's identities and to critically examine how these constructions themselves arose from and may affect the professional discourses and practice. Therefore Kaposi's (2011) proposal of a synthesis of these analytical methods offers evidence that such an approach can be valuable in the discussion of identity.

Research into professional identity in health and social care settings

In order to understand professional identity and the forces which can shape and drive professionals to restructure and reconceptualise their professions themselves,

an examination of the changes and tensions in these contexts, institutions and working practices should be undertaken.

Goodley and McLauglin (2008) examined focus group data gathered from both parents and professionals involved with the care of children with disabilities. Their findings indicate that professionals can and do act as 'socially embedded human actors, who are not passively affected by the changes around them, but have both choice and agency in the professional boundaries they draw and the conceptions of them as professionals are built and shaped by the way that they practice" (Goodley and McLaughlin 2008:19).

It is important to point out that not all professions or professionals are viewed as having equal power or status. Traditionally medicine, and also law, as disciplines and areas of practice are viewed as professions, characterised by autonomous practice, self-regulation and a type of 'collective altruism' where the needs of those being served are seen as having upmost importance (Kelly, 1998: 80). This idea of the medical professional as 'knowing what is best' and acting in patient's best interest in a paternalistic manner, establishes primarily doctors, consultants and surgeons professional identity as powerful and with a high degree of professional authority to define need and decide on treatment. This authority may result from the perception of what Schon (1992) calls professional artistry and indeterminate knowledge (Kelly, 1998). This is the ability to make decisions based upon their expertise and practical experience in order to deal with the variety of unique situations that they may be presented with. Another important point regarding the professional identities of health care specialists is through use of clinical expertise and empathic care practices individuals can discursively position themselves both as individuals and as groups sharing these characteristics within these organisations (McLaughlin and Webster, 1998).

Beck and Young (2005) in their analysis of 'the assault on the professions' also seek to explain how the role of professionals and their identities have been challenged, through questions over the autonomy, ethics and the legitimacy of professionals' claim to specialist knowledge. Their paper claims that a professional's relationship to knowledge has been altered by changes in the culture and contexts surrounding them, to a more 'marketised' and audit based culture. They lay some of the blame at

the feet of post-modern epistemologies which question the validity of 'expert' knowledge upon which the traditional conception of professional expertise rests.

The Community Care Act (1990) brought forth new questions about professional practices and conceptions of what it means to be a professional working in community health care. Care, which was traditionally the domain of the state and delivered within state-run hospitals and residential homes, was now to be transferred to teams working in the community, in individual homes and increasingly by private providers, less allied to established professions. Over the years since the Community Care Act much has changed about the ways that professionals work, not only with service users but also within the organisations through which care is provided (Parker, 2002). In addition to positive changes for the service user, such as increased involvement in decision making and care at home, Parker notes that there are increasing tensions between health and social care organisations and that assessing the needs of the service user which once was the 'cornerstone of care' has become a 'rationing device' (Parker, 2002: 3)

As a result of a new style of management and regulation in Public health organisations, professionals have been prevailed upon to change their practices in order to accommodate new notions such as 'empowerment', 'health promotion' and 'professional risk taking'. Defining and assessing need has traditionally been part of the role of health professionals, although this too is changing and now health authority managers and central planning mechanisms are increasingly becoming involved in what constitutes 'need' (Clarke, 1998).

McLaughlin & Goodley (2008) also discuss how successive governments have been key in bringing about changes in the management of health and social care organisations, which they term 'New Public Management' (NPM). For them this is a major factor, which is influencing the way professionals practice and make sense of their professional identity. Webb (1999) citied in McLaughlin and Goodley) characterises NPM as 'cost limited' and 'output driven' and damaging to the equitable provision of care, which has traditionally been bound up in the role of caring professionals.

McLaughlin and Goodley (2008) draw attention to the increased public doubt concerning professional's ability to decide and act in the patient's best interest. They cite well publicised scandals such that of Alderhay Hospital and the 2003 Laming

enquiry into the death of Victoria Climbie, as examples of incidents which have decreased the public's faith in professional power and self-regulation. At the same time as the public are beginning to doubt the all-knowing autonomous professional, the public themselves through specific patient/disability interest groups are 'creating a more critical and questioning context for professional practice' (McLaughlin & Goodley, 2008: 137)

Clarke (1998) in a discussion of community development and health professionals states that training of such professionals is often geared towards achieving objectives and certain patterns of activity which professionals are comfortable with in their roles. Practitioners could feel as though these new discourses force them to adopt contradictory positions as they adapt to changes in the organisational context and discourses around them, while still negotiating and at times attempting to preserve their familiar discourses and the professional identities within those. Changes in policy, socio-economic context and in the training of professions, have caused many healthcare professionals to question these traditional constructs, though there is resistance to letting go of the old modes of practice

Having central health management defining need could be a source of tension for professionals who are working with service users and assessing 'need' as they see it. This could cause conflict as this aspect of their professional and identity has been eroded, as discussed earlier. The old construction of their professional identity as caring for and meeting the needs of the patient or service user is likely to be problematic when faced with having to prioritise rather than cater for the needs as perceive them.

The meaning of new terms introduced through the changes outlined above may require an innovative approach and work on understanding how they relate to the new negotiated reality of practice. Changes to social practices have consequences for the way work is done as "*a social practice engenders particular ways of being and acting"* Goodley and McLaughin (2008). The work and talk around and about themselves and their role as a health or social care professional constitute a major part of the social practice of professionals. As such we see the idea of discourse as action played out in practice, and as creating a particular social reality, as discussed earlier (Potter and Wetherell, 1867)

A shift to new language such as 'health gain', 'resource effectiveness' and 'people centred' and focusing on 'those with the greatest need' are hard to argue with and arose again from changes in governmental policy such as the government white paper 'Caring for People' (1989) though some would call it rationing by the backdoor. 'Bedside Rationing' is far more emotive term than prioritising, therefore prioritising has entered the vocabulary of the health and social care work force as it forms a part of their practices and discussions as prioritisers at the individual practitioner level of primary or community care (Roulstone, 2007; Klein & Maybin, 2012).

The ability of professionals to freely assess and determine targets for patient health is beginning to be eroded, along with their freedom to be able to establish and define their interactions with patients or service users. Clarke (1998) suggests that this is due to the new forms of management, restricted resource levels, control over their roles and contractual obligations in the changing services within community care. Goodley and McLaughlin (2008) state that professional authority has also been undermined through increased governmental regulation and wider societal changes. Webb (1999) also sees NPM as a threat to professionals' ability to self-regulate, replacing this high trust ethos with 'low trust...quasi market regulation' (Webb, 1999 cited in Mclauglin and Goodley, 2008). Public scepticism, as examined earlier has meant that the ability to self-regulate and indeed conceive of professionals as self-regulators has decreased. This has been in part due to the public's view that regulating bodies such as the British Medical Association are less concerned with regulation and more concerned with protecting their members.

Not all those researching changes in social care organisations agree that NPM has eroded professional autonomy (Evans, 2010). Daudigeos (2013) discusses the ways in which individuals can exert their influence and exercise agency within organisations. He investigates how professional practices can be brought within organisations to either promote or disrupt practices within the organisations which employ these professionals. Others even question whether autonomy is the correct way to characterise what is claimed to be being eroded, preferring to characterise autonomy as an ideal state that few professionals can actually claim to possess, and choosing the term discretion instead (Evetts, 2002).

Given that conceptions of professionalism and professional identities are so dynamic, what about the power that professionals have? Kelly (1998) suggests that

the power of professionals could be relatively stable as she views its origins in the practitioner taking on responsibility for the welfare of the client. Metcalfe (1992) also suggests that power of caring professionals comes from more altruistic motives than that of mangers: namely, that they are taking on a duty of care rather than seeking power in and of itself. It is argued by Goodley and McLaughlin (2008) that this professional power can be useful, and increasing recognition is needed of the ways in which both professionals and the organisations in which they operate can and do use their professional power to benefit those that they work with.

Methodology

This chapter will explain the methodological approach employed in this research project and outline the epistemological and ontological positions delineated in the previous chapter. The implications these have for the investigation of professional identity construction, and the manner of data collection and analysis is also explained. The chapter elucidates the particular research process undertaken in this project, including a rationale for how and why it was carried out with these methods and how and why discourse analysis was chosen for the analysis of this data.

The aim of this project was to investigate how occupational therapists construct their professional identities and whether these constructions differ between therapists employed in health settings and social care settings. Following on from that, an additional question examined by this research is whether these different constructions may affect the practice of these professionals, specifically their judgements around providing equipment to children with complex health care needs.
As discussed in the previous chapter, it is theorised that professional occupational therapist's constructions of their professional identities relies on the discourses and subject positions made available to them through both their professional institutions and training, and their organisational employers as well as the changing discourses surrounding patients choice, healthcare consumerism and legislative changes.
Working with the occupational therapists when gathering information for a review of the children's equipment service in eastern Cheshire was an interesting experience, particularly their discussions about the current provision and how they worked on a day-to-day basis. Closer examination and reflection on not what they said but what their talk accomplished gave rise to an investigation of how these professional women were constructing themselves as professionals. This was not what an anticipated outcome of examining their talk but was a clear theme which through analysis will be explicated in this research thesis.
In order to establish the context in which participants were involved or recruited and the method by which data was collected and collated, it is necessary to explain the origins of this project. The research arose from a request by external organisations, namely Cheshire East Local Authority and the local Primary Care Trust, through

Manchester Metropolitan University to conduct an investigative review of processes within their children's equipment service and to make recommendations on how this service could be improved.

The project can be considered in as taking place in two stages, which are linked both by the participants, organisations and the data which were generated, but which remain distinct in terms of the aims, analysis and the findings or outcomes of these stages. These stages are referred to here for clarity as the initial consultation stage and the primary research stage. Additionally, one process ran concurrently throughout both stages - the ongoing engagement with current academic literature, which informed thinking and analysis throughout.

Initial consultation stage

The aim of initial consultation stage of the project was to gather data for a consultation report on the processes currently in place for the provision of specialist paediatric equipment in Eastern Cheshire. This involved detailing all elements of the current provision such as demand on the service, funding streams, figures for past and projected spending and the processes of referral, assessment and prescribing of equipment. During the initial consultation stage of the project, data generated was in the form of documents and interviews and focus groups with providers, therapists, managers and administrators. These data were analysed and used to detail a variety of aspects of the current provision which were under investigation (please see appendices for a breakdown of these).

Based on a review of this data, the PCT and LA required a consultation report to be produced which would make recommendations for improvements to refine these processes and for potential new processes or innovations which might transform the current provision. When initiating inquiries into the current state of the service and beginning this stage of the project, a broadly social constructionist position to discussing potential changes was adopted, influenced by a theoretical approach to organisational change – Appreciative Inquiry (AI).

AI originated from the work of David Cooperrider (1986) and was developed by Cooperrider and other proponents of this method (Cooperrider and Srivasta, 1987; Busche, 1998; Cooperrider and Whitney, 2000; Ludema, Coopperrider and Barrett, 2001; Coghlan, Preskill and Tzavaras Catsambas, 2003; Cooperrider, Whitney, and Stavros, 2003). AI is founded on social constructionist principles, and as such, this

method assumes that realities within organisations are co-created through the diverse experiences and perceptions of individuals within or involved with the organisation (Cooperrider and Whitney, 2000). AI is a method of researching organisational change that focuses on achieving positive changes within organisations and has been developed with people rather than mechanistic processes in mind, and pays particular attention to the language used by people when conceptualising the organisation and any change that is anticipated (Coghlan, Preskill, Tzavaras –Catsambas, 2003). This approach stresses the importance of understanding what works when the organisation is functioning at its best. As such AI suggests that any inquiry includes workers from throughout a particular organisation so that a more holistic set of views and accounts about what is deemed as 'best' are gathered. Through the generation of positive narratives and interview protocols, AI proposes that change within organisations begins with the co-construction of positive visions of the future. Proponents of the approach suggest that AI seeks to change people's thinking which can be a more effective practice for sustainable positive change (Busche,1998) than traditional organisational design approaches, which concern themselves with more mechanistic and behavioural changes (Busche and Kassam, 2005). Given the tensions surrounding health care and turbulent atmosphere and widespread opposition to the health and social care reform bill (Kings Fund, 2012; Pollock, Price, Roderick, 2012), it was decided that a more positive approach to discussing potential organisational change might be more fruitful and better accepted by the participants.

Due to the constraints of time and funding to fully implement this methodological approach, AI was used rather as a set of principles which informed the theoretical position or starting point for the collection of data for this research. To give an example, AI was used as a guide on how to prepare for and conduct interviews and focus groups, specifically the language used when discussing the project with potential participants. In accordance with one of the core principles of AI, that of simultaneity, "the very first questions we ask set the stage for what people discover and learn and the way they co-construct their future" (Coghlan et al, 2003: 9). So by approaching the inquiry using deliberately positive language even in preliminary phone conversations with potential participants, it was hoped that participants would adopt a positive framework through which to discuss the current and future state of

the service. According to AI proponents this approach produces lasting and transformative change more readily (Busche and Kassam, 2005).

As part of the initial stage, contact was established with key stakeholders from both the LA and PCT who were directly involved in the provision of specialised equipment to children with complex health care needs in the local area. These two stakeholders were both representatives from the joint commissioning team who directly commissioned the service under review. These individuals were a commissioning manager from the PCT and a strategic manager from the LA. Following familiarisation with processes and procedures, it was possible to proceed with gathering the requisite quantitative data for the consultation report, such as past present and projected budget figures, amounts and avenues for funding, as well as attempting to establish demand on the service. This was done through a series of requests to managers and administrators. Following this phase of data gathering, qualitative data was required to gain accounts of the experiences of professionals. Other workers from the PCT, LA and parents were invited to participate in one to one interviews and focus groups. The professionals included team leaders and members of the LA, or paediatric community occupational and physiotherapy teams. Initially these individuals were invited to participate via an information email which had a flyer giving details about the project. If an interest was expressed, then a time was arranged for the respondent to be interviewed or an invitation was issued to attend a focus group event with other professionals.

