Research in Health Psychology

Research Thesis

Using the COM-B Model to Explore Health care professionals' experience of working towards a collaborative care model within Long Term Conditions, Improving Access to Psychological Therapies Services (IAPT-LTC)

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A thesis submitted in partial fulfilment of the requirements of the University of the West of England for the award of Professional Doctorate in Health Psychology

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Contents

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Foreword: Undertaking the Professional Doctorate in Health Psychology

I have been undertaking the Professional Doctorate in Health Psychology at University of the West of England since November 2018, which has involved working towards and completing five areas of competency set out by the British Psychological Society.

Professional Skills in Health Psychology

This has been completed, submitted, assessed and passed by the University of the West of England and the BPS examination board in November 2021. Work submitted includes a logbook evidencing supervised practice to meet required competencies and a reflective essay.

Teaching and Training in Health Psychology

This has been completed, submitted, assessed and passed by the University of the West of England and the BPS examination board in November 2019.

Consultancy Skills in Health Psychology

This has been completed, submitted, assessed and passed by the University of the West of England and the BPS examination board in November 2020.

Psychological Interventions Health Psychology

This has been completed, submitted, assessed and passed by the University of the West of England and the BPS examination board in November 2020.

Research

The Research competency is assessed in two parts: a systematic review and empirical research.

A systematic review was completed during the first academic year on the professional doctorate entitled ‘How effective is primary care based 1:1 cognitive behavioural therapy in improving mental health outcomes in adults with long term conditions? A systematic review.' The systematic review has been completed, submitted, assessed and passed by the University of the West of England in November 2019.

The systematic review was then updated and later published in an international, peer reviewed journal: *Ansiedad y Estrés* (Stress and Anxiety). The systematic review was entitled 'What adaptions are effective for cognitive behavioural therapy interventions for those with long term conditions or medically unexplained symptoms?' (Sanders, S., Coppin, S., Moulson, H., Meola, J., & Meyrick, J, 2020).

This doctoral thesis describes the research study conducted to fulfil part two of the research competency.

Declaration of contributions

All aspects of this research thesis were Samantha Sanders' own work.

Samantha Sanders was the lead researcher and provided the initial idea for this research and conducted the research design, recruitment, analysis and write up under the supervision of Elizabeth Jenkinson and Helena Lewis-Smith.

RESEARCH THESIS

USING THE COM-B MODEL TO EXPLORE HEALTH CARE PROFESSIONALS' EXPERIENCE OF WORKING TOWARDS A COLLABORATIVE CARE MODEL WITHIN LONG TERM CONDITIONS, IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICES (IAPT-LTC)

Abstract

Objectives: Improving Access to Psychological Therapies Services have been implementing pathways for long term conditions (IAPT-LTC) since their pilot in 2016. An aim of these pathways is to integrate more closely with NHS physical health care teams. *Time to Talk Health* is an IAPT-LTC service in the Southeast of England. This study aimed to explore the experiences of *Time to Talk Health* staff and physical health care professionals to gain insight into the barriers and facilitators to collaborative care. The study also aimed to explore the experiences of those who were part of setting up the joint working model to gain an understanding at implementation level. The final objective of the study was to explore the potential of the COM-B model (capability, opportunity, motivation, behaviour) as a framework for understanding the findings.

Methods: A qualitative design using semi-structured interviews was adopted. Twenty-one members of staff from IAPT-LTC and physical health care teams were recruited. Interview transcripts were first analysed using an inductive approach through thematic analysis to generate themes. A deductive approach was subsequently adopted to map the identified themes onto the COM-B model.

Findings: An analysis of pooled qualitative data identified four themes: (1) the culture of ‘them and us’; (2) ‘can they see the value in it?'; (3) ‘it wasn’t new to me’ and (4) joint working seen as costly vs. enabling. A final theme which fell outside of the COM-B model was identified: collaborative working seen as unsustainable. Sociocultural factors linked to COVID-19 and challenges with staff retention are explored as part of this.

Conclusion: COM-B constructs were found to overlap, providing an understanding of bidirectional links between barriers and facilitators. The study highlights novel findings around the perceived sense of threat linked to loss of job role amongst physical health care clinicians. The current findings also highlight the need for further system-level consideration around targets and adaptions put in place for IAPT-LTC sites. The COM-B model may benefit from additional constructs ‘collective action’ and ‘reflexive monitoring’ from the Normalisation Process Theory which can support us to evaluate the *continued* implementation of organisational innovations. Interventions based on the COM-B model to enhance collaborative care practice and suggestions for future research are considered.

Introduction

This chapter will outline the key literature which has informed the current research. Firstly, long term conditions (LTCs) and medically unexplained symptoms (MUS) will be explored in the context of mental health. This is followed by a discussion around the Improving Access to Psychological Therapies (IAPT) services and their expansion to support those with LTCs. Collaborative care within IAPT-LTC services will then be described, before moving on to evaluate the breadth of research around collaborative care within physical and mental health care settings. Due to the recent roll out of IAPT-LTC service provision, contemporary research around IAPT-LTC services is specifically discussed towards the end of the chapter. Theoretical frameworks and the systematic review undertaken by the researcher will then explored with regards to informing the present research study. Finally, the aims and objectives of the present research are outlined before exploring the methodology within Chapter Two.

Long-Term Conditions and Medically Unexplained Symptoms

A long-term condition refers to a health condition that cannot be cured and requires self-management (Department of Health [DoH], 2012a), such as diabetes, asthma and cardiovascular disease. It is estimated that around eighteen million people in the United Kingdom have one or more LTCs (Office of National Statistics, 2020). This is expected to rise due to an aging population and lifestyle risk factors such as smoking, poor diet, excessive alcohol use and low levels of physical activity (DoH, 2012a). The term medically unexplained symptoms, otherwise known as common functional syndromes, describes persistent and distressing bodily symptoms which cannot be fully explained by a physical pathological cause and often have psychological processes involved (National

Collaborating Centre for Mental Health, 2018). Examples include chronic fatigue syndrome and irritable bowel syndrome.

Sixty-six percent of those with an LTC and 70% of those with MUS also have a mental health condition (NHS, 2019), with between 12 and 18% of all LTC costs to the NHS directly linked to poor mental health outcomes, such as increased levels of anxiety and depression (Naylor et al., 2016). This comorbidity exists due to the complex and interconnected link between physical and mental health (Naylor et al. 2016). The biopsychosocial model (Straub, 2012) allows us to understand these bidirectional links, with health being understood due to biological, psychological and social processes (see Figure 1).

Figure 1 Mechanisms through which physical and mental health interact (Adapted from Prince et al., 2007).

Whilst those with LTCs have been found to be at greater risk of poor psychological wellbeing, including diagnosable mental health conditions (Naylor et al., 2012), studies have also found anxiety and depression to predict the onset of LTCs/MUS. For example, Moss-Morris and Spence (2006) investigated whether there may be significant differences in the causation of illness or precipitating factors associated with common functional syndromes, such as chronic fatigue syndrome. They prospectively studied 592 patients with an acute episode of campylobacter gastroenteritis (food poisoning) and 243 patients with an acute episode of infectious mononucleosis (glandular fever). It was noted that none of the patients within the study had a history of functional syndromes. Levels of distress were initially measured during hospital admission using the Hospital and Anxiety Depression Scale (Zigmond & Snaith, 1983). Questionnaires were subsequently completed to determine whether they met the diagnostic criteria for chronic fatigue at 3 and 6 month follow up. The findings indicate that pre-morbid depression was the most significant predictor of the onset of chronic fatigue syndrome at both points of follow up. Another study conducted by Spence and Moss-Morris (2007) investigated the role of mood, personality factors, illness beliefs and behaviours as predictors of IBS for those who had previously had a positive test for campylobacter gastroenteritis. At both 3 and 6 month follow up after infection, 49 out of 620 participants met the criteria for IBS. Participants with high stress and anxiety levels were found to be significantly more likely to develop IBS following a bout of gastroenteritis.

Furthermore, for those with a pre-existing LTC/ MUS, untreated symptoms of anxiety and depression can predict poorer outcomes around self-management, health behaviours, mortality rates, employability and work attendance (Mental Health Taskforce, 2016). The need for integrated mental and physical health care is therefore driven by this rising comorbidity (Naylor et al., 2012).

Improving Access to Psychological Therapies services

The Improving Access to Psychological Therapies (IAPT) services were set up in 2008 to provide evidence-based psychological therapies for those suffering from common mental health conditions, including depression and anxiety (Clarke, 2019). IAPT is a primary care, mental health service available as part of the NHS to adults within the United Kingdom (NHS, 2022). It has been increasing access rapidly, with 1.69 million people referring into the services between 2019 and 2020 (NHS Digital, 2020). Patients can be referred via their GP, registered health care professional or through self-referral. Patients can expect to receive an initial assessment to discuss their difficulties and, if appropriate, they are placed on a waiting list for treatment (NHS, 2018b). There are a range of treatment options being offered within IAPT services, including High (HI) and Low (LI) intensity CBT which are carried out by Cognitive Behavioural Therapists and Psychological Wellbeing Practitioners respectively. Sessions range from between 4 and 20 sessions, depending on the longevity and complexity of the mental health presentation (NICE, 2011).

The Cognitive Behavioural Therapy (CBT) model (Beck, 1976) has been widely used within standard IAPT services. Cognitive behavioural therapy is a type of talking therapy which helps individuals to make changes to ‘unhelpful’ thoughts or behaviours to better manage their difficulties (BABCP, 2021). NICE guidelines (2011) recommend CBT for anxiety, depression, panic disorder, obsessive compulsive disorder, health anxiety and post-traumatic stress disorder. In people with LTCs, the model can be applied to understand the patient’s interpretation and behavioural response to their condition, as an alternative to pathologizing their distress (Coventry et al., 2011). For example, avoidance of physical activity after suffering a heart attack may be driven by a rational fear response. In the long term, this avoidance can predict poor physical and mental health outcomes due to inactivity and loss of social contact (Elliot et al., 2014). The provision of a CBT intervention within IAPT-LTC can therefore help to challenge unhelpful thoughts which are driving avoidant behaviours (NHS, 2019).

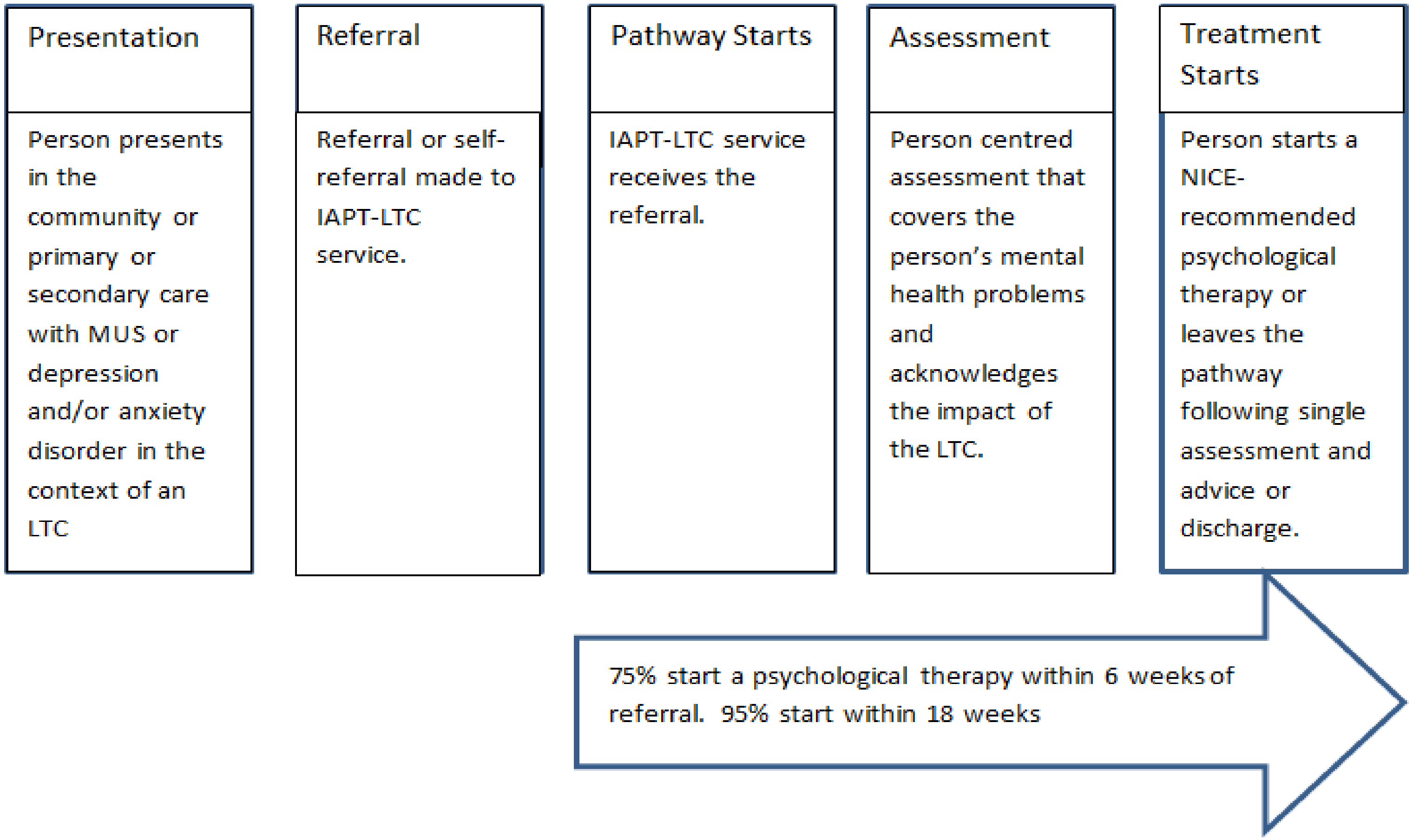
IAPT-LTC service expansion

Priorities for service development across IAPT include expanding services so that 1.9 million people are accessing treatment by 2024, with a particular focus on improving access for those with LTCs (Clarke, 2019). The government published ‘No Health without Mental Health’ in 2011, which identified the need for IAPT services to accommodate patients with LTCs/MUS and associated mental health problems (Department of Health, 2008; 2012a). The ‘Five Year Forward View’ (2015) stated that wider investment would support the implementation of new IAPT-LTC sites during 2017/18 across the United Kingdom (UK). Clinical commissioning groups (CCGs) commission community and hospital NHS care in local areas for which they are responsible. From 2018/2019, NHS England has asked all CCGs to recruit 3,000 extra staff to support the development of IAPT-LTC services for people with diabetes, respiratory disease, cardiac disease and MUS (NHS England & NHS Improvements, 2016). Since September 2016, NHS England has supported 22 early implementer sites in Wave 1 which were made up of several CCGs across the UK (National Collaborating Centre for Mental Health, 2018). This was further expanded upon in Wave 2 (see Table 1).

Table 1 Table of Wave 1 and 2 implementer IAPT-LTC early implementer sites by CCG (Adapted from the National Collaborating Centre for Mental Health, 2018)

Implementer Sites	Wave 1 (CCGs)	Wave 2 (CCGs)
1	North Tyneside	Lancashire North, Flyde and Wyre, Blackpool, Chorley and South Ribble & West Lancashire
2	Sunderland	Northeast Lincolnshire
3	Harrogate and Rural District	Sheffield
4	East Lancashire & Blackburn and Darwen	North Derbyshire, Hardwick, Southern Derbyshire & Erewash
5	Calderdale	Nottingham City
6	North Kirklees & Great Huddersfield	East Staffordshire
7	Warrington	Stafford and Surrounds
8	North Staffordshire & Stoke on Trent	Cannock Chase
9	Nottingham West	Southeast Staffordshire and Seisdon Peninsular
10	Cambridgeshire and Peterborough	Telford and Wrekin
11	West Essex & Herts Valley	North Warwickshire, Coventry and Rugby & South Warwickshire
12	Oxfordshire	Solihull
13	Aylesbury Vale & Chiltern	Wiltshire & Bath and Northeast Somerset
14	Swindon	Thurrock
15	Windsor Ascot and Maidenhead, Slough & Bracknell and Ascot	Thanet
16	Newbury and District, South Reading, North and West Reading & Wokingham	Canterbury and Coastal, Ashford & South Kent Coastal
17	Northeast Hampshire and Farnham,	Dorset
18	Northern, Eastern and Western Devon	Enfield, Barnet, Haringey, Camden & Islington
19	Crawley, Mid Sussex & Coastal West Sussex	Harrow, Brent, Ealing, West London, Central London, Hammersmith and Fulham & Hounslow
20	Portsmouth	
21	Hillingdon	
22	Richmond	

The IAPT-LTC pathway (see Figure 2) shows that a patient can be referred into IAPT-LTC services from any primary or secondary care provider or through self-referral (National Collaborating Centre for Mental Health, 2018). The patient’s referral is received and the patient is assessed to identify suitability for treatment within primary care or to determine whether signposting, advice or an onward referral to other services may be more appropriate. The National Institute for Health and Care Excellence (NICE) Guidelines (2009) recommended the integration of physical health care team involvement throughout the pathway of assessment through to treatment. At discharge, clear pathways and processes should enable a patient to progress within or between services. This includes the transfer of responsibility to physical health care colleagues if necessary (Collaborating Centre for Mental Health, 2018).



Presentation

Person presents in the community or primary or secondary care with MUS or depression and/or anxiety disorder in the context of an LTC

Referral

Referral or self-referral made to IAPT-LTC service.

Pathway Starts

IAPT-LTC service receives the referral.

Assessment

Person centred assessment that covers the person's mental health problems and acknowledges the impact of the LTC.