Publicity for the participatory focus group events was initially generated through a series emails sent to employees from both the LA and PCT who had attended a Cheshire equipment service event at Tatton Hall during November 2011, when the project was first introduced. The events were also publicised through either the LA or PCTintranet and using recruitment posters (see appendices) Email invitations were also sent to team leaders of occupational and physiotherapy services with the PCT and LA in east Cheshire. Additional posters and flyers (see appendices) were generated for display and distribution at local special schools, support organisations for children and parents who might access the service and in the communal spaces at the wheelchair service, the community health therapy centre and the independent living centre where the LA equipment provider was based.

As part of the data generation process, a number of interviews were held with key stakeholders and employees from both health and social care organisations and equipment suppliers. These interviews were to gain information about their experience of working within the service and implementing the current processes.

Two participatory focus groups were also held specifically to engage with a range of professionals and parents to discuss what was working and what could be done better in terms of the provision of childrens specialist equipment.

Participants who attended both the focus group events and interviews were issued with information sheets and consent forms (see appendices) and notified of the use of a dictaphone to record the interviews or focus groups. All participants signed their consent forms and were happy to proceed.

Participants

In total six one to one interviews and two focus groups were conducted. Two interviews were with representatives from equipment manufacturers. The manufacturers contacted and interviewed were the two who were currently in a pilot scheme with the LA to provide children's equipment and as such were providing the majority of specialist equipment to the service at present. This is why they were selected rather than suppliers who were operating using a model of provision which the LA was intending to phase out eventually.

A further interview was conducted with a representative from East Cheshire wheelchair service. Although distinct from the LA provider and funded soley by the PCT, an interview with the manager of this service was considered important for several reasons. Firstly, the wheelchair service provided some equipment that was also provided by the LA equipment provider. Secondly, in some key aspects their provision model differed from that of the LA equipment provider and thirdly the wheelchair service was an additional avenue through which children and their families could access specialised equipment.

In order to better understand the current processes of referral and assessment in the existing provision model, it was advised that a number of preparatory interviews were conducted with therapists from the community team. As the paediatric occupational therapy team and the physiotherapy team are based in the same

building, it was possible to conduct a joint interview with a paediatric occupational therapist (POT) and with the team leader for the community paediatric physiotherapy service.

Because of the requirements of the initial project the sample of participants was purposive; participants were chosen for the contribution that they could make to the initial phase of the project in terms of their engagement and were asked to participate voluntarily, although there may have been an element of persuasion by other stakeholders such as managers or team leaders to take part as a representative of particular teams. This was outside the control of the research protocol but is noted here as a possibility.

The first focus group conducted included a representative of the equipment service the LA equipment provider, a community occupational therapist employed by the local authority and a delegate from the primary care trust. The second focus group comprised a larger number of participants 10 in total; 4 occupational therapists employed by the LA, 2 from the community paediatric team employed by the PCT, 2 representatives from both the LA and the PCT representing the joint commissioning group, a parent who had not been previously interviewed, and a member of the children's complex health care team (again from the PCT). All the participants, except the parent who attended the second focus group were female. All participants described themselves as Caucasian and all participants were over 35 years of age. Full or individual details of participant's age and social demographic information was not collected as it was not deemed to be pertinent to the topic under investigation in the initial data collection.

Conducting the interviews and focus groups

Interviews

The interviews used a semi structured style and participants were invited to respond freely to questions which centred around the current provision and processes (please see appendices document detailing examples of questions asked by the researcher). It was made clear to participants that the questions were to be used as a guide only and they were free to say whatever they felt was relevant.

The interviews with the manufacturers took place at the Independent Living Centre, and the other interviews took place in the place of work of the team leaders or therapists being interviewed.

Focus groups

The focus groups also used a semi structured style where participants were encouraged to respond freely to questions which centred around the current provision and processes (please see appendices document detailing questions asked by the researcher). It was made clear to participants that the questions and any resources, such as printed copies of flow charts depicting the current process for equipment provision through the LA, generated through the previous interviews (see appendices), were to be used as a guide for discussion or for them to use to record written comments on and participants were free to say whatever they felt was relevant.

It was deemed most appropriate to conduct the focus groups in buildings not owned or associated with either the LA or PCT to facilitate participant responses. The two participatory focus groups were conducted at a local masonic hall and on the Crewe campus university respectively.

Handling the data

Each focus group and interview was recorded and initial feedback and comments made about the process and the service on pen and paper also, for inclusion within the report. The consultation report was completed in April 2012 and was presented to the PCT and the LA at a meeting of the Joint Commissioning Group where the key recommendations were discussed with the Joint Commissioning Team (See Appendices) Following submission of the report, the PCT and LA have done work to prioritise and refine the recommendations to produce an action plan for changes within the Children's equipment service. An additional participatory event was held to discuss the implementation of the action plan and to form work groups to carry out these changes. Since this participatory follow up event took place, one of the report's key recommendations has been taken up – re-writing the criteria for assessment in the service. Following successful completion of this report, funding was agreed for the primary research stage.

Primary research stage

The participatory focus group events and interviews described above provided the data from which this thesis was created. Initially when the interview and focus group data was used for the purpose of the consultation report, any explicit comments spoken or written down regarding how participants felt about the processes were gathered and included as staff recommendations or comments in the report . This was in line with the aim of the consultation report; to make recommendations for improvements to the service. Therefore, in this initial reading of the transcripts, only suggestions or comments about where the service functioned more efficiently or accounts of current working practices were sought.

When the transcripts were utilised as a source of data for the thesis research, they were analysed in greater depth using discourse analysis, and rather than the explicit denotation of spoken content, analysis focused on the use of language itself by participants and implicit connotations within the data. In analysing the data from the focus groups, I also incorporated my own observations of participant interactions to aid interpretation of the talk where applicable (see appendices for a sample of raw transcripts and initial coding).

The subsequent use of the data in this way lead to an examination of the research questions; how do occupational therapists from health and social care construct their professional identities and does the way in which they construct their professional identities differ and if so what impact might this have on service provision?

The participants were not responding to questions which were intended to directly illicit answers regarding their views on their professional identity. It cannot be claimed that the talk used here as data was naturally occurring as there was an specific and stated purpose for the interviews and focus groups and participants awareness of the fact that they were being recorded and were initially engaged in the discussion through the use of predetermined questions. However, once questions to gain specific information had been asked, there was a conscious effort by the researcher to allow participants to lead the discussion rather than being lead by further specific questions. As mentioned earlier, in accordance with AI principles there was an intention to introduce positive language into the discussion of potential changes within the service, but if participants appeared to stray repeatedly from any positive reframing by the researcher, then attempts to reintroduce this were relinquished.

It should be noted that here the involvement of the researcher as a participant in the data being generated is not seen as inherently problematic during focus groups, particularly because this research adopts a social constructionist stance. In her paper addressing the co-construction of the research process, Bell (2011) argues for a recognition of differing definition of the researcher- participant relationship and the experience of participation in interview situations generally. She draws on "Heidegger's ontological principles of authentic existence and reciprocity in interactions (Heidegger, 1975, cited in Bell, 2011: 5). Wendt and Boylan in fact assert that for research which is postructuralist in nature see "the interview as co-constructed between the interviewer and the interviewee" (Wendt and Boylan, 2008: 606). Therefore, as a contributing member of these interactions, in analysing the data of focus groups and interviews it is necessary to acknowledge that I brought my own understandings and prior assumptions about professional identity and experience into these conversations. This may have lead to the formulation of questions and responses, both planned and unplanned in a specific way. Researchers using social constructionist approaches and methods must be aware of and acknowledge their influence on the talk that they are part of creating. AI suggests that phrasing of questions in a positive manner is important if positive constructions are sought from participants. When deciding on questions prior to the interviews, phrasing questions positively was, in part, a conscious effort. During the interviews I also found that on a number of occasions, I attempted to steer the conversation by asking positive questions to elicit a more positive response than I felt I was receiving. Therefore, I cannot and do not claim to have been an impassive and objective observer, but acknowledge my role as part of a dynamic, co-constructive dialogue within the interviews and focus groups and must also recognise the influence this may have had on the interpretation of the talk of participants during the analysis.

According to Wilkinson (1998) the use of group interviews or focus groups can challenge the traditional power relations which are found in the more frequently used one to one interviews. She states "the relative power of research participants in a group discussion is manifested through their taking control of the topic of conversation" (Wilkinson, 1998: 114). This manifestation of control within the participant group was evidenced on numerous occasions during these focus groups,

where the participants set the agenda rather than the researcher. It is perhaps possible to assert then that as participants talk was focused not on directed questions about professional identity, that they would be less likely to talk in a way which they might feel was desired by the researcher and the responses were therefore subject to a lesser degree of influence.

It could be also be argued that by asking questions about the service, this indirectly generates data which is laden with examples of individuals asserting their professional identity through talk, rather than merely espoused identity. Frazer (1988) found that although she hadn't asked her participants about social class directly, they often raised this topic themselves as an issue. In the focus groups reported here, participants returned on numerous occasions to themselves as professionals and their professional practice even though the questions asked by the researcher did not pertain to professional identity per se.

In addition to the freedom to respond with more control, the situation or context created in the focus groups was in some ways not entirely different to that which these participants might experience in their professional lives. For example, many members of the group have professional association with one another and occasionally will be present in meetings together. Other participants worked together on a regular, if not daily, basis and there were points in the interview where the recording equipment was turned off while participants discussed a particular case in which they had mutual involvement.

The questions asked in the focus group sessions and in interviews largely related to areas of their familiar practice and on occasion participants would discuss incidents which, if they did not have direct experience of, they would demonstrate their mutual understanding. Therefore, under these circumstances, the focus groups had familiar elements which, it could be suggested allowed the participants to respond in a manner which was close to, if not precisely, natural. The nature of the process of analysis after the interviews were transcribed was iterative, with numerous readings and re-readings of the transcripts as well as repeatedly listening to the recordings to look for patterns, and emergent themes from the data. As part of a circular process, on reading and listening to the data, patterns emerged, were noted and coded and the data were returned to on numerous occasions until strong and consistent patterns emerged. This approach to initial treatment of data is recommended by

Potter and Wetherall (1987) and Edley in his model of critical discursive psychology (2001). Main coding categories included; *self as professional, clinical/professional judgement, experience versus novice, need versus wants, management 'speak', resistance to change, personal experience, the professional 'I', "all singing, all dancing", tick boxes* and *health or social care*, parent practitioner conflict, and These broad, overlapping categories were refined and where links between these categories remained, these have been explained in the analysis.

From these coding categories, three discursive themes were selected as topics for close analysis and are discussed in depth in this thesis. These are*, the experienced, autonomous 'I'*, '*We and they'* and *'defining needs and wants'*. In reading and re-reading the transcripts, these were the most prominent and frequently occurring themes or discourses apparent within the data and reinforced an over-arching discourse between the participants of themselves as professionals. The possibility should be noted here, that these particular themes were interpreted as more salient because of the simultaneous process of analysis and engagement with literature. For instance, it may be the case that on reading literature which emphasises the application of the 'sociological imagination' to workers managing personal and social identities (Watson, 2008), or the tensions that exist between health care professionals and 'New Public Management' (Goodley and McLaughlin, 2008), a certain sensitivity to concepts from such literature may have guided the analysis. Other themes were indeed present, but once again due to constraints on time and for clarity in terms of a consistent theme running throughout the analysis, these are not included in this analysis. However, the talk of participants within these discrete topics chosen does incorporate some of the other categories and links to these have been explained throughout the analysis.

Conducting research ethically

As part of the research process it has been necessary to attend to the ethical considerations of conducting a research project which, at its heart was a discussion around the provision of equipment to chronically sick and disabled children.

In submitting my proposed research to the University, I completed departmental and University ethics documentation and had these passed by the University on acceptance of my proposal. As I was being indirectly employed as a researcher in the NHS I was also required to apply for and be granted a NHS research passport

which involved ethical clearance of my proposed work and an assessment of risks to myself and to those I might have contact with. As part of this procedure I also was subject to enhanced CRB checking procedures.

But in addition to successful ethical clearance from the University it was important to address the main principles underlying contemporary research; protection from harm, respect for individual dignity, right to self-determination and privacy and the protection of confidentiality (World Medical Association, 2008).

In accordance with these principles and guidance on conducting research within the NHS, the research was conducted with full consideration about the risks to participants of potential harm. During the course of the project, as I as the researcher was to come into contact with professionals and parents who had sick children I was vaccinated against conditions which were identified as potential risks to these vulnerable groups.

Also in accordance with these principles and with the British Psychological Societies Code of Ethics and Conduct (British Psychological Society, 2009) the following steps were taken to ensure these ethical principles were adhered to.

I produced documentation which gave details of the projects aims, the intended use of any data collected, notifying participants that interviews and focus groups were to be recorded for later transcription and advising them of their right to withdraw consent. In addition all participants were required to sign documents which had statements of informed consent if they wished to participate in this project (please see appendices for these required ethics documents). It was made clear on these information and consent sheets that participants would be debriefed at a time when the research was ended. This debriefing is planned for later in 2013 due to the availability of participants.

All real names of participants or anyone mentioned by participants were removed from transcripts on first transcription and pseudonyms selected to replace those and identifying details were removed. At all times as a researcher I engaged with participants and anyone connected directly or indirectly with honesty and discretion, making sure to declare any potential conflicts of interest. At all times I have also taken steps to fully comply with University codes of conduct concerning the production and handling of data to avoid any fabrication or dishonesty.

Reflexivity and Criteria for Evaluation

As a qualitative research project, this thesis operates on certain assumptions and views about conducting research, which have implications for evaluation of the work conducted and claims for knowledge. As outlined in this and previous chapters, the epistemological and ontological framework for this research is that of relativist social constructionism. For instance using terminology or criteria such as ecological validity, replicability, reliability are in themselves no longer helpful or appropriate because the research is not making claims of a universal truth being revealed or that the research process itself can be thought of as objective. Put simply any assertions made here are both 'contingent' and 'situated' (Taylor, 2001: 319) and have been made possible under the specific conditions (both of place and time), participants and individual interpretation of this researcher. That is not to say that the position adopted is one of extreme relativism. Such a polarised stance might invite the *Tu quoque* critique or argument (Potter, 1996) whereby in claiming the 'socially constructed nature' of my findings on professional identity, my "findings too must be socially constructed and if the finding is that the…. findings are socially constructed is itself socially constructed it need not be taken very seriously and the whole enterprise is self-defeating" (Potter, 1996: 228). This kind of extreme relativist position is certainly not the starting point from which the findings are to be viewed. Foucault asserts that "discourses are practices that systematically form the objects of which they speak" (1974:49). Therefore, it is not unrealistic to assume that the therapists talk examined here could be meaningfully compared to the talk of occupational therapists in another study, as their practices and some of the discourse of professionalism available to them arise from and are maintained by organisations and institutions which these women are members or employees of, and as such share these discourses in commonality. This highlights an intention towards a more realist position where "our social constructions are mediated through… the materiality of the world and pre-exisiting matrices of social and institutional power" (Nightingale and Cromby, 1999:208). Adopting a social constructionist stance and a discourse analytic methodology which attempts to move away from extreme relativist positions is not uncommon. In his discourse analytic work in organisational studies, Fairclough (2005) sets out case for a more critical realist approach.

The use of qualitative methods or a social constructionist epistemology does not preclude meaningful evaluation nor does it lead to a situation where claims made by such research cannot be legitimated (Denzin and Lincoln, 1998). Rather it requires terms or criteria which are applicable to a research framework where "the researcher is inevitably present in the research" (Coyle, 2007: 21). Bias or differences in the participant sample are viewed as part of the context and are treated as such rather than being controlled for, or efforts made to exclude them . Noteworthy attempts have been made to produce a definitive set of criteria for the evaluation of qualitative data (Serle, 1999; Elliot, Fischer and Rennie, 1999; Yardley, 2000) and specific recommendations for good practice in discourse analysis put forward (Seale, 1999; Potter and Wetherell, 1987). Where applicable these evaluative criteria have been utilised in the process of understanding the value of this research project and in an effort to be transparent about the processes of data collection and analysis that have been undertaken, for example, sensitivity to context.

Through examination of current research literature in the area and attention to other studies which have utilised qualitative analyses to address issues within health and social care settings, this research attempts to be sensitive to the way research and the relationships between participants and the participant and the interviewer are managed and considered.

Specifically for evaluation of this research, it has been necessary to attend to the particular differences between participants in their occupational background and the contingent ideological positions that are available to them. For instance, workers employed by the NHS may have different ideological positions and experiences of the provision of services than those employed through the local authority. Similarly, the researcher may hold differing beliefs about professionalism because of a background and experiences working in the education system. Indeed, from the very beginnings of the research, differences in processes and attitudes to the organisations of the NHS and the local authority were apparent between both health and social care and the more familiar processes in educational institutions. It was important to recognise this and to ensure that the impact of this perception of differences and experiences was acknowledged during interpretation of the participant's responses during the interviews and focus groups. Davies (2004) suggests that experience is not something that can be easily omitted from the

research process and that attempting to do so is not recommended. Therefore, during the process of gathering data and during the analysis I have made attempts to document and be sensitive to occasions when my experience may have been leading me to make assumptions or unwarranted interpretations about what the participants were saying.

In addition to the occupational backgrounds of the participants and researcher, it should be noted that amongst the sample there were no male participants. Occupational therapy has been considered a female dominated profession for many years (Rider and Brashear, 1988) and therefore among the participants recruited here it was unlikely there would be any male occupational therapists present. When asked about whether there were any men working for this particular service, participants advised that there were none that were known. Therefore in terms of this local context the participants recruited for this study may be considered appropriate in terms ofthe gender ratio and this balance or lack of it is one which might well be common in other groupings of occupational therapists.

On reflection further details about length of occupation with the service and prior training and or profession might have been valuable information to collect about the participants, as this may have had an effect upon their views of themselves as professionals and their current role. However, once again because of the origins of data collection this was not possible.

It must also be acknowledged that upon initiating the interviews and focus groups, there was an awareness that the key stakeholders wished particular ideas to be discussed. For instance, there was an expectation that the main focus of the participatory focus groups would be refining both the current criteria and the process for providing equipment as a whole. As a researcher, my expectations were more flexible and I hoped rather that discussion would be less directed and that through this, participants would discuss elements of the process which were salient to them. Indeed although there was discussion around the criteria, participants largely set the agenda of the research themselves which lead to unexpected but strong and rich themes about themselves as professionals emerging from the data set.

This highlights another area which, as part of reflexive practice, it is pertinent to mention. Initially the data under analysis were collected as part of a commissioned review of the service with a stated aim to improve the status quo through changes to

the process of equipment provision. Although as a researcher from an external agency the participants may have perceived me as an outsider, I may also have been perceived as an agent of management or 'the boss's helper' (Loughlin, 2006; 52). According to Loughlin, no matter what the intent of the well-meaning researcher, the commissioners of the report were expecting some changes to working practices to come out of the review process and this could have influenced the way in which I as a researcher conducted the interviews and focus groups. It could also have influenced the participants view of me as a researcher, as someone who has been recruited to 'find new ways to tell the workforce that they are rubbish'(Loughlin, 2006:52). I must point out that I frequently reminded participants that it was their views that were important and that the purpose of the groups was not to monitor or to prescribe new practices. This does not mean though that the participants did not view me as the boss's helper and as such may have felt as though they needed to justify their current practices to either preserve the status quo or as a means of justifying their practices against scrutiny. It could be argued that the use of AI principles of positive framing could have mitigated their perception of me as boss's helper.

At times I recognised that there was a certain tension between some participants (management and non-management employees), often demonstrated in a change in tone of voice, or of body language, for instance folded arms and even demonstrated more explicitly through language. The extract below demonstrates this tension with Jenny and Bridie discussing the introduction of a checklist which occupational therapist would complete during an assessment. My notes on the meeting at this particular point in the exchange say that Bridie folded her arms and then made a hand gesture to indicate a marionette puppet being controlled (italics in this extract are to show the emphasis and change in tone from the actual participant).

Jenny:..from a commissioning point of view ... we thought that to be fair then it's its then everybody gets it its equality you know because at the moment we know it's not equal people will want things differently across the across the patch and what *you* might think is appropriate somebody *somebody else* might not not think its appropriate and somebody else will think well they need all this and someone else will say well they *don't* need that they can manage

with this so by having a criteria and more strict [hmm] criteria and a trigger for what is appropriate well will be urm fairer

Bridie: hmm well I mean we are *always* going to have OT's that will think differently *that's not going to go away you know*, you will always have clinicians thinking abstractedly yeah because we are autonomous *we're not automatons or whatever*

This may have arisen in part because of pre-existing power relations, but also because of the particular circumstance of bringing these particular participants together to discuss their ideas at a time when there were tensions around changes to working practices and constraints on the budget. This may have also contributed to some participants occupying defensive positions to justify why budgets should not be cut or in the case of their everyday practice why they worked in the way that they did. Overall, the adoption of these positions may have led these participants to overemphasise their role and their professionalism as a form of defence to any perceived threat to their role or their identity as professionals. As this could and likely did have an impact on their constructions, indeed on the very subject under analysis here it is important to note it. Perhaps at a time when there were not such tensions in terms of access to funding and changes taking place within the organisations, participants could be seen to utilise differing constructions.

When deciding where to hold the interviews and focus groups the location and the effect that the environment could have upon the participant willingness to discuss issues relating to working practices was considered. During meetings with the supervision team venues for the interviews and focus groups were discussed. Interviews were primarily held at the place of work of the interviewee. This could have implications for the power dynamics between interviewer and interviewee. The interviewee may have had more power in relation to the interviewer in these cases, as the environment was familiar to them and may reinforce their status and role as professionals because they are in their place of work where their professional identity is more salient.

The decision was made to hold focus groups in locations not owned by the LA or the PCT. This decision was based on an awareness of and sensitivity to power dynamics in the environment. As the focus groups were open to professional and parents and it was mentioned that parents may have felt reticent to attend or when attending may

have been reluctant to discuss their opinions of the service openly if the focus groups had been held in buildings owned by the providers of these services. Holding one focus group at a masonic hall and the other at the University campus was based primarily on the geographical suitability of these locations for the local catchment areas but it was also hoped that attendance and more open responses would also result from more 'power neutral' locations being selected.

During the focus group conducted at the University campus the power between those attending and the researcher may also have been different than at the Masonic hall. On campus the researcher is on familiar territory, surroundings which reinforced my status as a researcher and therefore providing me with a sense of power and perhaps more confidence in my participation (reference needed)

Power dynamics between participants during the focus groups is also a factor to be considered as a potential influence on the constructions highlighted in this thesis. For example, although the extracts are focused on the talk of the occupational therapists, it is almost certain that these therapists will have specific power relations with other participants because of their roles and positions within work place hierarchies. Work place power relations are thought to be asymmetric with those who have prescribed authority, with 'managers and team leaders' having more power because of their role. There are examples where this power can be seen to be played out in the extracts.

These asymmetrical power relations may have contributed significantly to the therapist's constructions of themselves as having power and their constructions emphasising their professional expertise and experience.

Power relations between the professional and parent must also be considered as part of the analysis. During the largest focus group session at Crewe Campus, when the parent attended the group I noted a palpable shift in tone of the discussion and the behaviour of the other participants which may be attributable to changes in the power dynamics caused by having a service user present. Again due to the nature and status of the occupational therapists as 'expert' and in a position to provide services, power relations may be assumed to be asymmetric. In fact the dialogue when the parent entered the group indicates an open acknowledgement of this by the parent

Bob: You've all got good titles then I'm just a foster carer {laughter from group}

Bridie: Well I don't know..you're the one with the harder job there I think

Ensuring that power relations and other elements of context are acknowledged and their impact on the data is recognised is fundamental to a sensitive approach to the context. Sensitivity to context is one of the criteria that Yardley (2000) highlights as an important criteria for assessing the worth of qualitative research.

It is also important to consider the demographic characteristics of the participants here also. The professionals who took part in the focus groups were all women, who were aged between 30 and 60. The only parent who was present was a man in his late 50's to early 60's. The fact that the parent was a lone male amongst numerous female participants, and that, as mentioned above, there may have been asymmetric power relations between him and the other participants due to his status as a service user versus the professional status of the other participants, provide a very imbalanced power situation between them. An attempt was made by the researcher at the time to make this participant feel as though his views had importance to try to redress this.

Having been engaged on this project for almost 14 months and having been in the process of analysis for the past 8 months, it is hoped that a high degree of commitment to this research is evident.

Analysis

The following is an in depth analysis of extracts chosen from amongst the coded themes. The focus group data from which the extracts were taken were very rich, and it was challenging to select these particular discursive themes while rejecting others. The selection was based on the pervasive nature of these instances throughout both focus groups and because of their relevance to an over-arching construction of the therapist's professional identities.

As part of the process of transcription, participant's names were substituted for pseudonyms. Later as analysis was conducted, these transcripts were updated and coloured text used to identify organisational membership[1]. Line numbers accompanying the extracts used are taken from the transcripts directly and as such, groups of extracts and their line numbers are not chronologically sequenced.

The experienced, autonomous 'I'

Through their talk and practices within and about the processes of the children's equipment service, occupational therapists participating in the focus groups were seen to be constructing their professional selves, both as individuals and as members of a group (their profession). The use of the personal pronoun 'I' and it's counter, perhaps preceding partner, 'you' have been discussed in research on identity as more than merely symbolic of an objective, external individual outside of the discourses being examined (Shotter, 1989; Benveniste, 1971 in Shotter & Gergen, 1989). In these examinations, 'I' and 'you' are used in each new instance to create understanding of both who is speaking and what the individual wishes to be understood about themselves. Shotter (1989) asserts that these terms provide 'social accountability', permitting the speakers to position themselves within the established social order enabling them "to act routinely and in an accountable

1 The following should serve as a key to identify organisational membership when viewing the extracts used throughout the extracts in analysis section. **RESEARCHER (MMU), SOCIAL CARE (LA) OT, SOCIAL CARE MANAGMENT, (LA) HEALTH (NHS) OT, NHS NURSING CONTINUING HEALTH CARE, HEALTH (NHS MANAGEMENT), PARENT OR CARER (PUBLIC SERVICE USER).**

manner – their actions informed in the course of their performance by such procedures" (Shotter, 1989: 142).