Treatment Starts

Person starts a NICE-recommended psychological therapy or leaves the pathway following single assessment and advice or discharge.

75% start a psychological therapy within 6 weeks of referral. 95% start within 18 weeks

Figure 2 The IAPT-LTC pathway (Adapted from the National Collaborating Centre for Mental Health, 2018)

Prior to the development of IAPT LTC services, care-as-usual from the general practitioner would differ to the above pathway. Patients with LTCs could be referred into psychological therapies (including those standardly provided by IAPT services) and/or provided with a prescription of psychotropic medication (Coventry et al. 2015). Mental health care services were separate, including psychological medicine departments within general hopsitals or specialist clinical health psychology services provided by multi-disciplinary teams (Carroll et al. 2020).

Joined-up care within IAPT-LTC

Current guidance states that IAPT-LTC services should be developed alongside existing health care services, with clear arrangements for joint working with professionals and practitioners from other sectors (National Collaborating Centre for Mental Health, 2018). The guidance further states that to work effectively with the wider system, it is important for services to be co-located within primary care, with participation in multidisciplinary team meetings, care planning and joint working. It is stated that the implementation of joint working and integrated pathways is put in place to work towards a more collaborative model.

It has been indicated that there is a lack of common definitions to describe the concept of ‘collaborative care’ (World Health Organisation, 2016). As a consequence, a range of terms such as 'integrated care', 'coordinated care' and 'collaborative care' are used within health care settings. Thus, “integration in healthcare is not likely to follow a single path and variations will be inevitable” (National Evaluation of the Department of Health’s Integrated Care Pilots, 2012, Executive summary, p. 5). It is therefore important to define terms used in relation to joined-up care, to support the interpretation of the findings within the present study. It is understood that through the use of co-located care and joint working (as stated within the implementation guidance), IAPT-LTC services are aiming to work towards a collaborative care model with elements of integration (National Collaborating Centre for Mental Health, 2018).

The glossary below provides definitions around each of these concepts. Each concept builds upon the previous with ‘integrated care’ being at the top of the hierarchy, representing a fully co-ordinated approach within one organisational framework.

Hierarchy of care glossary

1) Co-located care: Co-location involved the logistical integration of professionals working within the same facility (Bonciani et al., 2018). Mental health professionals are therefore placed in primary care settings or primary care providers are placed in mental health clinics to improve access to these services.

2) Joint/collaborative working: When two or more health care professionals pool skills, experience and/or resources for the joint development and implementation of patient centred projects (Department of Health and Social Care, 2008). This can be for a fixed length of time or a permanent arrangement.

3) Collaborative care: A multi-professional approach, requiring a general practitioner and at least one other health professional, a structured management plan, scheduled patient follow-ups and enhanced inter-professional communication (Gunn et al. 2006).

4) Integrated care: A single entity is responsbile for all services, either under one structure or by contracting services from other ogranisations. Entities function in parallel and offer a co-ordinated approach within on organisational framework (Curry & Ham, 2010).

Within a recent discussion paper, Daniel (2020) describes three levels of integrated care: integration within teams, integration within the same organisation and integration across organisations. *Integration within teams* includes care provided by mutidisciplinary teams, whereas *integration within the same organisation* includes generalised care within hospitals rather than sub specialisms working independantly. Lastly, *integration across organisations* includes joined up care by physical, psychological and social care providers.

The importance of integrated care *across organisations* is increasing in the presence of multiple physical and psychological needs. Daniel (2020) suggests that, in the absence of integrated care, services can be duplicated, resulting in conflicting information being given to patients and increasing psychological distress. It is suggested that a lack of communication between services, a lack of understanding around the provision of care by other services, not valuing the collaborative care model and data sharing restrictions can all contribute to these challenges to working effectively across organisations. These distinctions are particularly important as the current study aims to explore integration across organisations, due to IAPT-LTC services and physical health care teams working as separate physical and psychological care providers.

Working towards a 'collaborative care model'

> *Every patient has the right to a discussion and interpretation of his or her symptoms within a holistic framework where all relevant biological, psychological, and social aspects of health can be considered*. (Kvamme et al., 2001 p. 34)

Davies (2000) described the importance of working ‘together’ rather than ‘alongside’ one another for collaborative care to be successful. In practice, parties need to be both confident enough to face the unfamiliar and be respectful and trusting enough to listen openly to others (Williamson, 1999). Inequalities of power make it difficult for ‘less powerful members’ of a group to speak out, which requires all members to recognise that everybody brings equally valid knowledge and expertise from their profession (Braye & Preston-Shoot, 1995; Davies, 2000). Recommendations from the discussion paper provided by Daniel (2020) build upon these ideas and put forward key concepts that may be important when working towards a more integrated model. These concepts include striving to achieve parity of esteem across disciplines, moving towards a shift in culture so that MDT teams become the norm in physical health settings, with the provision of coordinated physical, psychological and social care.

Advantages and disadvantages of collaborative care

It is important to consider the costs and benefits of collaborative care once this has been achieved. There are few disadvantages documented within the literature, however Raue et al. (2010) suggest that limitations include poor patient adherence and remission rates, alongside difficulty with real-world applicability when applied to treating depression in primary care. Raue et al. (2010) emphasise the importance of a shared decision-making model which involves the patient advising the clinicians involved in their care of their values, goals, experiences and treatment preferences to inform decisions. They have noted that this can often be missing from collaborative care practice when decisions are made between professionals. This could further restrict patient choice and therefore reduce the patient’s sense of autonomy and responsibility. Raue et al. (2010) have also highlighted how collaborative care and shared decision-making models are time consuming for clinicians involved, particularly within primary care contexts. However, it is important to consider that this literature pre-dates the development of IAPT-LTC services and therefore collaborative care may have evolved since these limitations were explored.

Despite these challenges, the integration of physical and mental healthcare is said to hold many benefits for the patient (Ee et al., 2020). These include addressing both their physical and mental health needs, alongside reducing health care disparities for those from different socioeconomic and ethnic background, thus improving access to care. Benefits are also reported for service providers, including reduced health care costs (Unutzer et al., 2008) and high levels of satisfaction amongst clinicians (Levine et al., 2005). Overall, it is important for future research to explore the costs and benefits of collaborative care, as there is currently a lack of research in the field, with current findings considered dated. However, it can be useful to look to research conducted into the effectiveness of collaborative care for patient outcomes which will be further explored below.

Effectiveness of collaborative care

A randomised controlled effectiveness trial was conducted by Sharpe et al (2014) investigating the effectiveness of collaborative care for patients with cancer. They developed a multicomponent integrated treatment programme called ‘depression care for people with cancer’ for patients attending NHS cancer clinics in Scotland. In the experimental group, 257 patients were involved in systematic, proactive treatment, which was achieved through collaboration between a psychiatrist, a care manager, the patients’ primary care physician and the patients’ specialist medical care. In the control group, 247 patients received care as usual, such as the prescription of anti-depressants or referral to mental health services. The primary trial outcome was treatment response at 24 weeks, which was defined by a 50% reduction in symptoms of depression on a self-rated scale compared to baseline. The results show a significant difference in treatment response between the two groups. The improvement in treatment response was found to be 62% in the collaborative care group compared to 17% in the usual care group. There was also a significant improvement in outcomes including anxiety, pain, fatigue, functional ability and overall quality of life in the collaborative care group. The results were also maintained at a 48 week follow up. This study holds strengths in its recruitment of participants through the screening of cancer clinics, which included a population of over 4 million people. The researchers also report good participation in the programme and negligible missing outcome data.

Although the findings of this trial provide strong evidence around the effectiveness of collaborative care models for those with comorbid depression and medical conditions, it is important to consider its limitations. The sample consisted of mainly women receiving follow-up appointments for breast or gynaecological cancers, which limits the generalisability of the findings to males or those with other forms of cancer. Although statisticians and outcome data collectors were masked, the participants and primary care physicians were not masked to treatment allocation. This may have resulted in ascertainment bias due to primary care physicians delivering the intervention within the trial. When considering the implications of these findings for IAPT-LTC services, it is important to note that cancer was not a long-term condition that was commissioned by NHS England to be supported as part of the early implementer sites (NHS, 2018b). Therefore, the findings may not be generalisable to support the effectiveness of collaborative care within IAPT settings. It is therefore important to look to the research conducted within this field.

The only quantitative research to examine the effectiveness of collaborative care within a UK-based IAPT service focused on 387 patients with diabetes or heart disease, who also had co-morbid depression (Coventry et al., 2015). Within the trial, up to eight sessions of psychological treatment were delivered by psychological wellbeing practitioners employed by IAPT. Those randomised to the intervention arm received collaborative care, which involved two out of eight treatment sessions being delivered jointly with the practice nurse. Within these two sessions, a 10-minute collaborative meeting between the patients, the PWP and the nurse took place. The purpose of these meetings was to ensure that psychological treatments did not complicate management of physical health and patient safety, to check that patients adhered to antidepressants as prescribed, to deal with concerns about side effects and to help to arrange drug reviews with the general practitioner. The research had a comparison group of usual care, which was defined as GP support, prescription of antidepressants or standard referrals to IAPT services. It was found that those receiving collaborative care showed significantly improved outcomes for depression and self-management of their LTC compared to those receiving psychological treatment in absense of collaborative care. The research was a large trial conducted across a wide geographical area in the North of England, including areas of considerable socioeconomic deprivation and ethnic diversity. This offered a representative sample of a patient group who are more likely to be referred into psychological therapies (NHS Digital, 2018). However, limitations to consider include the lack of allocation concealment from practice staff and participants; researchers may also have been made aware of treatment allocation as outcome data was collected face to face at follow up. The authors note that interviews could have been conducted to determine whether the reseachers had learnt which participants had been assigned to the treatment group. However, assessment bias was not formally tested for, further impacting on the validty of the findings. It is also unclear as to whether outcomes are sustained in the long term as participants were not followed up after four months. Finally, the researchers did not collect measures around physical functioning. Therefore, the results of the study are unable to assess the impact of collaborative care on physical health.

Qualitative research was conducted by Knowles et al. (2013; 2015) to explore both health professonals' and patients' experience of collaborative care within this trial. Semi-structured interviews were completed with professionals delivering the interventions (11 psychological wellbeing practitioners, 12 practice nurses and 7 GPs), alongside 31 patients. Analysis was guided by the priniciples and precedures of the constant comparative method using an inductive approach to generate themes. The data was understood by two main themes of integration and division. Health professionals spoke about how the new care model has encouraged more effective communication between them, alongside more effective signposting to services. Professionals also reported increased opportunity for co-ordinating care and information sharing which enhanced their confidence to work effectively with co-morbidity. Professionals reported being able to understand patients' difficulties in a more holistic way, having increased access to each other's services and delivering mental health care in a less stigmatised way. However, whilst the findings suggest that the trial achieved service level integration, this did not apply to therapeutic integration. Patients preferred a protected focus to discuss mental health issues, and professionals maintained barriers around physical and mental health expertise.

The study was rated as methodologically strong using the CASP tool (Sanders et al. 2020), therefore allowing the results to be interpretted with confidence. However, it is important to note that the results from the study reflect how the the intervention was delivered and experienced as part of the COINCIDE trial (Coventry et al. 2015), and thus may not reflect naturalistic settings. Interviews were also carried out over the course of the trial and therefore the long term implications of embedding IAPT workers into primary care, and the sustainability of the model, is not explored. Additionally, it is noted that the sample of patients interviewed represented an older population who may have a preference for division in mental and physical health treatment. Therefore, these findings may not apply to younger generations with long term conditions. Finally, the findings may not generalise to contexts whereby collaborative care models include health professionals outside of practice nurses or GPs.

The authors suggested that future research should explore the role of clinical leaders, including IAPT supervisors, in supporting collaboration across mental and physical health care settings (Knowles et al., 2013). This is important, as working to support mental-physical health comorbidity involves interactions within primary care which are both horizontal (across teams and services) and vertical (between front line workers and service leaders).

It is beneficial to look to systematic reviews of qualitiative research in the field of collaborative care to review the findings around experiences of therapists more broadly, and to consider the quality of existing research. A recent systematic review of qualitative studies explored perceived barriers and facilitators held by health professionals around collaborative care for patients with depression, both with and without comorbid LTCs (Wood, Ohlsen & Ricketts, 2017). The review identified 18 relevant studies, however, only four included the care of patients with LTCs. All four of these studies utilised thematic analysis and were completed within primary care, including the findings previously explored by Knowles et al. (2013; 2015). The two additional studies were conducted within Canadian family practices (Wozniak et al., 2015) and a health maintenance organisation in the USA (Kathol et al., 2010).

Wozniak et al. (2015) evaluated the implementation of a collaborative care model for patients with diabetes and depression. Collaborative care was based upon a framework called ‘TeamCare’ with the aim of improving depressive symptoms through a combination of medication, behavioural therapy, improving HBa1c outcomes and modifying lifestyle behaviours. The care manager was an allocated nurse who co-ordinated care with the GP and relevant specialists such as psychiatrists, endocrinologists or internists. The nurse has fortnightly contact with the patient and weekly contact with specialists who suggested evidenced based treatment options. The GP made final decisions around medication and other treatment choices. The results found suboptimal fidelity and deviations from the model including limited degrees of collaborative care being practiced and discontinuity of care managers. Facilitators of collaborative care were identified at an organisational level including training, implementation support, professional and personal qualities of the care manager (nurse) and pre-existing relationships. It was concluded that a stronger culture of collaborative care may have improved implementation fidelity.

Kathol et al. (2010) aimed to examine practical aspects related to the development and continuation of programs that integrate mental health services in primary care settings in the USA. Eleven nationally established primary care programmes were selected for the research, and participants were chosen from each site based on their knowledge of the program operation. Participants included administrators, clinicians and care managers, who were directly involved in the care program. Semi-structured interviews were used to elicit information about their working definitions of integrated care; the development of their program; the model of integration used; how interdisciplinary services were delivered; critical clinical and financial success components and barriers to implementation, service delivery and sustainability. A key barrier to sustaining an integrated model included the financial challenges introduced by segregating physical and mental health reimbursement practices. Key facilitators to the sustainability of integrated care included a culture shift which valued patient outcomes with a population and a multi-disease focus, the provision of cross-disciplinary training, evidence of cross-disciplinary accountability, use of care managers to coordinate care, consolidated clinical record systems and the co-location of services.

It is important to consider the limitations associated with the highlighted studies from the systematic review (Wood et al., 2017). This research generally lacked investigation into issues relating to implementation of collaborative care by those within managerial positions and commissioners who are responsible for setting up collaborative care programmes. Identifying the perceived challenges to setting up these pathways may add further insight to the barriers around the sustainability of collaborative care models and day to day implementation of joint working. Additionally, there is a lack of generalisability of the research in supporting a range of mental health conditions outside of depression, alongside a range of LTCs. Existing studies have either had a specific focus on diabetes or heart disease (Knowles at al., 2013; Knowles at al., 2015; Wozniak et al., 2015;), or have failed to provide any details on the types of LTCs included within the research (Kanthol et al., 2010). Whilst prior findings provide some insight, they may not reflect the effectiveness of collaborative care for those with a range of LTCs, alongside the co-morbid presentation of anxiety disorders which is important for the generalisability of the IAPT-LTC model. Although Knowles et al. (2015) provides insight into experiences of joint working within IAPT services for those with LTCs, these results reflect how the intervention was delivered and experienced within the context of a controlled trial, rather than within routinely delivered primary care. In addition to this, the results cannot be generalised to collaborative care models that extend to health professionals outside of practice nurses and GPs. It is therefore unclear as to whether the findings from this study can be generalised to collaborative working that is being routinely carried out within IAPT-LTC services. Further, most of the research to date around collaborative care for patients with LTCs has been conducted before the development of IAPT-LTC services in 2016, and therefore, there is little research into how the present model of collaborative care is being experienced. The few peieces of contemporary research in the field are further explored below.

Contemporary existing research within IAPT-LTC settings

Contemporary research exploring barriers and facilitators to collaborative care within IAPT-LTC settings suggests that communication and teamwork between professionals can support a sense of working together rather than separately. The importance of training for staff has also been highlighted as improving confidence to work holistically with patients and one another. These key studies will now be discussed in detail.

An evaluation was commissioned by NHS England to examine the experience of Wave 1 IAPT-LTC implementer sites. The findings were published within a report by Clarke, Furmaniak and Pilling (2018), with the aim of informing the development of Wave 2 sites. The evaluation used a mixed methods approach to achieve a multi-layered picture of the sites and implementation process through the collection of publicly available national data, data from staff surveys and semi-structured interviews with staff and service users. Staff involved in the interviews were commissioners, service leads, managers, clinicians, support personnel and affiliated health care workers. Nineteen members of staff participated in this part of the evaluation and findings were analysed using thematic analysis (Braun and Clarke, 2013). Themes were generated from the responses from the interviews, alongside the responses gained from staff surveys. At implementation level, it was found that teamwork, effective relationships among healthcare teams, strong networking and access to health psychology services all supported the development of pathways. At practitioner level, it was found that strong leadership from senior clinical staff, alongside effective supervision and training, were important to work within IAPT-LTC pathways. However, limited space to allow co-location with physical healthcare teams was found to be a barrier.