The following extract was taken from part of the transcripts at a point when a specific aspect of the 'process' (here meaning the process by which specialist equipment is assessed for and ordered through the Cheshire equipment service) is being discussed directly. Bridie, a community OT speaks first and immediately begins by establishing her position on the policy laid out by the PCT and LA on community occupational therapy practice and adaptation. Here, if viewed as suggested above, Bridie's use of I and Emily's use of you are allowing them to construct and account for themselves in the context of this conversation. They do so in relation to established practice and account for actions in their individual practice which might resist the dominant social order of the 'process' laid down by their organisational employer. This 'process' is constructed here as potentially constraining – but as will be made clear Bridie is not prepared to accept such constraints as an individual professional.

BRIDIE: Can I just say that in Cheshire East now if you order something or your give somebody a prescription that is now you are back out you're finished! *Personally*, from a professional point of view I'm not prepared to do that I will follow it through to the end *I* will ring the customer up *I* will say have you got it? If it is a big piece of kit I'll say can I come and check it? everything alright? brill all closed but *I* am *not* prepared just to close without any follow up.
EMILY: Yeah even though the process says thats it end of you're you feel your care extends beyond-
BRIDIE: Yeah but no-one has taken me to task on that yet they will probably have a job when they go to the HPC whatever it is-
JENNY: But you are aware that you are out of the process on that? Because that isn't what you are paid to do-
GEMMA: Is there any way that-
BRIDIE: -I can't help it, *sorry!*
EMILY: Professionally you've got to

In lines 2297 to 2300 Bridie can be seen to be talking specifically about her own practice as an individual professional. Initially at line 2997 she had been using 'you' to refer to OT's in the service more generally. Then she says 'personally' (2997) intoning so as to emphasise that this is how she as an individual views her responsibility as a professional and in the next two lines the personal pronoun 'I' or 'I'll' is used on 5 separate occasions.

In line 2301 Emily, who is also an OT but is employed by the PCT rather than the LA and specialises in paediatric occupational therapy, adds to this discussion but using the 'you' pronoun here could be attempting to indicate that Bridie's practice is acceptable or recognised within the wider community of OT's and part of their duty of

care. Duty of care is a wider concept and element of practice that is outlined in documentation from the College of Occupational Therapists a key part of their professional standards and backed up by legislation. In line 2301 2303 the OT's explicitly state that they are aware that the actions Bridie outlined are beyond their 'remit' according to the policy 'process' of the organisations they work for, which Jenny reminds them of in line 2304. But Bridie, with the support provided to her by Emily who draws on the notion of the wider OT community, mentions that should she be challenged on this or 'taken to task' (2302) she would find support and recourse from her professional registering body.

Lines 2307 and 2308 see Bridie again talking about her practice as inevitable and just something she has to do, and Emily immediately legitimating her actions under the auspices of their professional identity. At this point upon uttering line 2307 Bridie shrugs her shoulders, which could be interpreted as another nonverbal demonstration of her indifference to organisational demands in the face of her own professional practice.

This extract brings into focus the tension highlighted by Goodley and McLaughlin (2008) between the professional and 'New Public Management'. The OT's here are constructing organisational policy demands as competing with institutional demands and discourses around 'Duty of Care' as professionals . In this exchange Bridie and Emily together construct their practice as individual actions underpinned by the shared implicit values of their wider professional group and use the wider discourse to jointly resist the challenge that Jenny presents.

This is not an isolated incident in the talk of the professionals and later in the discussion Bridie and Emily again appear to be explicitly reinforcing one another (2327 and 2328) in constructing their professional practice together.

Bridie again does this as an individual ('my' area and 'as far as I'm concerned' (2317) and Emily using the group term 'our' when drawing on their professional code of conduct (2328) and defending their construction from the interference of competing organisational demands which Jenny refers back to as a challenge to their construction (2319, 2322, 2331, 2333 and 2334).

Bridie's laughter here could be interpreted as a form of resistance to power dynamics of this situation as suggested by Holmes (2000). In Holmes' research, she asserts that humour can function to level power inequalities or to reinforce them, as well

'license challenges to status hierarchies' (Holmes, 2000: 160). It can be reasonably supposed that where tension is surfacing laughter is used here by the OT as a means of defending her own power, inferred by her status as a professional which is not inferred by the organisational hierarchy.

BRIDIE: Adaptation and stuff like that's my area its not about adaptations as far as I'm concerned its about finishing the job off
JENNY: But thats thats an issue for me as a commissioner because we haven't with resources being limited thats erm thats an issue because we haven't got the resources for you to be doing that you know
LAURA: Its an extra visit
JENNY: Yeah it is an extra visit you know its costing us time and effort when you should be doing something else
BRIDIE: Hmm
JENNY: And I do see why you are doing it and I understand that its
BRIDIE: Its a complex case and its a big piece of kit I want to check it out
EMILY: If you look at our professional code of conduct
BRIDIE: Thank you want you to help me here (laughter)
EMILY: but you know you start with an assessment you-
BRIDIE: I do understand I don't try to waste my time
JENNY: You have to understand that thats our process and you're-
BRIDIE: -No its not outside process because I haven't actually got anything written down
JENNY: No but its understood as the process as what you are supposed to do with because its their choice whether they pick that piece of equipment up and whether they employ it if they are given the prescription

This notion of the independent professional, who by virtue of their professional status is able to exercise their individual judgement, is highlighted in the following extract taken from a point early on during the first 10 minutes of a focus group. It should be noted that at this stage certain members of the group had yet to arrive. This may have influenced the power dynamics, as at this point there was no one in the room with organisational seniority, as there was in the previous extract. Here Sarah and Bridie are asked about how they make judgements about which equipment they will recommend.

Sarah: In line with the flow chart between assessment and… the electronic request I may have a discussion with local equipment provider regarding who *I* wish to provide the quote or the assessment with rather than just loading it onto MESALs and waiting for an email back saying "go to company A" cus I may have identified company C as who *I* think is most appropriate so I will have that discussion with Local equipment provider prior to booking the assessment visit and I've never had a situation *yet* where they've said "no you can't go with who you're choosing"
RESEARCHER: So based on your clinical judgement and networking?
Sarah: Yeah my knowledge and experience yeah 200 years of…
{laughter}
Bridie:: yeah 200 yeah!

Sarah: ..of looking at equipment
Bridie:: Now if you were a new member of staff right if you've got a new member of staff with a new MESALS number and who hasn't got your experience they would go onto the MESALs and put their- ask for the rep visit I wonder if they will sit there and wait for Local equipment provider to come back and say "yes you may" well you'd hope-
Sarah: *I* would hope that...
Bridie:: ..And will go with what they suggest
Sarah: I would hope that if they were in a situation where they weren't necessarily completely clear of what equipment they had that they would go to their supervisor…
Bridie:: I would hope so to
Sarah:…and get that information
Bridie::..but at least
Sarah: Or at least peer group. a peer within the…
Bridie::.. Yeah peer support yeah
Sarah:… either a supervisor or within the group
Bridie: So what we are basically saying is that we shouldn't have local equipment provider telling us…telling *us* who we are to use as a provider but they could make recommendations
Sarah: I think it is useful to have them guiding because they know who…
Bridie:.. but they shouldn't limit us
Sarah: No! I and at this moment I haven't found that they do

At the start of the extract Sarah uses an extreme-case formulation to construct her personal and individual experience as an OT as central and essential to her daily practice of decision making (line 15) by exaggerating the length of time she has been practicing as an OT. Potter (1996) citing Pomerantz (1986) suggests that in using this discursive device the speaker is working to persuade and strengthen their account and justify their construction of the subject, in this case the centrality of experience to Sarah's professional identity and ability to make independent decisions. Lines 13-32 of the dialogue between these two OT's serves as a further example of how these OT's are using their talk to work up a representation of themselves as experienced and how this experience underpins what they do as professionals.

Their talk is action oriented (Potter and Edwards, 1996) in that they are building up a narrative in order to accomplish something with their account. They describe a hypothetical scenario of a newly qualified OT in order to contrast this with their own professional practice which is based more on experience and less governed by 'process' or by the intervention of others. In line 33 Bridie makes this clear, what they

have been trying to do with their talk is suggest that they have full autonomy as professionals and should not be dictated to but allowed professional freedom (36) and Sarah agrees (37) and shows that she feels her professional autonomy is intact. The notion of autonomy as an individual professional is constructed still further in this next extract where Sarah and Bridie are working together in this dialogue. Sarah, Bridie and Laura all refer to 'they' (76, 77, 78 and 83). Here this is interpreted as an intentional construction. The 'we' is being constructed as distinct from the organisation 'they' despite the fact that these therapists are members of staff classed working for and with the children's equipment service. The nature of this in group (professionals) and out group (organisation) relationship is being constructed as constraining and detrimental to the skill of the therapists (74 and 75). Bridie suggests that the ability to gain experience through their practice which, as demonstrated above, has been framed as important to professional practice and autonomy, is being diminished through organisational restrictions of choice (73-75 and 79-90). Sarah however, offers another scenario (83, 84) which demonstrates her ability to act with complete agency as professional, even knowingly against the organisational policy, which they construct as financially driven (82) and which is represented as constraining them as professionals through the use of the notion of control which is being taken away (77 and 78).

Bridie: Its probably because with someone like nots rehab they are not manufacturing [because they are a retailer] and there is a mark-up because they are a retailer and not a manufacturer so understandably but if they are the only place you can actually, you can spend hours looking for a piece of kit and what tends to have happened is that now we have local equipment provider, we have become less.. well not less skilled *not* less skilled…but less aware of what is available out there because
Sarah: they have taken..
Bridie:… they have taken some of the control
Laura:…they have taken some of the choice away
Bridie:.. "this is where you will go for your beds" so thats where you home in so you don't look to see you don't find out so and so have got a bed thats does X Y Z and
Sarah:… but if the provider…
Bridie:.. but money is the thing
Sarah:.. But I was going to say that if the people that they direct me to could not meet the need in what *I consider* an appropriate manner *I would* go outside of that
Bridie: Yeah so would I

Sarah:… and *I* would put *my* case forward to purchase outside of that

Bridie: I have tried that with one piece of kit

Sarah: I haven't had a problem *yet* …… (pause) Hmm but other people may have different views on that

RESEARCHER: I think if parents were here you know one of the things I would be asking them is do you understand about the certain specialisms because you know its not on your badge is it when you walk in I'm a specialist in this don't ask me about sinks!!

{laughter]

Sarah: No but then thats around good practice and having that discussion with your client

Laura: its if your client raises that its about signposting them and networking]

Sarah: Yeah I mean I quite often

Laura: you wouldn't just say I'll stop you there because thats not my remit]

Sarah: Yeah I would say thats not something that I would do but I know a man who can and I'll put them in touch with you. I would hope that doesn't happen but if it does then thats down to the quality of the information that is given by the individual therapist

Laura: ..yeah and down to their manager isn't it

RESEARCHER: Well some of the one to one interviews I've had with parents so far have raised up how long pieces of equipment- that is that they are waiting for equipment for a long time and some of them don't understand why they have to see so many different people and that's where I was going with that comment they don't know that the person who walks in doesn't have any expertise in a particular area and in their particular case perhaps haven't had someone who is as professional with them

Sarah: Maybe not so confident [hmm]

Bridie: yes I think thats one of the things that you know we are experienced and I am quite happy to go well I don't know lot of the new comers and newly qualified OT's don't want to admit that they don't know

Sarah: whereas I have absolutely NO problem appearing stupid if its an area that I'm not an expert in

Again in the extract above, it can be seen that Laura and Sarah are using 'I' and 'you' to produce social accountability for Sarah's practice (212 -216) when asked by the researcher about how parents understand them as individual professionals. However, there is something else taking place in the talk here. This time the action being performed here serves to show that part of being experienced is to know your individual limitations in terms of knowledge (Bridie in lines 224 and 225 and Sarah lines 227). This may seem contradictory but it is something which these OT's construct as part of their professional 'good' practice (209) labelled 'signposting' and 'networking' (213) and which more inexperienced practitioners will not be confident enough to do.

The professional with an individual set of skills is returned to in both focus groups. The following extracts illustrate the construction of their professional identities as individualised and specialised.

Bridie: I went to somebody this week for an assessment and I was asked to go by the paediatric OT because she wouldn't touch the slings
Laura: I suppose thats down to budgets is it {laughter} – that's more about the budget
Bridie: Well its a joint budget and she's made the referral and when I got there I assessed that it wasn't necessary
R: So your assessment was that the sling wasn't necessary?
Bridie: The child had got the right sling, it took loads of other stuff so that was right that went and now we're putting another hoist in another room and doing a whole load of other things but I went for a sling which was actually fine.
Sarah: But then maybe thats but in some cases that could be down to the confidence of that individual [yeah] when something isn't sort of familiar
Bridie: yeah I wouldn't want to do a chair because of my experience [yeah] I wouldn't touch it
Sarah: There is a fine line I know where we all know what our limitations are and what our areas of expertise are
Bridie: yes and thats about helping customers understand the role of the different OT's

In this extract both Bridie and Sarah's account of their practice further establishes a distinction between OT's, based on knowledge and experience. In lines 191 and 201 Bridie says 'because she wouldn't touch slings' and 'I wouldn't touch it' –referring in her case to a specialist chair assessment. Here attention is to the connotation. It is safe to assume that the speaker and the paediatric OT she refers to are not literally avoiding touching pieces of equipment. Through the use of the phrase "wouldn't touch", Bridie is using this discussion to produce boundaries both for her practice and that of other OT's based on professional expertise. This constructed notion of professional boundaries is picked up and further accentuated by Sarah's use of a more obvious boundary metaphor in lines 202 and 203. This 'fine line' is being constructed by the two practitioners and the 'we' mentioned refers to the collective body of OT's. The multiplicity of modes of OT practice has in the past been problematic for understanding of the nature of occupational therapy (Finlay, 1998). Bridie appears to be in tune with this wider confusion, particularly when it concerns her 'customers' (line 204).