The findings from this evaluation provide preliminary data around some of the faciliatators and barriers to the implementation of IAPT-LTC pathways. However, due to the evaluation being based on the first pilot sites, there are several limitations to consider. Sites aimed to start delivering services from January 2017, however, the authors described a number of sites experiencing significant delays in fully establishing their services. Challenges were linked to the lack of availability of top-up training for staff at the time, to enable services to start supporting patients. Given that interviews were carried out from September 2017, there may not have been an adequate timeframe for participants to fully reflect on their experiences. Data quality was also mixed as data linkage systems were in the early stages of development. Authors note that findings mainly relate to the process of implementation and conclusions remain tentative around staff's ongoing experience of working within IAPT-LTC pathways. At this later time, it is important to explore research completed within the field of IAPT-LTC services now that Wave 2 sites have been implemented and services continue to be commissioned (NHS, 2018c).

Panchal et al. (2020) present four case studies within a discussion paper to outline the continued, successful implementation of CBT interventions for LTC patients within South East Staffordshire IAPT services. Authors also explore key factors they consider to be associated with the successful development of IAPT-LTC pathways. Key themes around IAPT-LTC service development include the importance of: engagement between mental and physical health care professionals, identifying key professionals in medical healthcare to enhance engagement, extended training for clinicians and developments in clinical supervision structures and practice. Although this paper provides some insight into facilitating factors to the development of an IAPT-LTC service, there are many limitations to consider. The authors do not describe their data collection methods for the case studies provided within the paper, further impacting on the quality of the findings. All authors were affiliated with the South East Staffordshire IAPT service, however, there was no further information concerning their job role. In addition to this, the paper offered little reflexivity in order to better understand how their roles may have contributed to the content of the discussion. Future research would benefit from collecting data from staff within IAPT-LTC services in order to better understand themes outlined within the paper. This is particularly important as engagement between physical and mental health care staff has been identified as a key theme which has implications for collaborative care.

The most recent piece of qualitative research in the field of IAPT-LTC was completed by Carroll et al. (2020), exploring therapists' perceptions of barriers and facilitators to uptake and engagement in therapy whilst working within new IAPT-LTC pathways. Semi-structured interviews were completed with 15 psychological therapists, including mental health professionals working within IAPT and psychologists working within physical health care settings. The results were first analysed using inductive thematic analysis (Braun and Clarke, 2013), and then a deductive approach was taken to map themes onto Normalisation Process Theory constructs. The following four themes were identified: working flexibly with barriers within the NHS, acceptibility of 'embedded' vs. 'separate' psychological care, levels of confidence in working with LTCs and navigating implementiation of online therapies.

The theme of working flexibly with barriers within the NHS encompassed a subtheme of 'patient barriers to engagement'. These barriers were LTC specific and impacted on attending appointments, including patient mobility issues and symptom exacerbations, which resulted in cancellations. 'Therapist and service level flexibility' described the need for greater flexibility around session frequency, attendance policies, mode of delivery and session location. The theme acceptability of 'embedded' vs. 'separate' psychological care encompassed the subtheme of 'normalising psychology and reducing stigma'. Therapists reported that uptake and engagement was affected by the language they used when communicating with patients about their psychological wellbeing in the context of their physical health. Words such as 'stressed' or 'frustrated', when being used in relation to the impact of their LTC, were found to reduce stigma, rather than using language such as 'anxious' or 'depressed'. The second subtheme was defined as the 'challenge of working in an integrated vs. non integrated setting'. Both therapists and physical health care staff valued working together to achieve shared goals, however, IAPT staff reported feeling restricted by time, large caseloads and challenges liaising with services that are not embedded within the team.

The theme of confidence in working psychologically with patients with LTCs was comprised of two subthemes: 'multi disciplinary professionals' confidence in communicating role of psychology' and 'therapists knowledge and confidence'. It was found that health care professionals may avoid having conversations with patients around psychological support due to a lack of confidence in doing so. Therapists within IAPT were also found to lack knowledge and confidence when it came to treatments for LTCs, which resulted in providing minimal information about available options. Therapists also worried about their understanding of LTCs and how far to 'push patients' or whether symptoms required medical attention, further impacting on the quality of therapy delivered.

Finally, the theme of navigating the implementation of online interventions was comprised of two subthemes: ‘widening access through tailored online therapies’ and ‘a tale of two therapists: divided opinion on online interventions’. It was found that online therapies support resource constraints and reduce stigma associated with one to one sessions. However, it is important that they are tailored to facilitate uptake and engagement. Therapists were divided in their opinion around delivering online therapies, with some demonstrating enthusiasm and some feeling apprehensive due to the potential impact on the therapeutic alliance and ability to monitor risk.

Overall, the results from this study highlight the importance of offering flexible, tailored therapy to those with LTCs and the importance of providing training and resources to enable LTC pathways to run sucessfully. The authors suggest the need for this research to be replicated within IAPT services outside London to explore a range of experiences of therapists across different teams. Although this research is of particular relevance to the present study, it is important to note that the focus was centred around therapists’ experience of working with patients with LTCs in the context of the new pathways, rather than their experience of collaborative working. Although the theme acceptability of ‘embedded’ vs. ‘separate’ psychological care with physical health professionals formed part of the findings, barriers and facilitators to working collaboratively were not part of the aims and objectives of the study. The present study aims to address this gap through exploring the barriers and facilitators to collaborative care between IAPT-LTC and physical health care teams specifically.

Theoretical frameworks

Previous research in the field (Carroll et al., 2020; Knowles et al., 2013) has based the analysis of data upon the constructs of Normalisation Process Theory (May & Finch 2009). The theoretical framework supports the identification of barriers and facilitators of complex interventions into everyday practice. Constructs include:

- *Coherence*: is there an agreement of the work across professionals?
- *Cognitive participation*: is there an agreement of who does what, both individually and collectively across professionals?
- *Collective action*: is there an agreement about how the work gets done and how professionals interact with pre-existing or established processes?
- *Reflexive monitoring*: is there an agreement on how to appraise the work and the collabortative model?

The use of NPT is therefore effective for research that may be aiming to newly develop, evaluate and implement complex interventions such as collaborative care. This theroretical framework was considered for the present project, however, the joint working pathways within *Time to Talk Health* have been in place and developed since 2017. All clinicians are allocated time in their diaries to collaborate with health care professionals as part of the service model. Consequently, this way or working has been normalised and formally implemented at a service level. It is therefore important to explore the barriers and faciliatators to effective joint working within an established IAPT-LTC service that makes the present research novel, and did not lend itself to the use of NPT as part of the data analysis.

Alternatively, the Capability, Opportunity, Motivation, Behaviour Model (COM-B) (Michie et al., 2014) was considered. The (COM-B) (Michie et al., 2014) views behaviour change as a the result of the *interaction* between the three components of capability, opportunity and motivation (see Figure 3). In the context of working towards a collaborative care model, the health professionals' behaviour can be influenced by their percieved capability, which can be psychological (knowledge, confidence) or physical (obtained skillset). Their opportunity can be socially driven (for example, social norms or culture) within the workplace or physical opportunity in terms of available resources. Lastly, their motivation can be seen as both automatic (emotive) or reflective (the professional's beliefs and/or intention), which contribute to the behavioural outcome of working collaboratively.

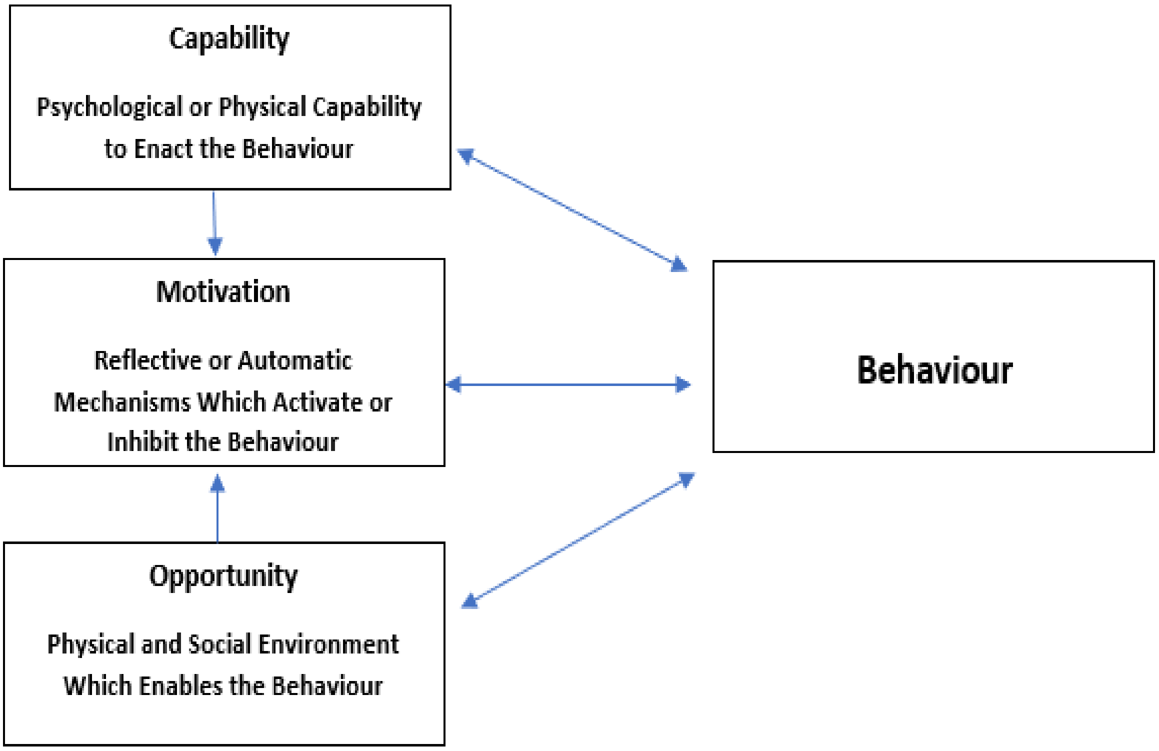


Figure 3 Components of the COM-B model (Adapted from Michie et al., 2014).

This model can be used to explore barriers and facilitators to joint working, by identifying whether its concepts impact on joint working in practice by health professionals, alongside the implementation of joint working pathways by senior staff. It remains unclear as to how to meaningfully translate barriers and facilitators around collaborative working into clinical practice, for which the COM-B model may facilitate understanding. Michie et al (2011) put forward a range of interventions associated with the different constructs of model to bring about behaviour change, (see Table 1).

Table 1 Possible types of behaviour change interventions associated with the COM-B constructs

Intervention (construct)	**Definition**
Education (capability)	Increasing knowledge or understanding
Persuasion (motivation)	Using communication to induce positive or negative feelings or stimulate action
Incentivisation (opportunity/motivation)	Creating expectation of reward
Coercion (opportunity/motivation)	Creating expectation of punishment or cost
Training (capability)	Imparting skills
Restriction (opportunity)	Using rules to reduce the opportunity to engage in the target behaviour
Environmental Restructuring (opportunity)	Changing the physical or social context
Modelling (motivation/capability)	Providing an example for people to aspire to or imitate
Enablement (capability/opportunity)	Increasing means/reducing barriers to increase capability or opportunity

The COM-B model has primarily been applied to intervention design, however, the Theoretical Domains Framework (Cane, O'Connor & Michie, 2012), which further devides the COM-B model into 18 theoretical domains, has been applied to many other contexts within systematic reviews of professional practice (Craig et al., 2016; Hestlehurst et al., 2016; McDonagh et al., 2018). It was believed that the COM-B model could meaningfully translate the findings into clinical practice. This further drove the present research aims and the deductive approach to map the COM-B constructs onto the themes within the secondary part of the analysis (Crabtree & Miller, 1999).

Systematic review

A systematic review was completed by the researcher in 2019 and brought up to date in 2020 for the purpose of publication. The systematic review reinforced why this is an important topic to investigate and is described in this section.

The systematic review, entitled 'What adaptions are effective for CBT interventions for those with LTCs or MUS?' has been published within a peer review journal (see Appendix A). The aims of the review were to identify how CBT interventions should be adapted for patients living with LTCs and poorly understood syndromes (referred to as MUS) within IAPT services. The review therefore included quantitative studies that assessed the effectiveness of CBT interventions for LTCs/MUS either completed within IAPT services or trials that recruited their participants through primary care providers within the UK. The IAPT-LTC model is unique to the UK and a review in this area had not previously been completed. The systematic review (SR) therefore aimed to address this knowledge gap. Many countries are building upon the UK IAPT model including Norway, Australia and Sweden, alongside many other countries with developing plans for

IAPT-like services (Clarke, 2019). The review was therefore important to an international audience and therefore published within an international journal.

Of 14,380 papers, eight papers were included within the review. Moderate to strong evidence found CBT adaptions were effective in improving outcomes, including the targeting of LTC specific anxiety symptoms such as bowel control anxiety for IBS, the inclusion of collaborative care through joint appointments with physical health professionals or implementing a range of therapeutic skills such as motivational interviewing, pacing and acceptance and commitment therapy. Weak methodology was associated with selection bias, lack of blinding and reporting around the validity and reliability of data collection tools. Overall, the findings suggested that CBT adaptions may be effective at improving mental health outcomes for those with LTC/MUS in the short term. Due to the limited number of studies included within the review and the mixed quality of studies, conclusions remain tentative. It was unclear whether interventions can sustain outcomes and provide financial gains in the long term.

The findings from the systematic review fed into the present research. The review provided evidence that working towards a collaborative care model was an effective adaption to support outcomes for those with LTC/MUS, however, research in this area was clearly lacking.

The present study

There is limited existing research around the experiences of joint working amongst physical health care staff and practitioners working within IAPT-LTC services. The present study aims to explore the barriers and facilitators to working collaboratively across IAPT-LTC with specialisms including diabetes, respiratory, cardiac and pain teams.

What will this research add?

The currrent research aims to build upon the recent findings of Carroll et al. (2020). Their findings offer an insight into therapists' experience of working with patients with LTCs in the context of new pathways. This research, however, will add depth around the experience of collaborative working as part of these pathways, alongside exploring the experiences of physical health care practitioners and those within leadership roles.

Previous research within the UK has focused on collaborative care between GPs and practice nurses. This research will offer insight into the experience of joint working with health professionals outside of these roles. The results from this research will therefore provide experiences of joint working within the breadth of pathways that have been created (with diabetes, cardiac, musculoskeletal and respiratory teams).

Since the implementation of Wave 2 pilot sites, research has offered insight into barriers around implementation of collaborative care for LTCs from the perspective of frontline staff within IAPT-LTC pathways. The current research will offer insight into experiences of implementation difficulties at a managerial/CCG level, using in-depth qualitative methods.

Although research has been conducted into experiences of those working within IAPT-LTC sites, no research has been conducted into experiences of collaborative care specifically. This study will therefore be the first of its kind to explore this aspect of IAPT-LTC pathways in more depth.

The results would be of interest at a national level, given the current expansion of IAPT-LTC and the focus on working towards a more collaborative model of care. The research could highlight important aspects of the service model that are working well to achieve collaborative care, alongside any implementation issues of joint working pathways. The results have the potential to inform the future development of joint working pathways within IAPT-LTC services. If joint working is perceived as important for health professionals in improving patient outcomes, there could be considerable financial gain for the NHS due to the associated costs of those with LTCs and related mental health problems.

Research objectives and questions

Research objectives

1) To generate understanding of joint working between Long Term Conditions, Improving Access to Psychological Therapies (IAPT-LTC) services and teams from other NHS sectors.

2) To better understand how collaborative care is being achieved and barriers and facilitators in relation to this.

3) To map barriers and facilitators onto the COM-B model.

Research questions

- What are the facilitators and barriers to joint working across IAPT-LTC and physical health care services?
- What are the facilitators and barriers to setting up joint working pathways within IAPT-LTC services?
- To what extent can COM-B be used as an effective framework to explore the above questions?

Methodology

This chapter will outline the methodology of the research study. The researcher's theoretical positioning will be discussed initially as this was considered to underpin many of the subsequent decisions around the methodology. The research design is then discussed including the method of data collection. The characteristics of the participants will be outlined, including the sample size and inclusion and exclusion criteria used to recruit participants. Ethical considerations will then be discussed, before outlining the research procedure. The method of analysis will be explored alongside the specific steps taken to analyse the data, whilst considering the researcher influence on the data. Lastly, issues relating to quality and rigour are outlined.

Theoretical positioning

Before engaging in this study, the researcher reflected on their theoretical standpoint from an ontological and epistemological perspective. The method of enquiry was also considered to identify how this standpoint may have shaped the research process and findings.

The researcher seeks to explore the experiences of joint working amongst health professionals working within the newly developed IAPT-LTC service. It is assumed that a notion of truth around their experiences exists independently of the researcher and their knowledge or views about this phenomenon, with an appreciation that the data collected is impacted by the interview process. The researcher also identifies that the data needs to be interpreted to identify what factors might be at play that could impact the way in which professionals work alongside each other. It is recognised that key factors might not be explicitly said by the participants, rather the underlying structures that generate the phenomena (Willig, 2013). It is impossible for the researcher to position themselves outside of the research matter due to their relationship with the participants as a colleague. The researcher also holds a relationship with the NHS trust as their employer and holds a relationship with the phenomenon that they are studying as they are actively involved in joint working as part of their job role.

It is important to consider issues relating to quality and rigour in qualitative research, which is explored fully later within the chapter. Tracy (2017) highlights the importance of relational ethics which encourage the researcher to be aware of the impact they have on participants within the study. The use of ‘acquaintance interviews’ meant that the researcher entered into ‘dual relationships’ as part of the study: as both a researcher and a colleague (Garton & Copland, 2010). Therefore, pre-existing relationships with participants and pre-existing beliefs about the research topic inevitably impacted the context of data collection, analysis and the write up of the study. The researcher therefore reflected on their role throughout the process of the research, which supported an understanding of how the research was shaped. This reflective approach supported the researcher to maintain a high level of relational ethics as outlined by Tracy (2017). The researcher also aimed to achieve resonance through conducting in-depth, situated analyses of contexts so that the reader can apply or transfer the findings to their own situation in a way that is meaningful to them (Tracy, 2017).

As the research aims to explore health professionals’ experience of collaborative care, the study was underpinned by a contextualist epistemological approach and critical realist ontology. From this perspective on the ontology continuum the researcher assumes that ‘truth’ is knowable (positivist perspective) while acknowledging the subjective and socially constructed nature of that truth (constructivist perspective; Braun & Clarke, 2013). Therefore, this implies that the truth exists, but we can only access part of it or a ‘version of’ the truth.

From a contextualist epistemological perspective, knowledge is shaped from context and can reflect the researcher's position and therefore aligns itself with a critical realist approach (Braun & Clarke, 2013). Within the current study these perspectives will facilitate an appreciation that experiences of physical health colleagues within one NHS Trust and one IAPT-LTC service may differ to the experiences of others.

Overall, it was considered that the positioning of a contextualist epistemological approach and critical realist ontology is well suited to the current qualitative project. However, it was important to consider an appropriate research design and method for data collection which would further allow the researcher to explore participants' experience whilst holding these contextual factors in mind.

Research design

A qualitative design was used to explore the experiences of health professionals working within *Time to Talk Health* (IAPT-LTC), in addition to those working alongside the team in physical health care settings. Using a qualitative design allowed for exploration of barriers and facilitators into collaborative care that may not have been considered or previously studied. This design can capture the complexity of real-world issues and allows us to make sense of patterns of meaning (Braun & Clarke, 2013). This design therefore fitted with the aims and objectives of the current research and has been used within previous research exploring therapists' experiences of working within IAPT-LTC services (Knowles et al., 2015; Carroll et al. 2020).

Data collection

Semi-structured interviews were used to collect data, as they allow freedom to explore issues that are important to the participant. They enable the exploration of key questions and topic areas (Britten, 1999), whilst providing flexibility for elaboration of information that participants feel is important (Gill et al., 2008). Braun and Clarke (2013) describe the ideal qualitative interview to be ‘on target while hanging loose’ (p. 78). This refers to the participants being able to discuss issues that the researcher hadn’t anticipated and are not on the interview guide, further requiring flexibility from the researcher.

Focus groups were considered as a potential data collection method, given that participants already have established working relationships and it is the interaction between participants that can give elaborated and detailed information (Wilkinson, 1988). However, it was felt that some participants may feel uncomfortable discussing their experiences in front of their colleagues or managers working within the same team. This may therefore have impacted on the richness of the data and prevented participants from being able to express their views and opinions openly (Morgan, 1998).

One-to-one interviews were therefore selected as the preferred methodology to encourage more honest responses. They are also best suited to explore understandings and perceptions of topics that participants have a personal stake in (Braun & Clarke, 2013), which would therefore be suitable for exploring topics such as working experiences.

Interviews

Interviews are said to allow the exploration of how participants attribute meaning to their experiences (Forrester, 2010), without the challenges posed by focus groups, as previously discussed. Braun and Clarke (2013) describe how interviews are ideally suited to experience-type research questions and provide flexibility to probe and ask unplanned questions. The interviews could be considered ‘acquaintance interviews’ (Garton & Copland, 2010) as they were conducted by the lead researcher who currently works within *Time to Talk Health,* therefore holding dual relationships with the participants as colleagues. The researcher is also considered an insider researcher as they belong to the group/community in which they are researching (Gallais, 2008). There are methodological limitations associated with insider research. These include a threat to objectivity which may impact on the researcher's ability to engage critically with the data (Drake, 2010). There may also be compromised validity due to the potential for lack of detachment from the field; Chavez (2008) describes this as the concept of being both the researcher and the researched. However, there were many advantages to insider research as it allowed direct access to the target population of IAPT-LTC staff and physical health colleagues. In addition, pre-existing relationships with many of the participants may allow them to be more open and enable the researcher to gain greater depth to the data collected (Dwyer & Buckle, 2009). Ethical considerations are further discussed later in this chapter relating to acquaintance interviews and insider research.

Face to face interviews have been previously suggested as the most effective way of collecting data as this allows the researcher to observe nonverbal expressions that are conveyed by the participant (Opdenakker, 2006). However, it was not possible to conduct the interviews face to face due to the COVID-19 pandemic at the time of data collection, and a growing body of literature highlights the potential value of online and remote interviews (Johnson et al., 2019).

Telephone and virtual video interviews

There are many advantages to completing interviews remotely with participants either over the telephone or via video call (Braun & Clarke, 2013). Firstly, participants can participate from the comfort of their own home or a location that is convenient for them. This also reduces the cost and time for both the participant and researcher associated with travelling to a venue to complete the interview in person (Musselwhite et al., 2007). Secondly, conducting interviews remotely allows for participants to feel more anonymous and may facilitate the participation of those who may be of a nervous disposition (Cachia & Millward, 2011). This is further reinforced by both the lack of visual cues and lessened feelings of judgement which may allow the participant to disclose sensitive topics when they are not sat in front of the researcher (Lechuga, 2012).

However, it is important to consider the disadvantages of conducting interviews remotely. Some participants may express themselves better when they are sat in front of the researcher and are able to see non-verbal cues which are missing over the telephone (Madge & O'Connor, 2002). This may also be important for the researcher as visual cues are lost, further contributing to making decisions around how to proceed with the interview (Braun and Clarke, 2013). Finally, there are technical difficulties to consider as these have the potential to disrupt interviews that take place over the phone or via video call (Hai-Jew, 2015).

Advantages of video-based interviews over telephone-based interviews include the opportunity to observe non-verbal cues (Irani, 2018) and the close resemblance to in-person qualitative interviews (Tuttas, 2015). Support for video call interviews with health professionals comes from Irani (2018). The researcher carried out qualitative research with nurses to explore nursing visit intensity. The researcher concluded that interviewing health professionals via video call was particularly successful due to them having high levels of competence with the technology and being able to speak in a confidential space about the nature of their work.

Previous research with health professionals in the field of IAPT has been successful in its mixed approach to interviewing participants either face to face or over the telephone (Carroll et al., 2020). A similar approach was therefore adopted for the current study; however, video calls replaced the option of face to face due to the COVID-19 pandemic.

There is growing support for the use of video communication as an alternative to face-to-face interviews, in the face of logistical challenges (Mirick & Wladkowski, 2019) and the constraints of social distancing imposed by the pandemic (Roberts et al., 2021).

Overall, there was mixture of uptake from participants, with five participants opting to complete the interviews via video call and 16 opting to complete them over the telephone. It is important to consider the how the interview schedule was developed as part of the research design which guided the interviews that took place between the researcher and the participants.

Interview design

The study design and interview schedule were developed based upon the methodologies of previous research conducted into collaborative care within an IAPT setting, prior to the development of IAPT-LTC services (Knowles et al., 2015). The schedule was piloted with one trainee health psychologist working within primary care services and one clinical service manager within social services. This gathered feedback from a health professional and implementer of joint pathways around the content of questions and interview structure.

The feedback from the trainee health psychologist was positive and encouraged the helpful use of prompts around barriers and facilitators as these allowed them to think of practical barriers rather than just psychological ones. The trainee health psychologist recommended the restructuring of questions so that questions that applied to all participants were at the beginning of the interview guide, and specific questions around barriers and facilitators for either health professionals or those within leadership positions were to follow. This supported the researcher to remove duplicate questions and better structure the interview guide with a funnelling approach, starting with broad questions and funnelling down to specifics. The clinical service manager also gave positive feedback around the interview guide and offered the suggestion to add a prompt around the perceived beliefs of other health professionals. They acknowledged that there may be assumptions held around what colleagues from other teams perceive the facilitators and barriers to be, which may be a mismatch to their own. A prompt was therefore added to ask, ‘What do you think your healthcare/ IAPT colleagues would say are the barriers/facilitators?’.

The final topic guide included questions in relation to the COM-B model (Michie et al., 2014). This supported the researcher to identify perceptions about joint working and its value, alongside perceived barriers and facilitators to joint working, and experiences of setting up joint working pathways for those involved in this process. Examples of questions to explore these issues included:

Capability

Do you feel confident about working collaboratively/or setting up joint working pathways?

Opportunity

How much opportunity do you have to work with professionals/IAPT staff outside of your team to support patient care or to set up joint pathways?

Motivation

How do you feel about working with patients with physical-mental health comorbidities?

Barriers and facilitators

What do you think the barriers are to joint working?

What are the facilitators to joint working?

Implementation of joint working

How did you find trying to set this up?

(See Appendix B for full interview guide.)

Participants

The project analysed data collected from a sample of 21 health care professionals (18 women, 3 men) working within NHS Trusts in the South of England and GP Practices within West Sussex. The participants were recruited from *Time to Talk Health*, IAPT-LTC (n=13) and physical health care settings (n=8). A description of the participants' field of work is included in Table 2. Four of these individuals reported to have been part of the set-up of the LTC pathways and are highlighted accordingly (*). Specific roles within the physical health care teams were omitted from the write up. This was due to smaller samples and to ensure anonymity was maintained for those with job roles that may be unique within their team.

Table 2 Participants' roles and settings in which they worked

Role	Number (n)	Involvement in setting up LTC pathway (*)
Senior Practitioner, *Time to Talk Health*	3	*
General Practitioner	1	*
Cognitive Behavioural Therapist	6	
Psychological Wellbeing Practitioner	4	
Health Care Practitioner, Cardiac Rehabilitation	4	
Health Care Practitioner, Pulmonary Rehabilitation	1	
Health Care Practitioner, Diabetes Service	1	
Health Care Practitioner, Chronic Pain Service	1	

At the time that the research was conducted, there were 6 areas of joint working across different health care teams (diabetes, COPD, pain management, GPs, IBS and cardiac) and the researcher was striving for a breadth of data to be collected across healthcare professionals within these teams. However, the researcher was unable to recruit health professionals working with IBS. The inclusions and exclusion criteria were given careful consideration to ensure that relevant participants were invited to take part in the study.

Inclusion and exclusion criteria

Initially, the inclusion criteria set out to recruit clinical members of staff within *Time to Talk Health* included those involved in joint working on a regular basis, or those who were part of setting up the joint working model. Clinical members of staff working in other NHS teams who are engaging in joint working with *Time to Talk Health* were also included within the inclusion criteria. The inclusion criteria stated that members of staff within one NHS Trust in the South of England were to be invited to take part.

The researcher continued to reflect on the recruitment process throughout the research. They learnt that the inclusion of only those members of staff who are actively engaging in joint working within *Time to Talk Health* may have missed important data around potential barriers to joint working. It therefore felt appropriate to adjust the inclusion criteria to invite all clinical members of staff working within the service to take part.

During the process of gaining ethical approval, *Time to Talk Health* experienced a high turnover of staff; therefore, potential participants left the service to work for other NHS trusts who may have been able to provide rich data for the study. In addition to this, the researcher learnt that colleagues from other NHS teams also fell outside of the inclusion criteria of being employed by the current NHS trust. In response to this, the HRA and UWE ethics were contacted to request an amendment to the study protocol, to allow the researcher to recruit participants from a range of local NHS trusts in the South of England. The role of the reflexive researcher (Braun & Clarke, 2021) benefitted the recruitment process and allowed flexibility to adjust the method. This enabled the researcher to gain an appropriate sample of participants for the study.

Inclusion criteria:

- Current or past clinical staff (within the last 6 months) working within *Time to Talk Health.*
- Colleagues from NHS sectors involved in joint working with *Time to Talk Health*.
- Those within *Time to Talk Health* who have had input around the implementation of joint working.

Exclusion criteria:

- Non-clinical staff working within *Time to Talk Health*.
- IAPT-LTC staff from services outside of *Time to Talk Health*.
- Teams/practitioners from NHS sectors not engaging in joint working with *Time to Talk Health.*

It was also important to consider an appropriate sample size ahead of recruiting participants for the study, which will be discussed in more detail.

Sample size

Braun and Clarke (2021) identify that reflexive thematic analysis generates meaning from the data based upon interpretation and therefore, meaning is not excavated from the data itself. Data saturation refers to the point in the research process where no new information is discovered, indicating that data collection can cease (Faulkner & Trotter, 2017). However, the concept of data saturation may not be helpful to strive for, as the ‘right sample size' is subjective. Braun and Clarke (2013) suggest aiming for a sample of 10–20 participants for a medium sized project such as a doctoral thesis. It was important to consider that the current study was aiming to collect data from a range of health professionals due to a range of areas of joint working across different health care teams (diabetes, COPD, pain management, GPs, IBS and cardiac). Although this allowed for a breadth of data to be collected, it was important for the researcher to aim for similar amounts of data from IAPT-LTC staff and HPs working outside of IAPT-LTC. It was also important that the research meaningfully impacts the audience to which is resonates (Tracy, 2017). Therefore, the researcher aimed to collect data from health professionals working across the different teams. Data collection therefore ceased when no more uptake was received to take part in the study and the researcher felt that rich and meaningful data had been captured. Overall, 21 participants were interviewed for the study in line with Braun and Clarke's recommendations.

Ethical considerations

This section discusses the ethical issues relating to this study. Ethical considerations were an important part of the methodology to consider at every stage of the research process. All participants were debriefed with the aims of the research after the interviews were completed and they were advised that they could have full access to publications arising from the study. No deception took place as part of the research study. Further ethical considerations are described in more detail.

Ethical approval

The research was conducted in accordance with the British Psychological Society Code of Ethics and Conduct (2009). Permission was sought for this research project from the Health Research Authority (HRA) with support from the Research and Innovation department within the NHS Trust supporting the current research. Permission was obtained from the HRA on 23rd September 2020 (Appendix E). The permission from the Faculty of Health and Applied Sciences Research Degrees Committee of the University of the West of England was sought on 14th August 2020 and the study obtained approval from the University of the West of England's Ethics committee on 16th October 2020 (Appendix F). Research sponsorship and insurance was granted by the University on 5th August 2020 (Appendix G).

Informed consent

Ethical considerations including informed consent, no deception, right to withdraw, debriefing and confidentiality (Elmes et al., 1995) were adhered to throughout the research project.

To ensure informed consent was obtained, all participants were asked to confirm that they had read and fully understood the participant information sheet and had all questions answered by the researcher ahead of the interview. Verbal consent was then documented within a consent log through printing the name of the participant against their participant ID and printing the researcher's name beside this (see Appendix H).

The researcher ensured that the participant was in a confidential space, either at their place of work or in their own home. The participant's consent was obtained verbally, and they were reminded of their right to withdraw.

Participant wellbeing

It was considered that mild levels of discomfort may be experienced by the participants if sensitive topics related to their work were discussed. To reduce the impact of this, the researcher made sure that participants were informed about the general topics covered in the interviews to ensure that those at heightened risk of distress would choose not to participate. It was also emphasised that participants had the right to withdraw from the study at any time or terminate the interview. The researcher is also trained and experienced in dealing with distress and was sensitive to the participants' experiences in case the interview needed to be ceased. The researcher was able to signpost to any relevant agencies if they felt that further support would be needed because of any distress. Richards et al. (2002) supports this approach and offers a framework for health services researchers to navigate ethical issues. They document that health practitioner researchers are more likely to recognise when participants need further support and are better able to signpost in the case that participants become distressed. The authors also identify the need to inform participants about the types of questions likely to be asked as part of gaining informed consent. This was therefore adhered to within the current study.

Participant anonymity

Participants were made aware that their personal information would be kept confidential, with pseudonyms being used to protect their identity throughout the research project. Participants working within the IAPT-LTC service were allocated a pseudonym (IAPT1, IAPT2, etc.), as were health professionals working outside of the IAPT-LTC service (HP1, HP2, etc.). It was considered that there may be issues surrounding confidentiality during the write up stages of the research, when some participants working in physical health care settings may be unique in terms of their job role throughout the project. It was therefore important that the participant's job role was not identified in the context of providing quotes throughout the results.

Acquaintance interviews

Binkmann and Kvale (2008) highlight that qualitative research is saturated with ethical issues which cannot be captured within these basic ethical guidelines, and this was important to consider within all stages of the current study. The use of ‘acquaintance interviews’ (Garton & Copland, 2010), for example, raises some additional ethical considerations. It was important that the researcher did not use their pre-existing relationship to pressurise colleagues to participate in the research. The researcher ensured that the same recruitment process applied to all participants and that they were only contacted through the admin team within *Time to Talk Health.* Only after the participant expressed interest in taking part did the researcher contact the participant directly. It was important to consider the impact of any potential power differences between the researcher and the interviewee: when there are close existing relationships, there could be an ‘abuse of trust’ (Duncombe & Jessop, 2002) if there is a hierarchical relationship in place. At the time that the researcher was engaging in the interview process, there were no staff who they had managerial responsibilities for, which reduced the chances of this occurring.

Procedure

Audit of joint working

In 2020, the researcher completed an audit of the types of joint working practices within *Time to Talk Health.* A summary of the result is discussed within the ‘Results’ chapter of this thesis. This initial data was important to guide the research and highlighted which teams were working closely alongside *Time to Talk Health* and consequently, which physical health professionals to invite to interview.

Recruitment Procedure

Careful consideration was given to the recruitment procedure (see Figure 1.) Participants were initially contacted via email by the admin team within *Time to Talk Health* with an attached information sheet inviting them to take part (Appendix C). Those who opted in were asked to email the lead researcher. The participant was then responded to via email by the researcher and asked about their availability to complete the 45-minute interview. This was then scheduled at a time convenient to the participant. The researcher asked if the participants had read and understood the information sheet and gave them the opportunity to ask any questions.