Sarah:..seating is not one of my great areas I must admit [yeah that would be more for the paediatric OT's] yeah they're probably more into that

In this small extract Sarah can again be seen to be drawing on the idea of discrete areas of practice for OT's with different specialisms. In the next extracts from another focus group Heather another community OT provides her account of how these discrete areas arise.

Heather: Well I'm a community OT but we..with the children's stuff we also work with the Paediatric OT's who are hospital based and they tend to provide slightly different things to what we do…. well that there is because.. they might not be involved with somebody that we are involved with so… it might be just us or it might just be them but and it tends to be that we do more of the bathing equipment urm… they do sort of specialist seating usually although we do it if they're not involved. They do things like standing frames and things like that which we don't generally….

In line 4, 7 and 8 Heather describes the division within OT practice as arising from what they prescribe. Although this is from a different focus group with a different group of participants Heather is mirroring Bridie and Sarah's constructions of differing areas of expertise as central to their collective professional identities as community and health occupational therapists. She returns to this idea in the extract below where she too is building an account of experience (lines 44 -46) as essential to practice and in creating the individual professional expertise of therapists (lines 51-53).

Heather: Some of us tend to have more children more than others new OT's who haven't had experience with children you only get that by doing it though don't you so unless you have that background.
Researcher: You don't get any specialist training then?
Heather: Erm no although we are sort of qualified in all ages and mental health and learning disabilities and children and adults and physical and everything so it is fairly broad
Researcher: Yeah
Heather: And so you can specialise a bit or tend to go either for mental or physical disability erm but the ….. I mean we sort of do sort of perhaps self-directed type of learning in areas where we need to have more experience or development with so if we haven't got the skills erm so we do we like local equipment provider have laid on stuff to do with children's equipment and an OT module which is like our moving and handling training and one year we asked for that to be specifically around children as opposed to adults although lots of the principles are the same, a

lot of the childrens is around the problem solving things so it doesn't make any difference and you look at the whole picture anyways so…..

The extracts above demonstrate how both individual therapists and through co-operative narratives of their practice multiple OT's negotiate their professional identities. In these instances of talk, the professional 'I' is constructed as an autonomous agent, with an awareness of conflicting organisational demands and discourses. Central to the professional identity is the experience and expertise this affords, allowing for professional agency and establishing boundaries between the newly qualified and between those with different areas of experience.

This distinction between groups of therapists is the focus of this next set of extracts where the analysis attends to talk of OT's from differing organisational settings.

'They' and 'We' - difference construction between organisational groups

Another discursive theme identified during analysis was the construction of difference between OT's employed by health organisations and those from social care settings. As highlighted above the occupational therapists constructed themselves as individual practitioners based on their personal practice and experience. In the following extracts, the participants are seen to be discussing how groups of OT's may differ in their provision of service, using a discourse of budget awareness.

Sarah: And I also think and I don't think this is necessarily a children's issue though specifically though it could be though because the group I'm thinking of would work across certain groups of very erm [long pause] certain groups are very budget orientated and we all are if there are two pieces of equipment that will do exactly the same job I will always go for the most cost effective you know I always look for the more cost effective route
Laura: yeah well its public money isn't it? you got to be mindful of that.

In this extract, Laura and Sarah are co-constructing an account of practice, which is influenced by a broader discourse of financial awareness and responsibility. Line 235 is the first time that Sarah refers to groups 'who are very budget orientated'. Initially it appears that in talking about these 'certain groups' she is putting her own practice at a distance from this. However, she then returns to an account of her personal

practice ‘I will always go for the most cost effective’ (line 236). She follows this with ‘you know’ which is often seen as an attempt to establish a notion of shared understanding. Sarah continues to construct a convincing account by using extreme case formulations again ‘all’ (line 235) and ‘ will always’ (lines 236 & 237) are a discursive devices to normalise and draw attention to the importance of what is being discussed. The use of ‘will’ infers that this is not just a one off case but a fixed trend or approach in her practice where she ‘will’ make this choice repeatedly.

Twice Sarah speaks the words ‘cost effective’ and this indicates that Sarah intends to depict her practice as complying with this financial notion. Laura joins in and gives this intention an imperative. Following a pointed hypothetical question (at this point Laura states ‘you’ve got to be mindful of that’ suggesting that there is little choice in the matter (line 238). This is important. Here wider institutional discourses and practices around the use of public money within the institutions of the NHS and local government are being accessed. Sarah revisits this notion of individual practice constrained by a wider ideology of financial responsibility, but this time she draws on discourse, which could potentially conflict with the financial responsibility discourse.

Sarah: I always look for the most cost effective route to meet my clients need [mm hm] but thats the second part of it to meet the need its the cost effective route to meet the need. I am aware of groups out there of staff that are very much budget related and [long pause] are very much driven by their chain of command around monitoring that budget and keeping that cost is very prominent in what their
Bridie: to keep costs down
Sarah.. yeah and I think that at times can make people reluctant to make recommendations or go outside of you know the...excuse my poor language the bog standard raised toilet seat or whatever...erm and I don't think thats a local equipment provider I don't think thats necessarily from local equipment provider thats from their own [mm] their own service
R: Well they have their own budgets don't they that they have to handle
Sarah: Yes thats from within their own service keep them very {pause} and don't know if ours do but we are very much around budget budget budget

In a repetition of her earlier assertion (‘I always look for the most cost effective route’ – line 239) Sarah responds to Laura’s imposition of the financial responsibility discourse, acknowledging its importance but introduces another concept that of ‘need’ mention three time in lines 239 and 240.

She constructs a two part consideration underpinning practice, the requirement to 'meet the need' (line 240) but to do so via the 'cost effective route'. Sarah then goes on to discuss her observation of other 'groups out there of staff' constructing an imbalance between these two considerations ('very much budget related' –line 241 and 'keeping that cost is very prominent' – line 243) and emphasised most forcefully in line 251 ('they are very much around budget, budget, budget'). She accounts for this with an implication that management ('chain of command' – line 242) is a potential factor in this limiting practice based on need. In line 245 and 246 this constraint is emphasised by the metaphor of unwilling to 'go outside' these constraints. Here Sarah is constructing a site of conflict between the professional discourse of need and the organisational demands and discourse of cost effectiveness. In the next, extract which takes place shortly after the last text, Bridie offers a rationale for these constraints and for the first time Bridie and Sarah are not working together towards the co-construction of their practice.

1659 **Bridie: I think in the past whether this is a sweeping statement or**
1660 **not shoot me down I think in the past a lot of things went under**
1661 **the radar and weren't examined hard enough or justified well**
1662 **enough I think the new system is robust and…**
1663 **R:…for the adults is this?**
1664 **Bridie: For both. We now have to justify pretty damn well what we**
1665 **are doing and why we are doing it and I think its right.**
1666 **Sarah: But we've always done that**
1667 **Bridie: no I don't think we have.. I think we have in the past we've**
1668 **ordered without that justification or that you know you didn't**
1669 **used to have to fill in as much do you not think?**
1670 **Sarah: Maybe its different paper work but I've always maybe**
1671 **thats just the way [yeah maybe its the way you work..**
1672 **Bridie: But I would say outside of the social services maybe its a**
1673 **sweeping statement thats why I'm saying that perhaps its not I**
1674 **think equipment was ordered or not thought about and when it**
1675 **went to like you said we went to a supplier that's always supplied**
1676 **[another participant entered] and we went to suppliers that we**
1677 **were used to and weren't competitively priced you know**
1678 **compared to now.**
1679 **Sarah: I think I've always been very needs led**
1680 **Bridie: I know you have I'm sure we all have**

Bridie draws on upon a stake inoculation twice in the above extract (lines 260 and 271 – 'a sweeping statement'). Potter (1996 – cited in Halton- Salway, 2001) suggests that this is an active use of language to counter potential challenges to the speaker's account, particularly when something controversial is being discussed. Bridie refers to practice in the past (260, 261 & 267) and present (264) using the past

and present tense throughout the passage. This again, is performative and creates an account of historical changes in both organisational demands and in wider OT practice. These changers are framed here by Bridie as a move from a lack of scrutiny ('under the radar' metaphor- 261) towards greater accountability in their practice (lines 262, 264 and 265).

There is a return by Bridie to this construction in lines 271 to 275 although at the start her account this time implies that the past problems were organisationally defined (I would say outside social services – line 271). As in earlier extracts Sarah wants to establish her practice as different, as hers ('but I've always maybe that's just the way' – line 269 and 276 I think I've always been very needs led'). Sarah is reintroducing the construction of the conflict between personal practice, informed by the professional discourse of 'need', and current organisational demands. This talk is returned to in the extract below.

Bridie: Well you are suggesting having days at the ILC where those three reps come take the child and find the chair that best suits the need its irrespective then of the cost isn't it its what is best for the child if you are paying the same flat rate with each company and then its about the chair
Sarah: It is always about the best chair….
Bridie: …yes well it should be…
Sarah:… its always about the best chair if you its about meeting the need in the most cost effective manner so if the 20 pound chair will meet the need effectively then thats what you use.
Bridie:..Yeah but its not having the option of the other of the other…

In lines 363 and 362 Bridie appears to change the construction of her practice, which earlier she had framed as led by cost effectiveness, to one which is needs lead ('that best suits the need' and 'it's what's best for the child' ('irrespective of cost'). Here Sarah returns to unite with Bridie again to reinforce her position now that she echoing her own practice – line 365 'it is always about the best chair'.

In the extract there is acknowledgement that in wider practice, however, there is tension (line 366 'should' here implies that it is the preferred but not always the chosen practice) about the freedom of choice OT's have (line 369). Nevertheless, in this short passage below Sarah again asserts that they have autonomy and freedom, if they have the experience to present their case (line 484).

Sarah:..Well we don't have things that are outside of what we can prescribe if it is the case that we identify a need then its up to you to put a [yeah] and to put a case forward and

Moreover, later in another extract Bridie is explicit about this tension between professional autonomy

Bridie:: hmm well I mean we are always going to have OT's that will think differently that's not going to go away, you will always have clinicians thinking abstractedly yeah because we are autonomous we're not automatons or whatever

The therapists talk indicates that between the OT's employed in health and those in social care there are differences in culture and therefore differences in practice. The following extract show's Bridie talking about her experience of these differences.

Bridie: I have to say I felt that health OT have seen it as an open purse and they have never had to actually manage the budgets so they just
Sarah:..Well I've never had to manage the budgets but if we're not under a statutory obligation to provide then we don't do it.
Gemma: Yes you are I have to say that I would absolutely have to agree with you. Thank you.
Bridie:: I used to get I can remember asking why has this person got a shocking list of items had been discharged from hospital had this shocking list and they just go not thinking about the cost of it and I think thats unfortunately that engrained and so if you're not thinking about the cost of it you are not thinking about who is paying for it or whether is a small item or big item
Gemma:..in the local authority we are much more..
Bridie::..cost effective lead
Gemma:..yes we have our hats on saying is there a cheaper way of doing this

In line 782 Bridie begins with a metaphor which acts to construct OT's employed by the NHS as unaware of financial constraints ('have seen it as an open purse') and in line 783 as 'never having to actually manage budgets'. She backs up this construction with an example from her own experience - in lines 787 and 788. She uses the words 'unfortunately that engrained' in line 789. Here there is a suggestion of this lack of awareness being part of the culture and widespread in the practice of health OT's.

At this point, it is important to point out that this particular extract is taking place when OT's who are employed by Health are not present, and the local authority employs all the speakers. Gemma, who is neither an OT nor employed by the PCT, strengthens her account by corroborating this with her own interjections as an employee of the Local authority (lines 786, 781, 793). Later Sarah takes this further constructing financial accountability as part of the role, perhaps integral to the

identity of professional as their 'responsibility', using extreme case formulations 'every single' 'every penny' to emphasise her account - lines 814 and 815.

Sarah:…well every single professional that is providing prescribing recommending or whatever should be able to justify every penny you've spent, that is your professional responsibility

Interestingly the tension between the 'New Public Management' and the 'judgment of professionals' appears to remain neutral and the tension about organisational practices seems to be present regardless of the organisation of employment. When a participant from health suggests that paperwork be introduced which would guide OT's during assessment towards cost effective choices, the following interaction ensues.

Sarah: And I can see it and I understand it which is why I just shut up and get on with it on a daily basis [yeah hm] But I do find it *absolutely infuriating* as a professional
Bridie::…all the trigger forms oh yeah I want to do your next trigger form!
Sarah:..I..I find them *absolutely infuriating*
Bridie::…yeah…I ordered a new bed a replacement bed and had to go through all these forms
Sarah:..because I often think *WHY* bother employing me?!] {LAUGHTER}
Bridie::..because she'd already got a bed what do you need all the trigger forms for? you know
Sarah:..What do you need *all* my professional assessment and opinion for when all as *I* have to do is tick a box? You know *anyone* can tick a box.
Gemma:..But you know its not easy ordering a bed
Sarah:..here's a good way of saving money *don't* employ senior therapists {laughing while speaking} it can be an easy option just employ people to tick boxes if thats all that they are going to do.
RESEARCHER: But do you need the skills of somebody like that to be able to tick the boxes?
Sarah:..and that's what annoys me I find it infuriating {laughter}
Bridie::.. {laughter} You need the skills to tick the boxes!
Sarah: But that's from a practitioner point of view as I say that's how it is its what we do so on a daily basis I shut up and I get on with it
Bridie:: yeah

Sarah's choice of words ('absolutely infuriating' lines 576, 578, 589), increased emphasis and intonation, pitch and volume (indicated by italics here) as well as her body language all serve to illustrate the visceral nature of her feeling about what she constructs as undermining her professional status and practice (line 528). It is clearly a point she wishes to emphasise and in lines 580 and 585 her account suggests that

this is a serious threat to her role and identity as a professional 'WHY bother employing me' and 'don't employ senior therapists'. These last comments although intended to strengthen her account, are also intoned in such a way as to indicate that she is using these statements rhetorically.