Depending on participant preference, the interviews were conducted over the telephone or via video conferencing software. Participants were recruited via email, initially using stratification sampling, which refers to dividing a non-homogeneous population into smaller groups (Jawale, 2012). In this instance, this was based on the participant's job role to gain a breath of participants across teams. The researcher works within *Time to Talk Health* with close working connections which enabled ready access to participants. Members of staff working outside of *Time to Talk Health* who met the inclusion criteria were identified by clinicians and the invitation to take part in the study was sent by the team administrator's inbox. These key health professionals forwarded on the invite to colleagues within their teams. This resulted in snowball sampling, which refers to initially sampled participants recruiting other persons believed to have the characteristic of interest (Johnson, 2014). This required the researcher to be flexible with the sampling technique, whilst still ensuring that the participants were not approached by the researcher directly to take part.

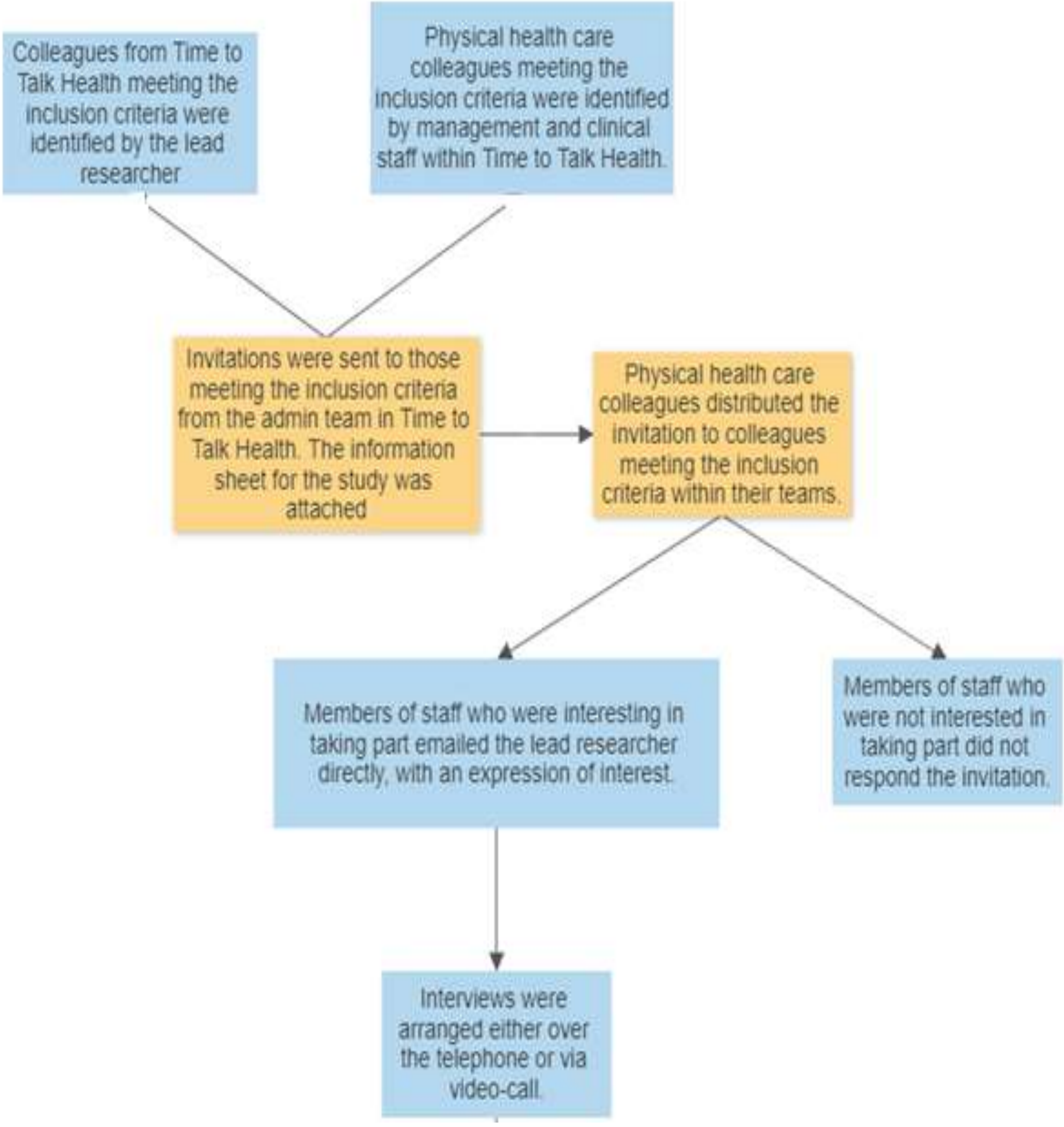


Figure 4 Flow chart of recruitment procedure

Interview procedure

Once an expression of interest was made, participants were contacted to arrange a date to conduct the interview and their preference for telephone or video call was noted. Twenty-one semi-structured interviews were conducted in total: five (24%) were held via Microsoft Teams with 16 interviews (76%) conducted on the telephone. The interviews ranged between 22 and 52 minutes with a mean time of 40 minutes. Participants were given a pseudonym within the interview, as previously discussed as part of *'patient anonymity.'*

The researcher ensured that the participant was happy to be recorded before the recording commenced. A rapport between the researcher and the participant was built at the beginning of the interview to put the participant at ease through asking the participant if they have any questions before the interview commenced. The researcher acknowledged the impact that the COVID-19 pandemic may have had on working practices at the start of the interview and encouraged the participant to reflect on their work both before the impact of the pandemic and afterwards. The interview questions (see Appendix B) started by asking about the participant's job role and what this involves before funnelling down to more specific questions around their experience of joint working (see previous section *'interview design'* for how the interview guide was informed). The interview finished with the researcher asking if the participant had any final thoughts or comments that hadn't been discussed and participants were debriefed at the end of the interview.

The interviews were recorded onto a Dictaphone, provided by the NHS, and were saved on an encrypted memory stick. The researcher transcribed the interviews verbatim into Microsoft Word documents. After transcription, the researcher ensured that names of individuals were removed to ensure confidentiality. Any documents returned via email to the researcher which may have contained identifiable information were stored securely on the researcher’s NHS encrypted memory stick, alongside data such as interview transcripts, write-up, reflections and analysis. The researcher was the sole person to have access to any person identifiable data. After analysis the digital recordings were destroyed and the transcripts will be held for 5 years (in line with British Psychological Society regulations and the Data Protection Act, 2018). Once the interviews had been completed and data had been transcribed by the researcher, thematic analysis was chosen as the most appropriate method of analysis for the data.

Method of analysis

Thematic analysis is a method for developing, analysing and interpreting patterns across a qualitative dataset (Braun & Clarke, 2021) and it has been argued that this method is ‘essentially independent of theory and epistemology’ (Braun & Clarke, 2006). However, a fundamental characteristic of thematic analysis is a reflexive researcher and the values of the qualitative paradigm which informs the research practice (Braun & Clarke, 2021). It is therefore important that the results of the study are framed within theoretical and epistemological context to provide meaning to the findings. Research questions exploring social phenomenology lend themselves particularly well to thematic analysis (Fereday & Muir-Cochrane, 2006), this maps on to the current study, which aims to explore health professionals’ experience of joint working. Attributing themes within this context helps the researcher to make sense of the participant’s subjective experience (Joffe, 2012).

Thematic analysis can also be flexible in allowing the researcher to adopt an empathic or suspicious approach to the analysis. This was important as the researcher’s critical realist stance meant that a suspicious approach was adopted during data analysis (Willig, 2013), meaning that themes would be explored behind the meaning of the participants’ responses.

Careful consideration was given to implementing a deductive approach to the analysis. It was decided that an inductive analysis would be completed initially by the researcher, with a deductive approach then being used to map the COM-B constructs onto the themes. It was also considered that this integrated approach was implemented successfully within previous studies (Carroll et al., 2021) and allowed for a clear, theory driven approach to the evaluation of the findings.

Previous research in the subject area has utilised a constant comparative method approach for data analysis, based in Grounded Theory (GT; Glaser and Strauss, 1967). This approach aims to provide an explanatory framework for the observed phenomenon and therefore construct theory from data (Charmaz & Henwood, 2008). An approach based in GT was considered for the current study as it is well suited to addressing questions around influencing factors and social processes that can underpin phenomena (Braun & Clarke, 2013). This is relevant to the current project, as social processes underpin the phenomena of joint working amongst health professionals. However, it was considered that this method adopts an inductive approach to construct theory from data (Glaser & Strauss, 1967), which is more suited to novel pieces of research. The current study is original in the sense that joint working is being explored within newly developed IAPT-LTC pathways; however, it was considered that research into collaborative working more generally is not novel. The aim of the current study was therefore to develop existing theory; using a mixed approach of inductive and deductive analysis would be better suited to allow the COM-B model to be mapped onto the themes.

Interpretative Phenomenological Analysis (IPA) is concerned with exploring the participant’s lived experience and the meaning they attach to this experience (Braun & Clarke, 2013). This was therefore considered as an approach to data analysis as this fit in well with the aims of the current study. The dual interpretative process involves the researcher trying to make sense of the participant making sense of their experience (Smith et al., 2009) and this critical approach to data analysis could lend itself well to the researcher's epistemological positioning and dual role as researcher and colleague. However, it was considered that IPA draws from relatively small samples of 'homogenous' participants (Braun & Clarke, 2013). The current study aims to explore experiences of joint working amongst groups of health professionals working within different teams within the NHS, alongside the experience of those in managerial roles. This therefore required a larger sample of 20–25 participants to gain rich data from all these individuals, alongside the need to include non-homogenous groups (Smith et al., 2012).

Overall, it was considered that the theoretical flexibility of thematic analysis alongside its accessibility to researchers who are new to qualitative methods (Braun & Clarke, 2021) led the researcher to adopt this approach to data analysis. This enabled the grounding of thematic analysis within their epistemological and ontological position whilst acknowledging that the data would be contextual and influenced by the relationship held between the researcher and the participant. This therefore influences how the researcher viewed the 'status of the texts' (Flick, 1998) and what they represented during the coding and analysis of the data. It is important to further consider the data analysis and the impact of the researcher influence on the data.

Data analysis

Data were first analysed using inductive thematic analysis using Braun and Clarke's (2021) guidelines.

The six phases of thematic analysis included:

1) Dataset familiarisation

2) Data coding
3) Initial theme generation
4) Theme development and review
5) Theme refining, defining, and naming
6) Writing up

This was not a linear process and the researcher spent time going back and forth between each of the phases. Recordings were repeatedly listened to by the researcher to familiarise themselves with the data. Transcripts were then coded line by line, relying on the verbatim. Coding was cross-checked within the research team (EJ and HLS) and no discrepancies were identified. Codes and themes were developed by the researcher using NVivo, a Computer-Assisted Qualitative Data Analysis (CAQDAS) software package (Bazerley & Jackson, 2013). An inductive approach to the analysis was adopted initially and similar codes were grouped together under the same label and themes were then identified through collating these similar codes. The researcher created a thematic map which supported the refinement of themes and definitions for each theme. A deductive approach then enabled the COM-B constructs to be mapped onto these themes which enabled a clear, theory-driven structure to evaluate the barriers and facilitators around working towards a collaborative care model. The final phase involved the write up of the report which involved presenting a narrative to the researcher's supervisory team for feedback and refinement. Although it would have been beneficial to present the report to the participants who took part in the research, unfortunately, time constraints meant that this was not possible.

First-person account of researcher influence on the data

It is important to consider the researcher's characteristics, including their sociodemographic characteristics and employment background, as these can all interact with the research process. It is also important to consider the background to the research itself and the involvement of the researcher in bringing the research topic to fruition.

The researcher is a White British woman, in her early thirties who has several years of experience working in psychological interventions-based roles within NHS settings, including four years within the IAPT-LTC service *Time to Talk Health.* It was of particular interest to the researcher that many of the participants were of a similar sociodemographic background to themselves. Whilst this may have aided rapport with participants, it may have also contributed to assumptions being held by the researcher that the participants' experiences may have been similar to their own. The researcher considers themselves to have experienced very few health inequalities which is important to reflect upon in the context of the present research. Surrey and Sussex have recently been found to be the most affluent areas of the United Kingdom (Office for National Statistics, 2020b), which also highlights the need for the research to be replicated in a range of locations across the country, with research teams that may relate to their participants in a different way.

It is recognised that the researcher is someone who has experience of working within the IAPT-LTC team and has an interest in this field of research. The researcher shares similar characteristics to those being researched and is therefore considered an insider researcher (Loxley & Seery, 2008). It has been suggested that insider/outsider status is on a continuum (Trowler, 2011) with some researchers relating to a *total insider* identity versus a *partial insider* (Chavez 2008). A total insider is said to share total identities or profound experiences with those they are interviewing, whereas a partial insider may have a certain amount of distance or detachment from the community which they are studying. Working as part of the IAPT-LTC team, *Time to Talk Health,* the researcher had a shared identity with some of the participants. The researcher also had their own experience of working towards a collaborative care model which is the focus of exploration within the current study. However, the researcher also has a separate occupational identity as a Health Psychologist in training, and therefore could relate to a sense of distance from those being interviewed, further allowing a space for increased objectivity.

It was important to recognise that the researcher inevitably had their own beliefs around what the barriers and facilitators of collaborative care may be before engaging in the research. Whilst this level of understanding and experience in the field may have been helpful when developing the research aims and interview guide (Bell, 2005), it was also important to keep a high level of awareness of these perceptions during the interview process (Braun & Clarke, 2021). The researcher tried to ensure that open questions were used to maintain curiosity around the experience of others, and to not only attend to the perspective of those whose views were like their own. It was important to develop the interview schedule collaboratively with the research team, alongside piloting it to gain feedback from others. High levels of reflexivity and collaboration with the research team are strategies put forward to overcome some of the challenges around insider research (Greene, 2014). These were adhered to within the current study and were also crucial when considering the research design.

The researcher was recruited to work within the service when it was in its pilot stages and has seen the development of joint pathways with health professionals as part of its movement towards a collaborative care model. An issue of concern on many occasions has been the difficulties integrating with physical health colleagues from other NHS teams and how best to work collaboratively together. This sparked interest from an applied health psychology perspective around the barriers and facilitators to working in this way within a new service.

During a monthly team meeting, the clinical lead reported back from an NHS conference and highlighted the need to disseminate information around the types of joint working carried out by therapists within the service. The researcher wrote an article for *Health Psychology Update* to support this request, and this further consolidated the need to evaluate this part of model as a new way of working.

When considering the 'worthiness' of a qualitative study, Tracy (2013) highlights the importance of contextual priorities and the recruitment of a researcher in a consultant-type role can be a way in which worthiness can be demonstrated by a third party. When COVID-19 restrictions meant that the initial quantitative research idea was unable to proceed, it became clear that this area of research was a worthy one to pursue and one of strong interest to the researcher. The researcher remains employed by the service within a different team, working as a Senior Psychological Wellbeing Practitioner.

Overall, it is acknowledged that the qualitative paradigm recognises that researchers bring their subjectivity into the research process, which is also considered a strength to the design (Rose & Johnson, 2020). It is therefore important to further explore issues related to quality and rigour in relation to the current study.

Quality and rigour in qualitative research

To ensure that research is conducted to a high standard, an established set of codes were agreed between lead researcher and the supervisory team, with cross-checking against two of the transcripts to ensure the reliability of coding. Braun and Clarke's (2006) 15-point checklist for good thematic analysis was referred to regularly to assess the quality of the research, alongside referring to the critical appraisals skills programme (CASP) checklist (CASP, 2019) for qualitative research.

To ensure rigour, the eight ‘big-tent’ criteria (Tracy, 2010) were referred to which provided guidelines around best practice in qualitative research. Key markers include a) worthy topic, b) rich rigour, c) sincerity, d) credibility, e) resonance, f) significant contribution, g) ethics and h) meaningful coherence. The researcher strived to ensure that these markers were met and the application of these to the current research can be found in Appendix D.

Findings

This chapter describes and discusses the findings of the study. Initially, a summary will be provided around the results of the audit of joint working that was carried out to inform this study, as this provides some context around the types of collaborative work that participants from *Time to Talk Health* were engaged in. The findings of this audit were published within the 'Health Psychology Update' autumn edition (see Appendix I). The findings from the current study will then be discussed in terms of the five themes that were found.

Audit of joint working

The results from the audit highlighted that 53% of staff were engaging with cardiac and pulmonary rehabilitation teams (see Figure 5.). Staff also reported to be working alongside diabetes services, GPs, IBS groups, physiotherapy and pain services.