At this point in my observation log of the non-verbal signals, I noted the participants' gestures and body language indicated to me that tension had risen, but that seemed incongruous with the laughter, which was also taking place. Laughter from both the speaker and other participants, appears several times during this interchange, and could be interpreted in a number of ways.

In this instance, it could simply be a mechanism to diffuse a situation (Boxer & Cortés-Conde, 1996; Jefferson, 1984a) that others than myself perceived as somewhat tense. Glenn (2003) posits that according to the theory of incongruity, laughter can result from "…a perceived inconsistency between what one believes will or should happen and what actually occurs" (Glenn, 2003; 19). So according to Glen it may be the *reaction* of Sarah and one or two other participants to a perceived incongruence between the suggestion under discussion and their experience of practice. Alternatively it may be an *active form of resistance* to the notion under discussion, that a 'tick box' document be added to the paperwork OT's need to complete on assessment and that this idea is not worthy of serious consideration. As seen in an earlier extract, it may also constitute an active attempt resist unequal power dynamics or status inequity, as discussed earlier (Holmes, 2000).

Defining 'needs' and establishing 'wants'

The extracts presented in the following section demonstrate how participants incorporated another dimension into the account of their professional identities and practices - their role as the definers/assessors of the needs of their clients. In doing so, they also build an account of a conflict in therapist-client relationships. This is achieved through a juxtaposition between the 'needs', which therapists assess and determine, and the expectations and demands of the parents. This construction draws upon wider political, cultural and academic discourses of parents, patients and service users as increasingly sceptical and powerful consumers of services (Beck and Young; 2005; Parker, 2002; Kelly, 1998; Evans and Harris, 2004).

Bridie: Yeah well they've been up to the erm well its our fault I mean I'm de-skilled in children's equipment so I say go up and

have look at the oh whats it called the place up north [oh yeah yeah] and they come back with all these wonderful ideas and its like I want this I want that my son deserves to have this and thats the issue that my son deserves to have this

In the extract above Bridie's talk begins to create an account of interactions with service users. The use of the term 'they' in lines 373 and 375 here is referring to parents of service users. Bridie describes her (the use of 'I' in lines 373, 374 refer to Bridie herself) advice to a parent to visit 'the place up north'(which is specialist exhibitor of children's specialist equipment) and the 'issue' which arises as a consequence of this. In line 375 Bridie mentions 'all the wonderful ideas' that parents have following their visit, the parent is constructed as having wishes and desires (lines 375 and 376) 'I want this I want that' and twice 'my son deserves to have this'. Crucially though Bridie's account suggests that this is problematic through the use of the words ' that's the issue' (line 376) and earlier with the implication of 'fault' earlier in line 373. In the extract that follows, work on the construction of the OT-Parent relationship is built upon further, and continues to be framed as in opposition to one another or as somehow problematic or contentious.

Bridie: I have to say...Its taken me a long..a number of years to have the balls to stand up to a lot of parents to be perfectly honest

Jenny:..yeah it isn't easy we know that..

Bridie:... and its having the confidence to do that

In the extract above a shared understanding of problems in interactions with parents is created by the use first of 'to have the balls to stand up to a lot of parents' and 'having the confidence' (lines 547 and 550). Suggesting that it takes a degree of confidence or bravery (bravery or courage is usually implied by the use of phrase 'have the balls') for OT's to confront ('stand up to') sets up a picture of conflict in parent-OT interactions. Jenny's input in line 549 adds to this account, signifying that there is a wider acknowledgment of this difficulty ('it isn't easy we know that'). But it also implies that parents have at least an equal degree of power in these situations, something which in traditional professional client relationships was deemed to be asymmetric, with the professional holding more power through their professional status. In this and the next extract the discourse of experience is drawn upon again to suggest that it is through the passage of time ('its taken me a long…a number of years') and building experience ('you get a newbie OT') that professionals become

equipped to meet the challenge of this parent-OT relationship (lines 547 - above and 559-564 –below).

Bridie:..Yeah not everybody has the skills that you or the confidence to..
Sarah:..Yeah I suppose so it's just from my point of view I always
Bridie:.. you get a newbie OT who goes out to a parent…
Sarah:..I acknowledge that but..
Bridie:...who is well battle worn and knows how to use the system and I'm not saying that that is wrong.. *I* would use the system but …
Sarah:..but for me..
Bridie:.. you are not going to be able to…
Sarah:… and I acknowledge that
Bridie:..It's got to be there in black and white

In the extract above, the OT-parent relationship is further characterised as a conflict with the use of a metaphor to describe a parent 'who is well battle worn' (line 561), the implication here being that the parent in this account is familiar with to having to fight for what they see as needed by their child. Bridie's accounts suggests that parent's have ways of handling this 'knows how to use the system' (line 561) but although Bridie states explicitly 'I'm not saying this is wrong…' there is an implicit connotation here that 'using the system' is not held as acceptable for parents by all. Bridie has to qualify this as something she does not admonish, but Bridie makes sure she adds that she understands why parents would do this '*I* would use the system but' (line 562).

The call Bridie seems to be making is for documentation for more inexperienced members of staff, outlining what they can and cannot offer to parents in terms of equipment. She emphasises that it should be laid out explicitly 'its got to be there in black and white' (line 566). Between them Bridie and Sarah imply that for them this is not needed but that more inexperienced staff will need this with an increasingly empowered service user population with whom conflict may arise.

Jenny:.. yeah and there is that difference between needs and wants because people will always want to give everybody the best and get most out of it [yeah] but what they need and what they want is very different [correct we discussed that earlier]
Sarah:..But then we spend our entire working life having that debate
Bridie:...I do find as a clinician when it comes to children's there are a lot more emotive raised [yes oh definitely] there are a lot more wants on the part of parents than there are [yes] with adults so yes but any any clinician is unable to battle with parents in a manner which might be very difficult

1900

In this extract the idea of ‘needs’ and ‘wants’ is discussed explicitly, with direction from Jenny who emphasises that needs and wants are distinct (line 502, 504). In lines 502-503 ‘people’ are the professionals who themselves ‘want’ to give ‘everybody’ (here everybody being the clients or service users - what ‘they need’ and what ‘they want’) ‘they’ is again the clients. By using these terms separately Jenny constructs a gap between what parents are likely to expect the service to deliver and what they actual deem as needed by the clients. This account suggests that power to define needs still lies with the professionals and perhaps increasingly their organisations.

Sarah in line 505 constructs this element as an integral part of a professional discourse (‘entire working life’ and ‘debate’) shared by OT’s (‘we’). This builds a picture of this element of their working practice as a central and persistent discourse. Therefore this analysis asserts that this is central to the constructed identity and practice of this particular OT and perahps the other OT’s present in this focus group as no one else challenges her. Bridie, certainly does not and continues with the construction of conflict between Parents and OT’s (line 508 – ‘is unable to battle with parents’) based on needs and wants (line 507 ‘there are a lot more wants on the part of parents’) which is shared by other OTS (‘any, any clinician’). There is also an implication here that this issue over needs and wants is greater when working with children, rather than adults. This is a theme which was persistant throughout the data set but has not been used as part of this thesis analyses, due the available scope of this thesis.

Bridie: its a bit like the old mini versus the rolls royce isn't it

Jenny: yes

Bridie: the mini will get us from A to B and the functional need is met by the mini right but you want the rolls Royce

In this extract the definition of the needs versus wants discourse is offered clearly by Bridie using an analogy of motor cars. (lines 1177 and 1179-1180). Here the needs determined by the organisation and the therapists will be met (1179 – ‘will get us from A-B’) by a simpler less expensive option (the ‘mini’ in this example) but the clients or parent (‘you’ in this extract – line 1180) ‘want the rolls-royce’. In employing this metaphor the distinction between need as defined by the organisation and service user ‘wants’ is exemplified and exaggerated by the use of a small and basic car being (the need) and a luxury car (the want). Bridie is accessing a shared understanding about these two vehicles to aid her characterisation of the debate.

Few people are thought to have a rolls Royce because of the cost to buying one, but it is held up to be an object of desire and of status. The mini performs the same function but does so with less opulence and luxury. This is a powerful analogy, and constructs parents wants as being far above what the functional need of their child is and something that few are likely to achieve.

So what might be the origin of this construction of parents as demanding consumers with a taste for the best ? In the following and final extracts we see the therapists engaged in building an account of an increasingly powerful consumer-service-user. These extracts also feature talk from a parent who participated in this focus group. His contributions add another dimension to these constructions. To provide some context for the following extract, on joining the focus group after about 2 hour Bob gave an account of his experience and on several occasions mentioned the very positive professional relationship he had had with his grandson's allocated social worker.

Researcher:Would you generally say that you have had a positive experience in accessing services to get equipment
Bob: So far yes
Researcher: and what has been key in that apart from the social worker?
Bob: Just the social worker {laughter}
Researcher: really thats the main thing?
Bob: Yes and acquiring knowledge of what is available and then feeding her with the information
Researcher: Ok so did you have any knowledge of what was available did you do any research yourself or?
Bob: Yes I did research on the internet finding out whats out there going to exhibitions and going to those and seeing if there is anything that he could use and get the information

In this extract Bob highlighted the importance for him of the social worker's involvement[2]. In line 968 Bob also refers to 'acquiring knowledge'. Here the

2 A wealth of 'in talk' and non-verbal reaction stemmed from this parent's arrival at the focus group and from his assertion that his positive evaluations of the service originated from his interactions with his social worker. As a researcher, with a critical interest in power relations and in parental involvement in academic research I found this very interesting. In addition to making observational notes about nonverbal behaviour at the time, on the original transcripts when analysing and in my research diary, I coded this as a point of significant interest. However, unfortunately due to word limit constraints and the overriding themes already explored, there was no capacity to include this fascinating multimodal encounter in this analysis.

knowledge is information about specialist children's equipment available outside of the statutory provision. Bob's account is of himself as an informed consumer. Line 971 and 927 show that Bob was active in investigating options for his grandson and accruing information. This construction echos the wider 'service user as consumer' discourse identified in the literature. This more powerful construction of the parent-consumer is further accentuated by Bob's use of the phrase 'feeding her the information' (line 969) which implies control and agency on the part of Bob as the feeder of information and a degree of passivity on the part of his social worker. Perhaps in this construction of a parent-professional relationship, where power might be thought of as equal or asymmetric -with the parent being more active and powerful, it might be possible to infer this as one potential reason why Bob's experience of his interactions with his social worker have been so positive.

The next extract serves illustrate a number of the discourses previously identified. Initially, it serves to build on a construction of increasingly knowledgeable clients [3]and how, as professionals, these OT's are adjusting to the implications this has for their professional-client relationships. In lines 1773-1776 Sarah relates a scenario of visiting client - '(you go out' - line 1774) who has information or knowledge about legislation ('they've got it there' - line 1774) and who have prior wishes and expectations about what their child should have ('they are ready and they know what they..' - lines 1774-1775). In line 1775-1776 she states that parent's increasing knowledge is a positive thing ('that's good people should have that information') but with negative implications for them as practitioners ('and you are sat there like a dummy). Using the simile 'like a dummy' contrasts with the more knowledgeable active parent, a dummy being mute and inactive.

Sarah: But that is what the policy needs to that is what that policy needs to link that to the legislation and you know yes that legislation is out there and its in the public domain families pick it up and they and we get it you go into the house and they've got it there they are <u>ready</u> and they know what they... and thats good people should have that information and you are sat there like a dummy and

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3 *in this case parents of clients as the children themselves are not deemed to have capacity to be the active client*)

Emily: They've just found you a massive literature search to do (laughter)
Bridie: We are its true and its not just local equipment provider its everything that we do because things have changed so much
Sarah: But because children's equipment is I think you do find that
Bridie: we haven't got a leg to stand on on any of the the things that we actually do
Sarah: And whether this is right wrong or indifferent er but parents are very savy and they possibly have the skills to access that information
Bob: And the internet is very useful for getting information (laughter from OT's)
Bridie: Yes it is

Sarah continues to build on this account in lines 1782, using at first a stake inoculation 'whether this is right, wrong or indifferent' to defend her construction of 'very savy' parents with 'the skills to access that information'. Bob follows this with his own experience of gathering information, to which the OT's respond with laughter. As discussed earlier laughter could be an attempt to bond or to readjust power dynamics. However, it could also be a tacit acknowledgement of their experience of parents doing as Bob suggests and using the internet to gain their information.

Emily, in line 1777 is also establishing a difference in the parent-professional relationship. In her account though the parents 'they've' have generated a task 'a massive literature search' for the professionals to do – and it is the parents active engagement for knowledge which is dictating the practice of the OT in this construction.

Bridie's comments in lines 1778, 1779 and 1781 are highly illustrative of some of the other discourses identified. For example in line 1778 and 1779 she says 'its not just the local provider its everything that we do because things have changed so much'. Here she is not only referring to the organisation demands of the local provider affecting their practice. She uses the extreme case formation 'its everything that we do' to build an account that the nature of their practice and their identity has changed. In saying 'we are its true' she is also reinforcing Emily and Sarah's constructions of OT's as in increasingly different parent professional relationships. Line 1781 is an utterance which taps into the wider theme that the OT's occupy a position where they feel unstable ('haven't got a leg to stand on') and again extreme

case formulation is used ‘in any any of the things we actually do’ at the intersection of increasing public, organisational and legislative demands.