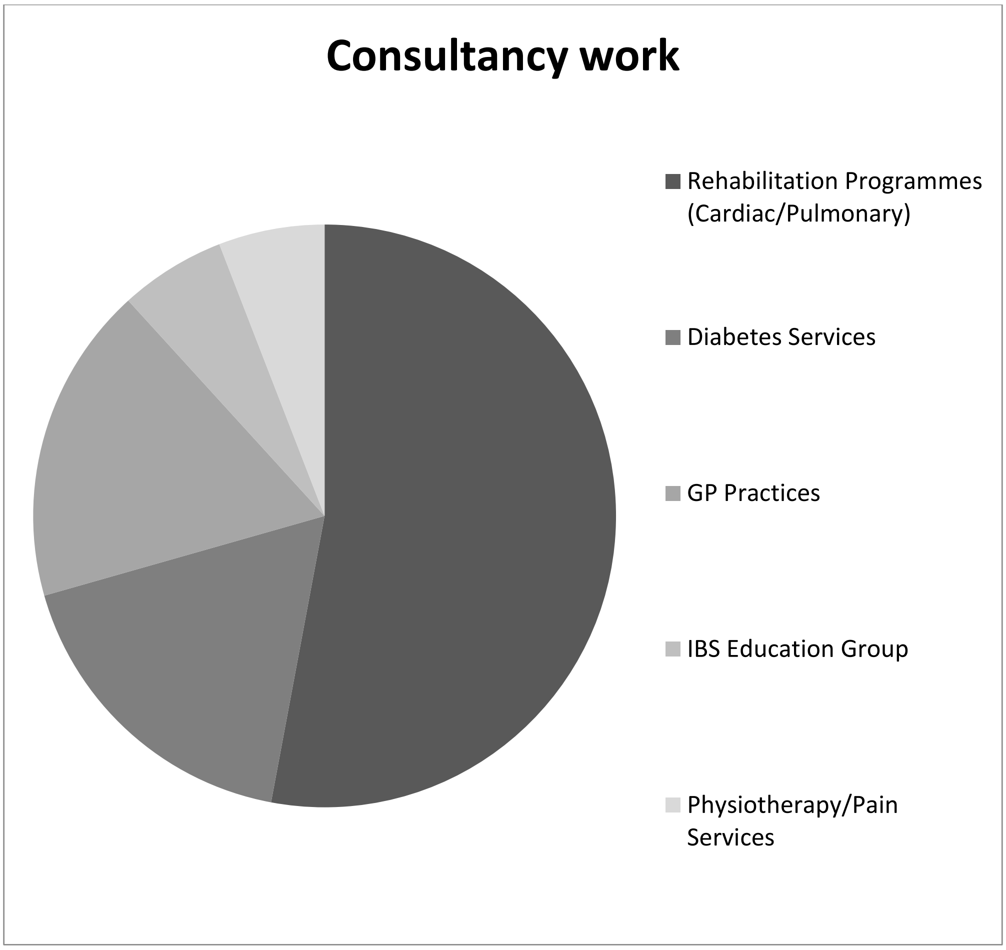


Figure 5 A pie graph to show distribution of joint working pathways created between *Time to Talk Health* staff with other NHS teams (Sanders, 2020).

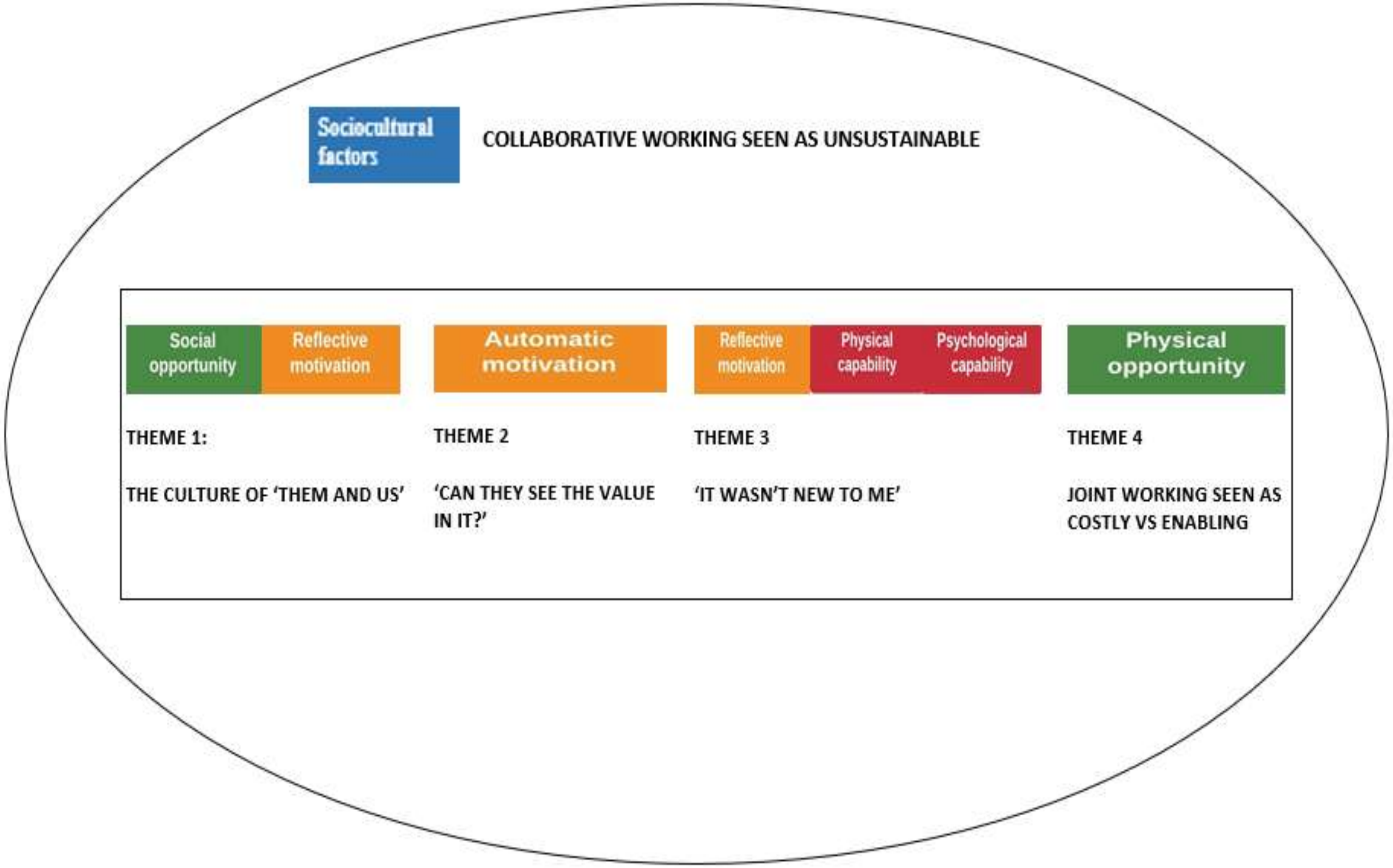
Those practitioners collaborating with cardiac and pulmonary rehabilitation teams reported involvement in their rehabilitation programmes which consisted of exercise classes and educational sessions. *Time to Talk Health* staff reported that they engaged in the exercises alongside patients, provided a source of information and advice to physiotherapists and volunteers, as well as delivering presentations around physical and emotional wellbeing within the educational sessions.

Practitioners who were embedded within local GP surgeries reported that they would offer extended appointments for patients after they had seen their healthcare professional and offer information and advice to staff when required. Practitioners working within diabetes teams reported that they offered joint appointments for patients, support with clinics and education groups, alongside providing training to staff. One member of staff collaborated with a dietitian to co-facilitate a group for patients with IBS. A final member of staff worked alongside chronic pain and physiotherapy teams and attended their multidisciplinary meetings alongside providing behaviour change support to both staff and patients.

Themes

Four key themes were identified through inductive thematic analysis. Themes captured the barriers and facilitators to working collaboratively and setting up joint working pathways for physical and mental health care clinicians and those within leadership positions. The four main themes included (1) the culture of ‘them and us’, (2) ‘can they see the value in it?’, (3) ‘it wasn’t new to me’ and (4) joint working seen as costly vs. enabling. The constructs of the COM-B model were mapped onto the four themes using a deductive approach (see Figure 6.) The theme ‘collaborative working seen as unsustainable’ did not fit neatly into the constructs of the COM-B model. This theme is also discussed in more detail, to highlight novel findings. Health professionals and leadership transcripts were analysed independently in the first instance. Upon revising the themes, it became apparent that they conceptually overlapped. Therefore, the data set was considered concurrently to provide a more integrated analysis. (See Appendix K for step-by-step theme development.) Health professionals that took part in the study included a range of allied health professionals, nurses and one GP. Distinct differences in how the themes applied to each group of participants are explored within the findings.

Figure 6 The COM-B model mapped onto themes



Theme 1: The culture of ‘them and us’

Participants described a sense of divide between physical and mental health care which was driven by a difference in how teams work with their patients, a difference in culture between the teams and societal stigma around mental health. The COM-B construct of social opportunity was mapped onto this theme as social influences such as social pressure and norms were found to be at play in contributing to this divide. The subtheme of ‘we didn’t deliver on what they had in their heads’ will be discussed further as to how this sense of divide was further reinforced by having different expectations of one another when the joint working pathways were set up. Reflective motivation was also mapped onto this theme as different expectations held by the teams were found to impact on beliefs around their capabilities, roles and identities

Staff within *Time to Talk Health* reported feeling that they often felt they were working separately with the patient rather than with their health care colleagues, due to differences in the way they practice within their roles. They felt patients were being given different advice by their physical and mental health care practitioner, which then gave the patient the sense of ‘being in the middle’:

> *Try as we might, there, there is still that, there’s some ‘them and us’ kind of scenario … it still feels as though it's two separate professionals working with the same patient. I feel like sometimes we might be offering advice that might contradict what the other professionals are saying. Not on purpose, it just doesn’t join up quite as smoothly when there’s a sense of them being in the middle between that information and this information.* (PWP)

Working with two separate agendas seemed to impact on collaborative working as physical health care practitioners may not always see the benefit of mental health input and utilising these colleagues as a resource. Most of the participants demonstrated a belief that, to some extent, physical health practitioners still work in line with the medical model. This then impacted on their clinical work with patients and the way in which they approached their work with mental health colleagues.

> *The majority of us come from a, I hate separating the two, but from a sort of biomedical, medical management and training point of view, as opposed to a psychological health and well-being point of view.* (Health Care Practitioner, Pain Team)

Another wider factor potentially contributing to this divide is how society perceives physical and mental health care. One of the goals of IAPT-LTC is for mental health support to be seen as a 'normal' part of a patient's health care package, further reducing stigma related to being referred into a mental health care service. However, participants still reported that societal stigma around mental health was at play.

> *I think it, it still feels very much like there is two camps ((laughter)) and the stigma lies with the, the mental health.* (Cognitive Behavioural Therapist)

Mental health practitioners perceived patients to hold the medical model in higher regard. Participants reported that patients would often request confirmation from their physical health care professional about advice given to them by their mental health care professional. This further reinforced how they valued medical input and perceived their physical and mental health care as separate. There was a sense that these attitudes held by patients could create splitting between staff and act as a barrier to effective joint working.

> *I think, from the start, especially towards their healthcare, we're being put at kind of a lower level of expertise around these things … We live in quite a medicalised model. And so even if (we) were saying things were okay … a lot of patients wanted to hear it from their consultant.* (PWP)

However, participants agreed that the presence of *Time to Talk Health* staff within physical health care settings made patients more receptive to receiving psychological care. This was therefore a facilitator in reducing societal stigma that was impacting on a sense of 'them and us' between the teams. Practitioners reported that working within physical health environments enabled them to manage patients' expectations of the staff, alongside reducing apprehension about contacting the service. *Time to Talk Health* staff described how their integration with cardiac rehabilitation classes noticeably reduced stigma for the patients and enabled them to see psychological support as a 'normal' part of their package of care. Being integrated with physical health care colleagues at every stage of the patient's journey meant that practitioners were able to work collaboratively around the patients care throughout and was therefore a facilitator to reducing the sense of divide.

> *I think it really normalised the fact, that people do struggle with it, you know, just the fact that we were able to be there, on the ward, we were able to be there within the cardiac classes ... Quite often, the feedback that I've got was 'Oh my gosh, it's really helpful to actually meet somebody that works in that service and see that you're normal ... people can just see a real person, maybe not seeing me carrying around like candles or incense ((laughter)).* (PWP)

The culture of 'them and us' extended to those in leadership positions responsible for setting up joint working pathways. Systemic barriers within the NHS were described as continuing to contribute to the divide between physical and mental health teams due to the way in which services are structured and set up to function independently. This therefore meant that teams had different targets driving their clinical work, different record keeping systems and often different clinical commissioning groups responsible for the commissioning, designing, planning and funding of health services. These structural issues were seen as barriers when it came to mapping out joint working pathways.

> *The other thing about Western (CCG) is its spread over two sites and I'm not sure that they're always ideologically aligned, there's some very unusual setups in the system about who provides what ... some of its community services with a different provider.* (Senior Practitioner, TTTH)

Overall, the sense of divide between physical and mental health care teams seemed to be multi-faceted. This was driven by differences in culture within the workplace on a practitioner level, the perception held by patients on a societal level, alongside structural issues within the NHS on a systems level. The subtheme ‘We didn’t deliver on what they had in their heads’ will be further explored in relation to the expectations held by health care professionals which further contributed to this sense of divide.

Subtheme 1: ‘We didn’t deliver on what they had in their heads’

The culture of ‘them as us’ appeared to be driven by engrained culture and differences in practice between physical and mental health care teams. Once *Time to Talk Health* was set up as a new service, practitioners could identify those differences in expectations of what the service could offer, and this reinforced the sense of two teams working separately. These barriers were described as evident at the point of referring patients into *Time to Talk Health,* once referrals had been made and in the process of actively working alongside *Time to Talk Health* staff.

At the point of referral, different expectations around *Time to Talk Health’s* waiting list were noted by participants. Many expressed frustrations at how long their patients would be waiting for support once they were referred to the service and how this didn’t match the time frames they were expecting. For practitioners to effectively work alongside each other in supporting the same patient, they felt it was important that they were able to access each of the services within the same time frame. Physical health professionals therefore found long waiting lists for *Time to Talk Health* to be a barrier in achieving this.

> *They did say ‘we haven't got a great waiting list, so please refer people in’ … it’s a six week wait, which I thought probably isn't a great waiting list, but I thought ‘that's a fat lot of good’ ... when we refer someone, I suppose we want things to fit with our time frames.* (Health Care Practitioner, Cardiac Rehabilitation)

Once a referral had been made into *Time to Talk Health,* health professionals continued to report that their expectations of the service were not met around the policies and protocols that *Time to Talk Health* adhere to. Staff reflected that this is driven by the way in which they practice within their own team, and therefore expect there to be similarities in protocols with those teams they work alongside. This seemed to create some reluctance in continuing to refer patients into the service due to feelings of frustration. A health professional working within pulmonary rehabilitation gave an example of these difficulties. They described referring their patient into *Time to Talk Health*, who was placed on a waiting list for many months to then be quickly discharged due to missing their appointment. This was described as impacting on future collaboration if health professionals become reluctant to refer into the service.

> *I find it quite difficult with their process and I suppose they have a very clear pathway which I do understand to a point, but they are very quick to discharge … I don't think that's good enough for the patient need, and actually I run my service in a very different way.* (Health Care Practitioner, Pulmonary Rehabilitation)

Once professionals were actively engaging in joint patient work, differences in expectations around what *Time to Talk Health* could offer as a service remained and were described as a barrier to working as effectively together as possible. Physical health care colleagues were unsure of the role that *Time to Talk Health* colleagues held and could expect staff to provide ad hoc psychological support to patients. However, this was not how *Time to Talk Health* staff perceived their ‘consultative role’ to be. Overall, a lack of understanding around the boundaries of each other’s role was found to adversely impact on the joint working relationship.

> *There were times when I went to cardiac rehab and I was asked to kind of manage something in the moment, you know someone was feeling really anxious or really upset about something … I wasn't really there for treatment; I was there just to kind of aid with referrals and introduce the service. So definitely sometimes was a little bit of a difference in what we were both expecting from each other.* (PWP)

Differences in expectations around what *Time to Talk Health* could offer was also echoed as a barrier amongst those setting up joint working pathways during the early stages of service development. Participants reported that stakeholders held an expectation around how two teams would work alongside each other which may have been more integrated than what was achievable. Some had a vision of having their own therapist from *Time to Talk Health* sitting within their team who would work from the same waiting list as their own team and by their own processes. Participants described how the element of co-location within the joint working pathways caused some confusion around how the two services would work together but remain separate.

> *Why are they going on a waiting list over there? … This person is sitting in our team so surely, they're ours? so we can get them to do what we want?... so that becomes a barrier in itself, 'cause then they get frustrated with us because we didn't deliver on what they had in their heads*. (Senior Practitioner, TTTH)

Overall, the subtheme 'we didn't deliver on what they had in their heads' was found to contribute to the overall theme of 'the culture of them and us.' The differences in expectations held across practitioners and stakeholders provides an understanding of some of the cognitive processes which may contribute to this sense of divide. The second theme of 'can they see the value in it?' will now be explored further.

Theme 2: 'Can they see the value in it?'

There were mixed levels of motivation to engage with *Time to Talk Health* across those working within physical health care teams and amongst wider stakeholders. Some clinicians working within physical health care settings described being resistant at first, but after some experience of joint working were able to see the value in *Time to Talk Health's* input. The sense of not feeling valued was cited as impacting on levels of motivation amongst those within senior roles who were setting up the service. The subtheme of 'don't take my role away' is discussed further; the perceived sense of threat to job role was particularly key as a barrier to working alongside one another. The COM-B construct automatic motivation was mapped onto this theme as it describes motivation that is instinctive and relates to emotions such as feeling threatened.

Those in managerial positions reported a lack of 'buy in' around the concept of joint working during the implementation stages of *Time to Talk Health*. This impacted on how valued they felt in their roles and therefore levels of motivation in the process of setting up the joint pathways. One participant described how they felt that joint working isn’t valued by stakeholders which further impacts on their motivation to make changes to services.

> *I think there's still that perception that it's not something that's as vital to be accessed in that way … It's something that people think it could be accessed as a bit of a side thing.* (Senior Practitioner, TTTH)

Participants described their experiences of meeting with stakeholders to discuss putting joint working pathways into place. They spoke about how they were often met with resistance and how this impacted negatively on their motivation levels to engage in the process. There was a sense that meeting with others who did not share the same vision for collaborative working caused a strong emotional response for those staff who were invested in putting joint working pathways into place.