Findings

The constructive actions identified in the talk of these occupational therapists evidences a tendency towards adopting wider collective social identities (Brewer and Gardner, 1996). These professional women repeatedly referred to 'we', and constructed their social accountability, shared as part of a collective group. Their use of language constructs their social workplace identities and relationships as practicing members of their profession, creating a local discourse of occupational therapy. Judith Butler (1993; 1997) discusses what she refers to as performativity, "…that reiterative power of discourse to produce the phenomena that it regulates and constrains" (1993:2). Talking repeatedly about individual acts of practice, 'good practice', their duty of care, and the repetition of meeting and identifying clients 'needs' shows the performativity of the participants' language. The participants draw on discourses of professional practice from both their organisational and institutional environments to create professional identities reworking the discourse of professionalism in the moment.

From this analysis, it is clear that the participants highly value autonomy in their practice and as an integral part of their professional selves. Mindful of Evetts (2002) caution about confusing autonomy with discretion, attention has been paid to the elements of autonomy she outlines in her paper; decision making determined primarily by client need, unrestrained by the interference by management or lay people and where professionals are able to freely utilise their expertise and knowledge without the constraints of bureaucratic paperwork. The participant's constructions of an experienced autonomous I, indicates that for these professionals, it is most clearly their autonomy that they value as part of their professional identities. Nevertheless, it could also be seen within these extracts, that this autonomy is being simultaneously constrained at times, by organisational demands and challenged by a better-informed parent population.

The talk of participants around their interpretation and use of organisational policy and procedures, suggests that they acknowledge and will work with these policies. However, they will exercise their own judgement and, if needs be, put forward their clinical reasoning, which some therapists constructed as rarely being challenged. This supports the view of Evans (2012) that "it is the way in which professionals, even in rule-saturated organisations …… retain significant freedom in their work, and

that the ways in which professionals relate to organisational rules is a key dimension of understanding discretion" (Evans, 2012: 1).

However, the extracts and themes identified also evidence the dynamic nature of identity construction amongst occupational therapists as described by MacKay (2007). In her paper examining professional identities from a Foucauldian perspective, she asserts, "occupational therapists do not have natural and unchanging characteristics. Their practices are constructed at multiple intersections of the occupational therapists individual and collective experiences, of histories and traditions, symbols languages and practices" (MacKay, 2007: 97). In the extracts presented in this paper, the participants are shown to be sharing their individual and collective practice and to be providing narrative accounts to construct the diversity of occupational therapy practice and identities. Their accounts show sites of intersection between occupational therapists and their manager, between the therapists and their clients and between their work organisations and their professional institutions.

At each intersection, differing accounts of their identity are created. On the one hand participants emphasised their agency and ability to use their judgement when defining need and making requests for equipment to managers. They demonstrated how parents, who increasingly possess knowledge about what legislation allows them, can also diminish professionals' feelings of agency. Negotiating their identities as members of their profession, they were shown to be led by client needs, while having to balance this with organisational drives towards budget awareness, 'meeting the need via the cost effective route'.

Analysis of these extracts indicates also that the participants are recapitulating some discourses, such as those of the autonomous and powerful professional defining and upholding the needs of the client (Kelly, 1998; Beck and Young, 2005). However, they are also seen to be offering resistance to the other discourses available to them, such as service user empowerment and managerialism (Clarke, 1998; McLaughlin & Goodley, 2008; Webb, 1999).

Health services and social care services and their attendant cultures, organisational discourses and practice are being more closely integrated through the mechanisms of organisational, political and legislative change. The tensions that these shifts create are demonstrated in the ways in which these therapists constructed themselves, as members of one profession but with roles distinct because of their

specialised skills, knowledge and approach to practice. As individual practitioners and members of a diverse profession, their relationships and status with the people they serve is shifting. Cultural trends and public awareness of legislation increase the power of patients and service users. The OT and parent participants showed that negotiating a new relationship between OT's and parents as consumers, could have affects for the identities of the professionals, if as Pratt et al (2007) and Beck and Young (2005) suggest claims to specialist knowledge is what creates professions. In the future much specialist knowledge may lie in the hands of expert patients and parents in the future.

In the talk analysed as part of this research, discussion of evidence based practice was absent in their constructions of occupational therapy practices. This was unexpected as EBP is yet another agenda introduced through governmental initiatives that seek to modernise the way that professionals work. EBP is 'the use of the best scientific evidence integrated with clinical experience and incorporating patient values and preferences, in the practice of professional patient care' (Houser, 2012: 410). Many professions including health care have been called upon in recent years to ensure that practice is based on evidence gained from randomised controlled trials. However, some see this as a move towards practice led by experimental, academic evidence rather than on the judgement and personal experience of individual practitioner (McLaughlin and Goodley, 2008). Although EBP is now supposed to be part of the dominant professional rhetoric, this research suggests that these participants are not chosing to include it in their constructions. Reasons for this may be complex though and could include a need for training, flawed data and institutional barriers within the NHS and the resistance of some staff to change their practice (Metcalfe, Lewin, Wisher, Perry, Bannigan, Klaber Moffett, 2001; Bennett, Tooth, McKenna, Rodger, Strong, J Ziviani, Mickan and Gibson, 2003; Caldwell, Coleman, Copp, Bell & Ghazi, 2007). Therefore, it could be suggested that although EBP is part of the language of some professionals, it has yet to become a sufficient part of the practice of these OT's to influence their professional identity. Alternatively, it could be that EBP underpins all of the experience and judgement, which the participants constructed as central to their accounts of their practice, but that this was not explicitly discussed.

The importance of defining need identified in the extracts was framed as at times as part of a battle with parents and clients as to what is needed and what the service

users want. This could be problematic if this leads to an overly paternalistic 'professional knows best' approach. Western professionals have come under criticism from professionals in other countries suggesting that the privileging of experts does not solve or cure the ills of society. In fact, is it is argued that traditional western model of professional care offers only palliative support (Clarke, 1998). Illich (1977) questions the role of the professional, when he coined the term the 'disabling professional'; one who clings to the traditional styles of practice and fails to empower or create awareness within the community. This disabling professional only serves to maintain their own power, and continue to promote the 'latest cures' rather than encouraging the public to challenge the health or poverty status quo. It could be suggested that to some extent the therapists talk indicated some reluctance to accept growing power of parents as consumers, who define for themselves what is needed for their child.

Conclusions

Based on the analysis and findings of this project it is clear that occupational therapists can and do construct varied versions of their professional selves. Mackey's (2007) assertion that there is no fixed, unchanging identity for occupational therapists is supported by this analysis. The accounts of these professionals both serve to modify and *are* changed themselves by organisational and professional discourses. This shows Foucault's archaeology of knowledge and technologies of the self are indeed useful when addressing dynamic working selves and their practices.

Managerialism discourse present within some literature and theorising on professionalism has in the past seemed imbued with a corrosive power to undermine professionals and their sense as autonomous practitioners. This research both offers some support to this discourse while simultaneously offering some challenges. Through its illustration of the therapists practices it can be seen that professionals can, and do, subvert organisational demands to retain freedom in their practice.

The implication of the changing power dynamics in parent professional relationship, also illustrated in the professional's explanations, leaves questions which warrant further investigation. With once specialist knowledge pertaining to legislation being more widely available, through parent support groups and online communities, could this be chipping away at the basis of the occupational therapy profession, their claims on this specialist knowledge? As the 'tick box' culture increases and research investigates a potential drive towards self-assessment (Tucker *et al,* 2012) where does this leave occupational therapy as profession in the future?

What is sure is that changes are a part of the domain of health care and social care, past, present and most certainly in the future. The constructed nature of identities demonstrated here, suggests that whatever changes are afoot, these will be incorporated into and, in part shape the identity stories of occupational therapists. Therefore this raises the possibility and need for more research into and organisation awaresness of how changes within health and social care organisations affect the identities of their professional workforce. Subsequent examinations of the talk and interactions of professionals and parents may be beneficial in exploring the nature and extent of change within the professional-service user relationship. Future application of critical discursive research may also aid in understanding the impact of

the UK’s ongoing Health and Social care reforms on the autonomy and workplace identities of our health care professionals, as well as exploring who has the role of defining patient needs.

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Appendices

I. Breakdown of areas for investigation in CES report
II. Information Sheet issued to participants at interviews and focus groups
III. Blank participant consent Form
IV. Interviews and focus groups – example questions
V. Flow chart detailing the current process of provision
VI. Sample pages from transcripts showing initial coding
VII. Children’s Equipment Service report summary

I.

Breakdown of areas for investigation in the Children's equipment service review

1. **Demand on the service** – numbers of children identified as needing provision and yet to receive, number of children receiving service in comparison to previous years

2. **Funding streams** – to identify past present and future sources of funding

Local Authority, NHS, Section 17, Third Sector organisations

3. **Spending**- Past, present and projected spending in the service

4. **Provision Mapping** – Mapping the current processes in place for the provision of all equipment to children

5. **Referral** – how many people can refer, who can refer where do these referral go to, how long did referrals take

6. **Assessment/prescribing** – how long between referral and assessment. Who can assess? On what basis/criteria are these assessments carried out?

7. **Supply of Equipment** – who are the main suppliers? What are their current provision arrangements. Investigate alternative models of provision. Rental or Retail.

II.

Information sheet for participants

It is important in any research to explain to those involved exactly what the research is hoping to achieve and how any data that participants contribute will be used in that research.

This particular research project is has two main sections

1. The review of the East Cheshire's Children's equipment provision for children with complex healthcare needs.

   This part of the research aims to investigate the current provision (including funding, assessment and supply of equipment) and the views of stakeholders and service users about the current processes and practices. After these investigations, a report will be drawn up and recommendations will made on the basis of information gathered during this initial phase. This written report will be presented to East Cheshire and Central Primary Care Trust and East Cheshire Council. These recommendations may or may not be acted upon by those authorities.

   Data gathered in this initial phase, including views of participants gathered through events and interviews and documents provided to illustrate the process will be used to inform the recommendations. Once incorporated into the report all data will be annonymised and participant's data will be treated in accordance with the Data Protection Act. If you chose to participate, you will be giving you informed consent. At any point, you can withdraw your consent and any data that you have contributed will be removed from the study and destroyed.

   If you wish to participate, you need to sign and complete a consent form (at the back of this pack).

2. Research into the constructions of ill health, complex needs and disability

   The second part of this research project will commence once East Cheshire and Central Primary Care Trust and East Cheshire Council have accepted the report. The researcher will conduct it for the purposes of investigating the way in which parents, children and professionals involved with families where a child has complex health care needs talk about and construct their experiences.

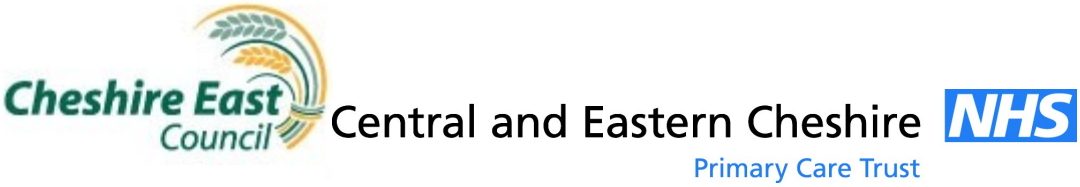
   Data gathered in this phase of the research will be in the form of interviews and focus groups and will be transcribed and analysed closely in order to understand the way in which identities and ideas are constructed in talk. Again all data will be annoymised and participant's data will be treated in accordance with the Data Protection Act. If you chose to participate in this section, you should declare your informed consent. At any point, you can withdraw your consent and any data that you have contributed will be removed from the study and destroyed.

   As this part of the research has not begun the consent sheet will be provided for this section at a later date.

   Many thanks.

Katie Dixon – Research Student at MMU Cheshire (0161 247 5062)

III.



CONSENT FORM

Title of Project: Children's equipment service review

Name of researcher: Katie Dixon

Please initial box

1. I confirm that I have read and understand the information sheet dated…….. (version……) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my data collected during the study, may be looked at by individuals from [Manchester Metropolitan University], from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

4. I agree to take part in the above study.

_____ _____ _____

Name of participant Date Signature

_____ _____

_____

Name of person taking consent | Date | Signature

When completed, 1 for participant; 1 for researcher site file

IV.

Interview questions

Please describe you involvement with the Cheshire East equipment service

What is your role within the service?

How long have you been involved with the service?

What elements of the service have worked well for you?

Tell me about the quality of the service you receive(d) from the service.

If you were to make suggestions for improvements to the service what would they be?

Have you encountered specific issues with the service?

Focus group questions

What elements of the current provision work well for you?

When things are going well, what do you think made the difference?

Tell me about your experiences of working within the service/accessing the service

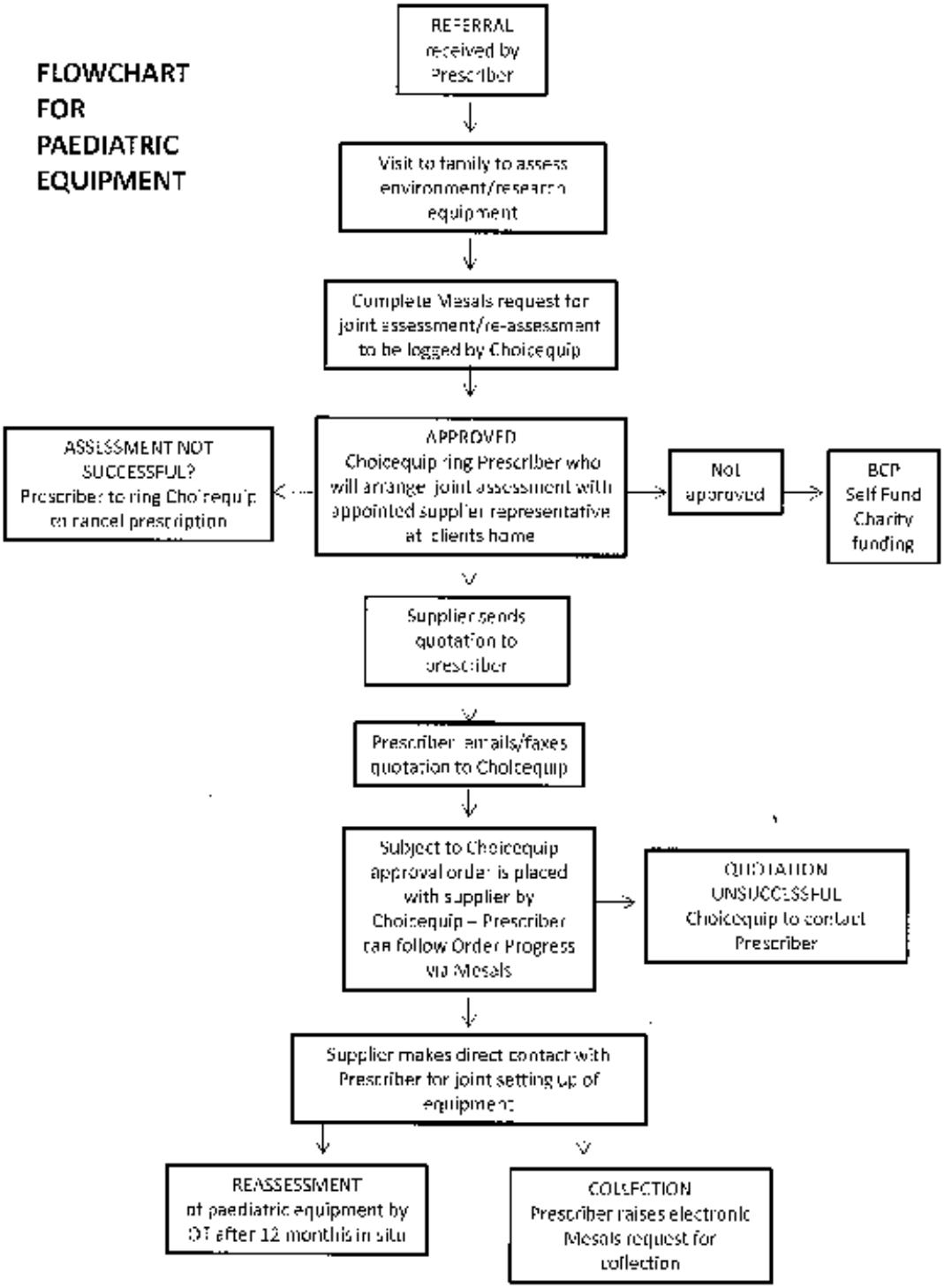
If things are not going well what do you think made the difference?

Can you describe to me how the process works for you?

Let’s discuss where changes to the service might be made.

What do you think is central to a positive experience in the children’s equipment service.

FLOWCHART FOR PAEDIATRIC EQUIPMENT



2658 V.

But I was going to say that if the people that they direct me to could not meet the need of what I consider an appropriate manner I would go outside of the [so would I] and i would put my case forward that purchase outside of that

I have tried that with one piece of kit

I haven't had a problem yet ..... (pause)

Hmm but other people may have different views on that

Its a little bit like the system in councils and stuff where they have procurement they will only go with certain people for [approved lists and you have to go with them]

Choicequip cannot do that or say that because they are in they have to go to an open market what they do have is people that they have an established relationship with

Like r82 because they are in a pilot did you know that?

No

R They are talking about retail and non retail or rental which is about renting rather than purchasing pieces of equipment choicequip are looking at making a contract with r82 and have one with jenx where the rentals

I think I was with some head teachers a few weeks ago and they were talking about standing frames and how they have to purchase standing frames and one of the special schools have for the first time rented a standing frame to see how it works out any cheaper what happens is when the child grows out of it the school are left with a standing frame that they can't use

So there is a rental model

So yeah they are looking at the at but how its going I don't know

Well they do that with the beds they rent some of the beds from them we have a set stock that they own that they rotate and if the an urgent need comes up outside of they they'll rent on a short term won't they

Yeah and that is one of the things that choicequip seem pretty happy about Jane might be able to talk more about that and how she's dealing with the pilot scheme they are running but they are trying to include more supplier in that because not only are the piece of equipment going to possibly be looked after better if they rent it but they come back into the system and can be refurbished and will hve more regular assessments and whether that piece of equipment is [still meeting the need] yes and at the moment they are dealing with 12 month reassessment and are hoping to take it to 6

So you can tell them you can havev an upgrade next year?

Yes sort of

hm haha

I think from a children's perspective they need that don't they

2659 VI.
2660

The child had got the right sling, it took loads of other stuff so that was right that went and now we're putting another hoist in another room and doing a whole load of other things but I went for a sling which was actually fine.

But then maybe thats but in some cases that could be down to the confidence of that individual [yeah] when something isn't sort of familiar [yeah I wouldn't want to do a chair because of my experience] yeah [I wouldn't touch it] Experience and professional 'I'

There is a fine line I know where we all know what our limitations are and what our areas of expertise are [yes] and thats about helping customers understand the role of the different OT's constructing diff between OT's based on Expertise + experience

Yeah and I think if parents were here you know one of the things I would be asking them is do you understand about the certain specialisms because you know its not on your badge is it when you walk in I'm a specialist in this don't ask me about sinks!!

laughter if there is good there is bad, individual practice

No but then thats around good practice and having that discussion with your client [its if your client raises that its about signposting them and networking] Yeah I mean I quite often [you wouldn't just say I'll stop you there because thats not my remit] Yeah I would say thats not something that I would do but I know a man who can and I'll put them in touch with you. I would hope that doesn't happen but if it does then thats down to the quality of the information that is given by the individual therapist [yeah and down to their manager isn't it]. constructing practice as individual

Well some of the one to one interviews I've had with parents so far have raised up how long pieces of equipment is that they are waiting for equipment for a long time and some of them don't understand why they have to see so many different people and thats where I was going with that comment they don't know that the person who walks in doesn't have any expertise in a particular area and in their particular case perhaps haven't has someone who is as professional with them

Maybe not so confident [hmm] yes I think thats one of the things that you know we are experienced and I am quite happy to go well I don't know again this idea of knowing + not knowing the realm of expertise

A lot of the new comers and newly qualified OT's don't want to admit that they don't know whereas I have absolutley NO problem appearing stupid if its an area that I'm not an expert in [most people are understanding when you say its not my area and I'll have to pass it on what they don't want is]

Yes, yes constructing OT as profession of diverse expertise + specialism.

But you do get like its down to the therapists or the professional going out some people don't like it when you say that

And I also think and I don't think this is necessarily a children's issue though specifically though it could be though because the group I'm thinking of would work across certain groups of very erm [long pause] very budget orientated and we all are if there are two pieces of equipment that will exactly the same job I will always go for the most cost effective you know I always look for the more cost effective route [yeah well its public money isn't it? you got to be mindful of that] I always look for the most cost effective route to meet my clients need [mm hm] but thats the second part of it to meet the need its the cost effective route to meet the need. I am aware of groups out there of staff cost effectiveness + practice differences

need + cost effectiveness

Just the social worker {laughter}

really thats the main thing

Yes and acquiring knowledge of what is available and then feeding her with the information

Ok so did you have any knowledge of what was available did you do any research yourself or?

Yes I did research on the internet finding out whats out there going to exhibitions and going to those and seeing if there is anything that he could use and get the information

I'm presuming that an Local authority OT actually came and assessed the child's needs and actually installed.

We haven't seen an ot at home for quite sometime actually apart from the one that we had when we first moved into this place she installed the hoist

So you acquired you got the equipment but through the social worker?

It would have been been a LA OT I think that would have arranged that

I'm just wondering if it was the social worker may have made the links but it would have been an OT that came out to see you about the ordering about the bed?

Well we've had the bed a long time so that was originally an OT but that was about 14 years ago and the um tracking system is several years old [yeah that would have been the ot] yeah but as I say we haven't seen anyone since we had that fitted so.

I was going to say you did access it through the social worker that you got the links to OT

So when you think you need sort of new slings or that sort of thing you when they are getting either worn or broken are you happy that you know where to go to?

Erm I probably would yes I would say not having met any OT's recently I would find out at the time

I'm actually the allocated OT for hebden [right] So if any come through school it might be me but if it is something purely for home then we would link with the local authority OT then to sort of look at that but yeah if there is any calls for school OT then you might meet me

Goo well I don't want there to be too much pressure on you all of us firing questions at you {laughter}

It is good to have a parent here to make some contributions because one of the things I wanted to do was to get parents involved and thats unfortunatley the uptake hasn't been very high probably because of the pressure that parente are under but we are just trying to talk about how we could make the process better from the perspectives for funders, or prescribers and parents so if there are any contributions that you'd like to make to the discussion then please do

Yeah I'll probably join in if there are any bits of discussion then I will if I think its relevant but apart from the bit about how his needs are met but I'll listen and join in.

The process I want to try and is to talk about what is currently workign and then that will mean that we can eliminate the things that don't work so you were saying about the process

Yes

That works for you

Yes

So can you just repeat that for the recorder.

In line with the flow chart between assessment and... the electronic request I may have a discussion with choicequip regarding who I wish to provide the quote or the assessment with rather than jsut loading it onto MESALs and waiting for an email back saying go to company A cus I may have identified company C as one that I think is most appropriate so I will have that discussion with Choicequip prior to booking the assessment visit and I've never had a situation yet where they've said no you can't go with who youre choosing

So based on your clinical judgement

Yeah my knowledge and experience yeah 200 years

laughter yeah 200 yea

of looking at equipment

Now if you were a new member of staff right if you've got a new member of staff with a new MESALS number and who hasn't got your experience they would go onto the MESALs and put their ask for the rep visit and will sit there and wait for Choicequip to come back and say yes you may hope

I would hope that...

And will go with what they suggest

I would hope that if they were in a situation where they weren't necessarily completey clear of what equipment they had that they would go to their supervisor [I would hope so to] and get that information [but at least] Or at least peer group a peer within the, either a supervisor or within the group

So what we are basically saying is that we shouldn't have choicequip telling us..telling us who we are to use as a provider but they could make recommendations

I think it is useful to have them guiding because they know who [but they shouldn't limit us] No! I and at this moment I haven't found that they do

No I don't either especially from the bed point of view they've got the good three bed suppliers at the moment and that' fine they've got a couple of decent shower chairs and turner people [yeah] we've got options [yeah]

I think as long as they are offering options and its not one

2666
2667 VII.

Summary of CES report

The aims of this project and subsequent report were to investigate the current provision of specialist equipment to children in East Cheshire and to recommend improvements or redesign where applicable.

The project began gathering information on local and national drivers. The provision of specialist children's equipment services across the UK faces many challenges; rising numbers of children needing services, pressures on Health and Local Authority budgets, and specialised commissioning with joint working between agencies and professionals being a key factor in successful provision.

Locally, the service already has joint budgets and commissioning in place. There had been noted rises in spending on children's equipment by the PCT's and the Local Authorities over the past two years, with this trend looking set to continue.

1. The project has gathered data from identified providers, managers, suppliers, prescribers and parents through participatory events and interviews to gain a clearer picture of what is working within the service at present and how the service could be improved to deliver a better level of care to the child while attempting to address increasing financial pressures.
2. **Summary of conclusions**

- Demand on the current service requires improvement
- Funding streams are under pressure from increases in spending on children's equipment, others are in dispute and some have been found to not be available.
- There are a variety of ways that prescribers may access the service and referrals go to a number of teams where methods of triage and working practices vary.
- The models of provision in place are generally working well with the processes in place are followed.
- Local equipment provider and the Wheelchair service both
- There is significant confusion between professionals about the provision, their responsibilities with the processes which is causing delays
- Additionally there are identified training issues and some staffing concerns, which need to be acted on.
- Communication between all human elements of the current processes needs to improve through training and clearer transparent processes and criteria.
- Notable disparities between the provision of equipment to adults and children need to be addressed

3. **Summary of recommendations**

Short term and long term recommendations were identified

- Through monitoring and auditing a clear picture of funding and spending need to be established and cascaded to staff to increase awareness of budgeting restrictions, as well as increased reporting of spending and accountability for personal budgets.
- Work must begin on clarifying and simplifying the current processes including adopting the rental model of provision more widely, producing and ratifying a new children's criteria, defining functional need, writing a policy on self-funding and working towards improved joint working.

- Disseminating this information to staff and users to ensure that the processes are clearer and more transparent and parents have access to more information than they currently do.
- Training and communication issues need to be addressed including: training on processes, IT systems, better information sharing through revised documentation and cascading information to staff.
- Support and communication to service users to be worked on through feasibility studies into the use of Independent Living Centres for Children's equipment assessment and display, a website for information and advice on the service, processes and criteria.
- Long Term recommendations centre around improved working between current providers and a simplification of initial entry into the service.

One central referral centre is proposed, with triage and allocation to the service providers being done by a qualified member of staff using the clear and transparent processes and criteria defined through implementation of short term recommendations.