> *I don't know if you've ever tried to sell the idea of psychological care, to someone who's not at all interested? It's quite a depleting experience ((laughter)). And trying to get very busy, not very interested people together … They'll meet you, and then look at you as if ‘Why are you bothering me?’* (GP)

Senior staff spoke about the impact that a lack of buy in at the commissioning level had on the amount of work needed to identify key individuals to support the setting up of pathways. Staff discussed having to spend additional time and energy engaging stakeholders who shared a similar vision of collaborative care. Not having this level of support from the outset seemed to have an impact on the participants’ levels of motivation levels to engage in the process.

> *In areas where we couldn't get that level of buy in from Commissioners or GP leads, we had to do the legwork and basically hunt around to find out who were the people with influence.* (Senior Practitioner, TTTH)

Participants described a lack of feedback given by NHS England during the pilot stages of *Time to Talk Health.* They reported being benchmarked against key performance indicators (KPIs) by other IAPT services that were not working specifically with LTCs. However, they highlighted that there was a lack of outcomes recorded around the success of joint working pathways specifically. This was described as impacting on levels of confidence and motivation in the process of setting up the working model as they were unsure as to what degree the joint pathways were working and how valued this was by commissioners.

> *We always had to submit data to NHS England with clearly which teams we were integrated in and was it integration? Was it co-location? And what did that mean? That was never measured ... I don't think there's anything robust along the way to show that that was a success ... we were always being buffered up against KPIs for services that have been around for 10 years and that were with a different patient group.* (Senior Practitioner, TTTH)

Participants also described the constant need to justify outcomes to local commissioners, which left them feeling scrutinised and further impacted on their motivation levels. Consequently, they found themselves investing time and energy in striving to meet targets which were unrelated to collaborative working, rather than ensuring that joint working pathways were working effectively. This further left them questioning how valued the collaborative element to the joint working model was by commissioners.

> *We had really, really high scrutiny from NHS England and therefore our local commissioners to a point, where it felt we were spending a lot of the time just in meetings, providing data, justifying things … So I think the bits that really knocked my confidence at times was the way in which that it was kind of scrutinized as a pilot.* (Senior Practitioner, TTTH)

However, working alongside like-minded people who held a shared vision for collaborative care seemed to instil motivation. Working as part of a team seemed to reinforce their sense of purpose in achieving a shared goal, alongside increasing their sense of optimism.

> *So yeah, I mean, the thing is, I was always energized by people at Time to Talk, so just found them really, really inspiring… so I felt confident … just meeting loads of really nice people who are only too pleased to have someone sort of shouting for them and banging the drum for them.* (Senior Practitioner, TTTH)

All the practitioners interviewed within physical health care teams and *Time to Talk Health* reported that they could identify the benefits of collaborative care including shared learning for staff, improved clinical outcomes and a better overall experience for the patient. They spoke about the benefits of learning from one another and being able to draw from each other's expertise to be able to work holistically with the patients that they are jointly supporting.

> *I think it's just that joined up working, filling in the gaps where we haven't got that skill or knowledge or expertise, so it's really beneficial and really useful…especially the joint clinics, I think it enriches that whole experience for the person attending.* (Health Care Practitioner, Diabetes Service)

When this level of buy in was then in turn recognised by their colleagues and they perceived that their input was received positively, this was found to facilitate joint working. Participants reported feeling valued within their role and a sense of working towards a shared goal, further facilitating levels of motivation. One practitioner within *Time to Talk Health* described how the level of buy in changed from their health care colleague, once they could see the positive outcomes from one of their patients that they were both supporting. In this case, the patient's diabetes management was being affected by taking recreational drugs. The participant went on to reflect upon how they felt about collaborative working as part of their role, which further demonstrated high levels of motivation.

> *The turning point was when I started to work with one of their patients who was a young guy who was taking a lot of drugs and was having a terrible time with his diabetes … I worked very successfully with him; very quickly he stopped the drug taking and stabilised. After that she could see the value of what we did … I absolutely love it and it makes me go home at the end of the day and feel like I've done a b****y good job*. (Cognitive Behavioural Therapist)

Overall, the sense of feeling valued by colleagues and stakeholders was found to impact on levels of motivation to engage in joint working. For some practitioners, they reported being faced with resistance initially, however after some exposure of working alongside one another they were able to value each other's input. The subtheme 'don't take my role away' will be explored further as a key factor which was cited by some practitioners as contributing to this initial resistance.

Subtheme 1: 'Don't take my role away'

A sense of threat to job roles was initially found amongst some of the participants working within physical health care teams. Many of the clinicians expressed that they had an interest in mental health; some had additional training and others had developed aspects of their service to support with mental health difficulties. One practitioner working within pulmonary rehab described how she responded to *Time to Talk Health*'s input and joint working pathway that had been implemented.

> *How much do I want their service coming in and changing the way that I do things? And that's been something that I'm really trying to reflect on; am I being stubborn because actually I don't want them to take my role away?* (Health Care Practitioner, Pulmonary Rehabilitation)

The participant was able to reflect on how their initial reaction was to feel threatened and protective over their role. There was a sense of ownership over this part of the service which they had developed to support patients with any psychological difficulties. Despite, this sense of threat, the participant was able to appreciate that the joint work may be beneficial.

> *I think actually, they can just enhance the role and we can work well together… things like getting involved in the education, I mean obviously something happened there and they wanted to do more than we were comfortable with.* (Health Care Practitioner, Pulmonary Rehabilitation)

These findings highlight the need for compromise in areas of work whereby physical health practitioners may feel strongly about continuing to support mental wellbeing. The use of negotiation may support collaborative working to identify where members of the team feel comfortable to work alongside each other.

Other participants found that the sense of feeling threatened came from health professionals who may not have initially valued psychology as part of their service model and therefore were resistant to collaborating with IAPT-LTC. A practitioner from *Time to Talk Health* described certain health professionals as trying to influence the type of work they engaged in within the wider team. This created some apprehension when it came to working alongside those who were perceived as more resistant to their input.

> *They were very defensive around me ... kept sort of trying to take over and tell me what my job was… I tried not to take it personally; I tried to empathise with perhaps why they were being defensive ... I could really understand, you know, they'd spent years making it their baby… and they hadn't figured in the psychological element.* (CBT therapist)

This resistance was also expressed by those setting up the joint working pathways. Participants described stakeholders within physical healthcare teams perceiving a sense of threat to service provision. This was experienced if they had already spent time developing aspects of their service to support mental health, creating a sense of ownership.

> *These were two, I think they were nurses? And they'd done a huge amount of training and a lot of CBT training as well and they weren't quite sure how we might affect their way of working, so they had a lot of questions. I suppose it might be that they wondered whether we would undo what they've done already?... If you've invested a lot of time in setting up a way of working ... they might have felt slightly undermined.* (Senior Practitioner, TTTH)

The subtheme of 'don't take my role away' also extended to psychological professions more widely, which impacted on the process of setting up the joint working pathways. The recruitment drive, in line with service expansion, has meant training up large amounts of staff to work with LTCs. This raised some questions around the competence of the workforce to be working with this client group and impacted levels of motivation to engage with IAPT-LTC services.

> *I know XX has been doing some work with health psychology to try and to break down some of those fears and myths about IAPT and our competence and/or incompetence in the work that we're doing. There's been a fear that there's a threat to roles and services and genuine anxiety, has there been enough training in IAPT for these complex patients?* (Senior Practitioner, TTTH)

Overall, the subtheme of ‘don’t take my role away’ was found to contribute to the theme of ‘can they see the value in it?’ due to the perceived sense of threat that was described by some of the participants. This initial resistance was reported by some of the physical health care professionals and wider stakeholders when *Time to Talk Health* was rolled out as a new service. This subtheme contributes to the novel findings of this research as this has not be previously documented within the literature. This further highlights the importance of engaging with practitioners and stakeholders at the initial stages of implementation, to involve them further in decision making around the boundaries of their roles. The third theme of ‘it wasn’t new to me’ will now be discussed further.

Theme 3: 'It wasn't new to me'

Prior experience of working alongside physical and mental health care colleagues meant that there was a sense of familiarity with each other's work and the culture of each other's teams. This was described as a facilitator to working collaboratively, which further fed into high levels of confidence to do so. For those in senior roles, having prior experience of project management was perceived to facilitate the process of setting up joint working pathways. Increased knowledge around how each other's services functioned, their respective colleague's area of work and knowledge of key stakeholders were also described to be facilitating factors. COM-B constructs of psychological and physical capability were mapped onto this theme as their knowledge and obtained skill sets fed into their sense of capability to work collaboratively. Reflective motivation was also mapped onto this theme as participant's belief around their capability to do their role has a direct impact on their confidence level.

Some of the participants reported having worked across different NHS settings before working within their current job role. Those who had worked within a physical health care setting prior to training in mental health described a greater sense of capability in working alongside physical health care colleagues. Participants spoke about feeling confident in understanding terminology used by health care staff and feeling comfortable working alongside them. This was due to understanding the nature of their work and the ways in which they practice. These participants also talked about feeling comfortable within the clinical environment of a health care setting due to its familiarity, further reducing apprehension about being co-located. Participants reported having a good understanding around of long-term conditions and this knowledge enabled them to approach health care colleagues with confidence.

> *In terms of how the kind of words, you know the language they were using and the way they talk … the culture was very comfortable for me.* (CBT Therapist)

In contrast, those participants without experience of working in a physical health setting felt that this was a barrier to them being able to work as effectively alongside their healthcare colleagues. This lack of experience seemed to foster feelings of anxiety and a lack of confidence in working collaboratively. Participants reported a fear of embarrassment with colleagues that they may not have developed close working relationships with. However, having members of the team with prior experience of working within physical health settings seemed to provide a source of confidence to the rest of the team. This further increased their sense of capability to engage in joint working.

> *Just having a few people in the office that had a bit of experience in physical health also helped people who hadn't got that experience to get a bit of confidence in their working with the physical health teams.* (PWP)

This theme was also echoed across those responsible for setting up joint working pathways. It was of interest that all four of these participants had come from physical health backgrounds which therefore facilitated the process of setting up the pathways. They described working within hospital settings which supported them to feel confident in clinical environments. These participants also described having experience of project work within the context of physical health settings, which increased their capability around developing the new working pathways.

> *I've worked in physical health 'cause I was in radiotherapy and, and diagnostics you know, so I've worked in hospitals, in lots of physical healthcare settings … and set up projects before, so working in hospitals wasn't new to me.* (Senior Practitioner, TTTH)

Participants reported mixed levels of confidence in working collaboratively across teams, which was found to be directly linked to prior experience of working across settings. It was evident that high levels of confidence facilitated joint working, whereas low levels of confidence acted as a barrier. For those working in *Time to Talk Health* it was found that those who had greater exposure to joint working and had regular contact with physical health care colleagues had higher levels of confidence due to increased familiarity with the team and a sense of integration. This supported staff to build positive working relationships with one another, further reducing apprehension to make contact.

> *I feel like if you've not kind of got that relationship there, those 'not pressing' questions would have been something I wouldn't have taken to other teams, but I did to the cardiac team, because I had those working relationships established.* (PWP)

There was a sense that engaging in joint working was still a choice for *Time to Talk Health* staff and that practitioners were able to put themselves forward to collaborate with health care colleagues when opportunities arose. This therefore highlighted the bi-directional link between experience gained and motivation levels to engage in joint working.

The theme of ‘it wasn’t new to me’, extended to levels of knowledge about each other’s services. This was found to be important in acting as a barrier or facilitator to working alongside one another. Participants seemed to be knowledgeable about their own services; however, they lacked understanding of wider services, stakeholders and examples of previous working models to support the set-up of joint working pathways. Physical health professionals described feeling unsure about *Time to Talk Health’s* inclusion and exclusion criteria, alongside whether the patients they wanted to refer onwards may fall under primary or secondary mental health services.

> *If they've got long term mental health problems, or they have mental health services in the past then it’s hard to know who they come under.* (Health Care Practitioner, Pain Clinic)

This was also echoed by mental health professionals working within *Time to Talk Health* when it came to referring patients to their physical healthcare colleagues. Participants described an apprehension around making referrals for patients that may be of benefit. This was due to a lack of understanding and previous experience of having referrals rejected. Referring in and out of each other’s services was reported to be one of the main forms of joined up working, which further highlights the importance of clarity around each other’s criteria.

> *We deal with this person, but we don't deal with that person … that's as much in mental health services as it is health care professionals, it's happening in those as well … I don't really understand the referral process for most of the pain services.* (CBT Therapist)

The lack of understanding around the nature of work being completed by colleagues in respective teams was also a barrier to working collaboratively. A practitioner from *Time to Talk Health* described their experience of attending a diabetes clinic and this lack of awareness impacted on their ability to be able to collaborate with the team.

> *It does impact on confidence; people actually question why you're there in the first place … I find it really difficult to just turn up, in a completely different team and keep introducing myself to people who have no idea who I am or what I do.* (CBT Therapist)

This was also echoed by leadership as a barrier in the process of trying to develop the LTC pathways. There was a lack of understanding about *Time to Talk Health* as a new IAPT-LTC service and a sense that wider communication around its implementation had not been disseminated in the lead up to its launch. Participants spoke about the importance of effective and memorable communication to stakeholders, which is important for the collaborative process of mapping out joint pathways.

> *I just think them not really understanding who we were and what we were meant to do … for them it really had come from nowhere, somebody was like 'Ta Dah!' we've got an LTC service in your area.* (Senior Practitioner, TTTH)

This lack of knowledge and understanding of one another seemed to be directly linked to the subtheme of 'we didn't deliver on what they had in their heads,' as previously discussed. Stakeholders had different ideas around their requirements for psychology provision within their teams, and the lack of knowledge around *Time to Talk Health* fed into unrealistic expectations.

> *… they wanted their own health psychologists, but what they had was this team of CBT therapists, that doesn't really make sense to them, and who we are? What is that? And why are they not sitting with us and just seeing our patients soon as we refer?* (Senior Practitioner, TTTH)

It was found that having increased knowledge of one another's discipline was linked to increased confidence in working collaboratively. Many physical health care practitioners who had received training in talking therapies described a desire to work alongside psychological professionals, despite not having direct experience of working in mental health. The training they had received had altered their beliefs about their capabilities and their identity as a practitioner to work holistically, which therefore improved their motivation to work across disciplines.

> *I am quite experienced and knowledgeable of what I'm doing already, by no means at all mental health trained but I have done some counselling courses to help with diabetes, I now can understand more about how that fits with the whole consultation.* (Health Care Practitioner, Diabetes Service)

However, levels of confidence were found to be a barrier exclusively amongst those working in *Time to Talk Health* when this perceived level of knowledge was lacking. Participants described having gaps in their knowledge base around long-term conditions and therefore perceived their health care colleagues as 'the experts'. A PWP who had this level of training described how their knowledgebase had given them confidence to work across teams but could reflect upon how it may feel different for those without this.

> *I think my impression from the team members is that they might feel a bit out of their depth … There may be acronyms, you know, medical language terminology that they don't understand. I think it is hugely driven by lack of confidence. And one thing I've been trying to continually instil, actually being someone that did have enough knowledge to feel comfortable and confident, is that it's okay to not know.* (PWP)

The process of setting up the joint working pathways was facilitated by the input of those who had knowledge of both physical and mental health services. One of the participants was a GP with involvement in the commissioning of mental health services and therefore had knowledge and experience of how both physical and mental health teams' function. This participant described how they were able to fully understand the barriers that each team faced and was able to translate this in a meaningful way to the respective teams. This further supported a mutual understanding of one another’s needs and facilitated collaboration in the process of setting up joint working pathways.

> *I've always seen my role as a sort of conduit, or like a translation service between physical health services and mental health services, because I had a foot in both camps. I realised that the language and culture in one group of professionals is very different from that in another group, and unless there was a go between, they weren't going to be able to work together.* (GP)

In addition to the knowledge and understanding of services being key to the theme of ‘it wasn’t new to me’, those responsible for setting up physical health care pathways describe the importance of having familiarity with key stakeholders. Participants described the challenges of not being regularly updated around changes in leadership and key points of contact across the different teams. This meant that this information was consistently new to them and added time pressure to continually scope key stakeholders. This was further impacted by the vast number of individuals needed to collaborate with across the teams that *Time to Talk Health* had been commissioned to work with.

> *I mean one of the things about system changes; you don't always know when you're outside of their system, who is the key player in their system?... When you've got so many stakeholders and they've all got their own pressures, agendas, ideas, passions. They're all in different areas and trying to actually map that out successfully, it's really challenging, and you need people in the know.* (GP)

Finally, the theme of ‘it wasn’t new to me’ extended to those setting up the joint working pathways as they highlighted the barrier of having no previous prototype to follow. This did not allow for any previous knowledge to be drawn upon to support their capability in setting up the new working model. The expansion of LTC sites was new to IAPT; therefore, guidance was given by NHS England and interpreted by local services across the country in different ways. Participants described *Time to Talk Health* as unique compared to local IAPT services regarding how the service is set up. They described *Time to Talk Health* as operating as a separate service from Time to Talk, its sister service working with non-LTC patients. *Time to Talk Health* is therefore very different to other IAPT services locally who had fully integrated their LTC pathway within their core services. This further acted as a barrier in the process of putting LTC pathways in place, as there was no prior learning to draw from.

> *We had no other IAPT-LTC service at which to look to guide us on that, we had to do it all completely from this structure with NHS England and then translate it … in Kent, Surrey, Sussex, I don't know about all of the other national sites, and, how they set that up, but I know for our locality we are quite different.* (Senior Practitioner, TTTH)

Overall, prior knowledge and experience of working alongside physical and mental health care colleagues, was found to facilitate joint working. In addition to this, experience of project work and knowledge around setting up joint working pathways was important for some of the senior members of staff responsible for implementing the joint working model. Increased knowledge and experience seemed to feed into high levels of confidence for participants and further increased levels of motivation. The final theme that the COM-B model mapped onto; ‘joint working seen as costly vs. enabling,’ will now be explored in further detail.

Theme 4: Joint working seen as costly vs. enabling

The COM-B construct, physical opportunity, relates to opportunity linked to the environmental context which can impact on one’s behaviour. In relation to joint working, participants reported many costs, including a lack of time and resources. However, having a key point of liaison was found to enable collaborative working across all participants, whilst service level flexibility and working with colleagues in person were found to enable better collaboration across health professionals specifically. Participants could all draw upon the costs and enabling factors that created a ‘double edged sword’ when it came to joint working, which are explored in greater detail.

Mental health practitioners within *Time to Talk Health* spoke about a lack of time being a barrier when it comes to collaborating with colleagues from other services. Many felt that their clinical work took up most of their diaries and often found themselves prioritising clinical work during the time that was set aside for joint working.

> *I mean I have one hour allocated in theory per week … for consultation but It's very easy not to have this time at all when you have other stuff. My days are full of clinical contacts, so it’s hard to find, yeah, that time to link with others*. (CBT Therapist)

There was a shared belief amongst participants that engaging in joint working was ‘taking time away’ from their primary role. For example, a health professional working within pain management expressed concerns around how the practitioner they link with from *Time to Talk Health* could ‘make their time back up again’ after supporting with their pain management programme. The perception that joint working contributes to ‘time taken away’ from one’s role, further contributes to the sense of divide between physical and mental health.

> *What are we doing with the time that you guys are taking away for a pain management programme that's not going to be (the practitioner’s) working function in Time to Talk Health? How do we backfill that time or where does that money come in?* (Health Care Practitioner, Pain Team)

The barrier around lack of time and resources was also echoed by those in leadership roles responsible for setting up joint working pathways. They described a shift in priority away from attending joint clinics and engaging in work with health care professionals due to the increasing waiting lists within IAPT-LTC. They described how staff were asked to redirect their time to meet the service’s needs rather than collaborate with other teams. This further adds to the notion that integrating across teams is to the detriment of the service through reducing resources and increasing demand.

> *We had to withdraw from one or two things as well, so for example, the diabetes DESMOND talks that we used to do, it just became too time consuming. There were things that were actually quite valuable, but we had to start to withdraw from them*

> *because we had to focus on the waiting list and getting people into treatment.* (Senior Practitioner, TTTH)

Time to Talk Health practitioners described difficulties in being co-located with their physical health care colleagues due to limited room space. They were unable to work from the same venue, which reduced capacity to support with joint clinics and patient work. Practitioners reported that this would either reduce the amount of collaborative working that they engaged in or change the nature of their work meaning that they would be making contact virtually.

> *Because I also wasn't based there for clinics, that's the difficulty, I think, we have a real difficulty with practicalities … I can't really be based there because the venue is not available when I have my availability*. (CBT Therapist)

During the process of setting up the joint working pathways, resources linked to space and venues were also a barrier in planning the co-location of staff. These participants all described co-location as the 'gold standard' in terms of an integrated model of care but felt unable to achieve this due to lack of resources in the NHS to allow them successfully to plan this.

> *Basically, you know, most rooms are taken up aren't they, if you think about clinic space … if we were going to do that consultative approach, there were those kind of barriers in terms of there wouldn't be a room available for you.* (Senior Practitioner, TTTH)

Another barrier linked to room space was the differences in how teams' function and utilise venues. Participants described it being easier to plan the co-location of staff with teams who were permanently located in one venue. However, some teams would work from a variety of community venues or provide home visits to patients, causing difficulties in mapping out how *Time to Talk Health* staff could work effectively alongside them.

> *So we had to work that out with the teams, because some teams don't have bases, they're quite nomadic, so we know where the Diabetes Nurse Specialists in Coastal West Sussex, they go in and out of GP surgeries and some home visits, but they don't have a space necessarily where we can sit alongside them in the same way we can in a hospital clinic ... so we've had to adapt what that looks like, for each team.* (Senior Practitioner, TTTH)

Despite the challenges linked to finding room space to work alongside one another, participants expressed the benefits of being co-located with their physical or mental health care colleagues to support working collaboratively. One of the practitioners working within *Time to Talk Health* described how they were co-located in the hospital alongside the diabetes team twice a week. This allowed for joint appointments with the nursing team, consultants and dieticians. They were also able to attend team meetings, provide training to the team and ad-hoc advice. They reported feeling a sense of integration as a direct result of being present in the same environment with the team.

> *Yeah, I just felt a part of the team, I used to clean the kitchen every fourth Friday because it was my turn … and I did my turn of bringing in the cakes, you know, it's all part of just being in a team … I think that was essential for me, is actually to be there physically … and not being part of the team in name only.* (CBT Therapist)

Benefits of being co-located included the ability to have ad hoc corridor discussions which would also allow for the free flow of discussion between practitioners and provide an opportunity to learn from one another. Participants reflected that these conversations are less likely to happen over the telephone or via video calls, which often have an agenda and are more formal in nature.

> *Being able to go in and say, 'Oh I was just wondering, that procedure or that medication' or 'I've heard this on the news about something to do with pain, is it true?' or 'How does COVID affect pain patients?' But you could just have those discussions as you walk in the meeting room.* (CBT Therapist)

Many of the participants reported that being co-located also supported building a sense of team and improved working relationships through having more memorable communication with one another. This directly links in with the theme of 'it wasn't new to me' as having face to face contact with colleagues increased levels of familiarity and reduced apprehension about contacting one another.

> *Having the practitioners coming in to deliver the talks meant we had a very, very good working relationship with them.* (Health Care Practitioner, Cardiac Rehab)

Participants working in *Time to Talk Health* and in physical healthcare teams both identified that having a key member of staff to link in with facilitated communication across teams as they provided a designated point of contact. Participants reported that having a designated member of staff who is responsible for communicating with a particular health care team enabled communication to be upheld and for collaboration to take place on joint projects. One of the Psychological Wellbeing Practitioners within *Time to Talk Health* describes how they have become a designated point of contact for the cardiac team.

> *I worked quite specifically with the cardiac team at (the) hospital ... Having like a designated person that is there making regular contact, joined up working in terms of the information sessions, to me, I think works really well.* (PWP)

The advantages of having a key point of liaison included having one person that could disseminate information and updates to their own team, being able to take their colleagues' queries to the respective team, building strong relationships with staff and increased learning gained from the team they are linked to. One of the health care professionals spoke about the importance of having the sustained link with one *Time to Talk Health* practitioner and how they have developed knowledge and understanding of the team over time. They described the practitioner's continued attendance as part of their weekly MDT meeting.

> *She knows the service very well. As, as we know well here, it’s not just a case of taking out one professional and sticking anyone, anybody in that hole because there’s an element of training that goes alongside that.* (Health Care Practitioner, Pain Team)

Having a designated person for a point of contact was also found to be important for those responsible for setting up joint working pathways when identifying stakeholders. Participants described the importance of linking in with those who have both enthusiasm for collaborative care and the seniority to develop new pathways. It was found that ideas were more likely to be actioned through identifying these key individuals, alongside them supporting the dissemination of information about *Time to Talk Health* within their respective teams.

> *You learn about people like service managers ... the hierarchy and who the person worth speaking to is ... you start to go in the path, not of least resistance, but the path with the most enthusiasm. So, if there's someone who's a mover and a shaker, who's got some seniority, you target them.* (GP)

Clinicians reported the need for flexibility in the way they practiced, enabling effective joint working and collaborative care. This flexibility was needed around how often staff might attend multi-disciplinary team meetings or contact their respective teams. It was found that being able to adjust the frequency of their contact to fit in with the needs of the practitioners and their patients enabled them to make the most of their time and work effectively alongside each other.

> *You just review it as you go along, you know, if you find that you know, you get into these meetings and there's not really a lot to discuss, then you, know you can make it less frequent.* (Health Care Practitioner, Cardiac Rehab)

Both physical and mental health care staff reported challenges of having a high caseload and long waiting lists which further contribute to difficulties of working flexibly within the NHS. Having autonomy over diary management seemed to support working flexibly in the face of these challenges. One of the psychological wellbeing practitioners spoke about the ability to add additional pieces of joint working into their diary or cancel joint working plans if their diary didn't allow for it. They described this as a helpful way of managing their time and allowed them to prioritise different aspects of joint working practice.

> *If there was a week where something else came up, I could either fit that into my diary as an extra or I could maybe not go … We were a little bit more flexible, maybe even had a bit more time on our hands sometimes, than they did.* (PWP)

Practitioners within *Time to Talk Health* also spoke about having protected time within their diaries each week to link in with physical health care teams. This therefore contributed a flexible working model, with practitioners reporting that they had a sense of autonomy over when they could use this time during the week. This enabled them to fit this in around their clinical work and with their respective physical health care colleagues. Participants also felt that having protected time as part of the service model placed significance on joint working as part of their role and was a positive service adaption to support collaboration.

> *IAPT services are notoriously high-volume caseloads; it would be extremely difficult to even envisage any sort of contact outside of your immediate IAPT service without some prioritised designated time for that function … With the best will in the world, all the motivation all the enjoyment, but it just wouldn't happen. There has to be protected time.* (PWP)

Overall, there were many factors linked to physical opportunity that were reported by some of the participants which either facilitated joint working or acted as a barrier to working alongside one another. Most participants reported the need to navigate these challenges and make the most of the enabling factors to broaden their opportunities to work collaboratively. Barriers to working collaboratively such as limited time and resources could represent wider challenges within the NHS and could be considered further at the implementation stage. The final theme of 'joint working pathways seen as unsustainable' will now be explored in further detail. This is discussed as a separate theme that could not be fully explained by the COM-B model.

Theme 5: Joint working pathways seen as unsustainable

A theme that was found across all participants was the importance of sustaining joint working pathways as being key to its success. Two subthemes within this included the retention of staff and the impact of COVID-19. These subthemes appeared to be multifaceted and the impact on sustainability could not be fully explained within the COM-B framework.

> *I think what we're really good at doing is initiating but then it's the sustainability of that, which then falls off as both sides are busy trying to do their roles … Unfortunately, I think there was a big drive to become more collaborative and then I'm not sure about how we've been sustaining that collaborative working.* (PWP)

Subtheme 1: Challenges around the retention of staff

Issues around staffing linked to recruitment and retention were found to have a direct impact on being able to sustain links with health care teams across the breadth of LTC services that *Time to Talk Health* work alongside. The service is commissioned to provide IAPT-LTC support to the whole of the county. Participants therefore felt that collaborating with all the relevant services across the locality was unachievable, particularly in the context of staffing issues.

> *I think we're understaffed, … it needs to increase, we need more of it. We don't have enough therapists at the moment to make it work to its full capacity.* (CBT Therapist)

The difficulty around the retention of staff within *Time to Talk Health* seemed to be a barrier to joint working. Participants reported that members of staff who had previously been working with the healthcare teams on a regular basis had left their role and that they were subsequently not replaced. This therefore created difficulties with maintaining joint working relationships and familiarity of staff which were found to facilitate collaboration.

> *[Ellie] was the main link and then she left and there was [Julie], she left as well … they left, and they weren't replaced by anybody.* (CBT Therapist)

Participants described the lack of recognition and incentives for practitioners to remain within their role. Staff described there being no difference in pay, despite the additional training required to work within the service. Staff also reported retention to be linked to the complexities of working with co-morbidity and the additional requirement for collaborative working with health care professionals. Participants believed that a lack of recognition for these additional aspects to their role was linked to a high turnover of staff and that IAPT-LTC services would continue to struggle to retain staff as a result.

> *I think the fact that the staff do have additional training in order to do this job… they have to have an awful lot of knowledge in lots of different areas, they have to be confident in liaising with lots of different staff … it's not recognised professionally and in financial terms as well … They're the same banding as the staff would be in a core service … that doesn't always help to encourage people to stay …* (Senior Practitioner, TTTH)

Alongside difficulties with retention, participants descried a difficulty around recruiting new staff into the service. Participants believed this was due to the wider perception of the workforce around what it is like to work with patients with LTCs. Some commonly held beliefs included the complexity of working with LTCs, the expectation of low recovery rates and therefore a lack of job satisfaction. This consequently feeds into a difficulty with recruiting and retaining a full workforce who can engage in collaborative working with health care teams.

> *I think a lot of people in the core service still have that perception that it's impossible to work with people with LTCs because they would never recover. So, all the time people have got that impression of what it's like working with LTC patients, we're not going to get people wanting to come and work in our service. So, it is a bit of a Catch-22 really*. (Senior Practitioner, TTTH)

Overall, the subtheme of ‘challenges around the retention of staff’ was explored as part of the wider theme; ‘joint working seen as unsustainable.’ There was a sense that the challenges around the recruitment of staff within *Time to Talk Health* was particularly difficult due to being set up as a separate IAPT-LTC service, and therefore the work being perceived as a specialism. Furthermore, challenges in recruiting and retaining staff presented difficulties in sustaining joint working relationships and ensuring that the joint working model was working to its full potential. A second subtheme of ‘COVID-19, it completely changed everything’ will now be discussed in terms of the impact this also had in sustaining the joint working pathways.

Subtheme 2: COVID-19 ‘It completely changed everything’

Participants reported further challenges around the sustainability of joint working due to the COVID-19 pandemic. The sociocultural factors associated with the impact of the pandemic on joint working did not fit neatly within the COM-B model and are therefore explored separately. All participants described COVID-19 as having a negative impact on collaborative working. In particular, the frequency of communication was significantly reduced, with some teams ceasing communication altogether. Participants described placing the responsibility of getting in contact in the hands of their respective colleagues, with brief communication being exchanged via email.

> *So, for a lot of the clinicians the contact just ceased_... I just sent a cursory email just once in once in a while just reminding them that we're still open for business and anything they need help with let us know.* (PWP)

Participants working within physical health care settings also spoke about the impact that redeployment had on staffing within their team due to the COVID-19 pandemic. A significant loss of staff often meant that they adapted their practice to maintain the functioning of their service. Joint working was therefore not considered as a priority at that time. Communication was further impacted by the fact that health professionals were no longer in their previous roles or environment and therefore not contactable in their usual way.

> *I was redeployed for two months… that was tough for my colleagues that were left behind, in fact, a very small team; two part time nurses. So, my colleague, she was having to sort of basically hold the fort ... our roles changed completely … I think we had a couple of emails come through saying 'How are you girls?' really nice, but when those came through, I was working on the ward, doing 12 hour shifts with COVID patients.* (Health Care Practitioner, Cardiac Rehabilitation)

For those participants who described maintaining some communication with wider teams, it was clear that the impact of COVID-19 meant that the contact made with both patients and staff had shifted to working remotely. This therefore reduced the opportunity to co-locate and offer joint appointments for patients which was previously found to facilitate collaboration.

> *I think it's difficult at the moment when we're not all in the same room physically, and we're not always seeing the patient physically as well. I think that makes it very difficult … it's all a bit different at the moment, (the TTTH practitioner) is actually on a video call while we're talking to patients on the phone.* (Diabetes Practitioner)

Health practitioners described how COVID-19 meant routine patient work was not going ahead at all, further impacting on how *Time to Talk Health* colleagues were able to refer into their services and work alongside each other in their usual way. Other services had adapted their service provision, which excluded *Time to Talk Health* from elements of their practice that they would usually be involved in. A participant working within cardiac rehabilitation described how their education sessions, which were previously being delivered by *Time to Talk Health*, were now due to be recorded by their own members of staff to deliver to patients remotely.

> *Obviously, we're having to deliver our services a different way. And I think we need to record things like the stress management talk now, we've recorded our other education sessions.* (Cardiac Rehab Practitioner)

There was a sense that COVID-19 had indefinitely changed the way in which health professionals' work alongside each other. Some participants suggested that practitioners may be more guarded around collaborative working due to the pressure that COVID-19 has put on the NHS and therefore increasing waiting lists for many services.

> *Increasingly because of COVID everyone's becoming more and more defensive of their waiting lists and referrals that they are and aren't accepting, kind of being more boundaried.* (Pain Management Practitioner)

Staff reported that their teams have changed their practice to such an extent during the pandemic that joint working pathways needed to be re-established. There was also a sense of uncertainty around how services would 'reset' and work alongside each other due to the significant changes that were brought about by the pandemic.

> *We’re all having to work in a different way at the moment, so we're not quite sure what the future holds I think really.* (Cardiac Rehab Practitioner)

Overall, the impact of the COVID-19 pandemic, alongside the difficulties associated with retaining and recruiting staff within *Time to Talk Health* were both considered to be wider socio-cultural factors impacting on the sustainability of joint working.

Summary of findings

Following deductive analysis, a thematic map was created (see Appendix J), which highlighted the bidirectional links between practitioners’ capability, opportunity and motivation to engage in collaborative working. The constructs clearly overlapped and outlined a cyclical model for understanding the predictors of an individual’s behaviour. For example, a participant with an increased sense of capability through previous experience of working across disciplines had higher levels of confidence, and therefore motivation to seek out opportunities within their role. This increased exposure further reinforces their sense of capability, feeding back into the cycle.

However, the initial inductive analysis highlighted the need to understand sociocultural factors which were impacting on the sustainability of collaborative care. Challenges around maintaining a full workforce within IAPT-LTC meant that it was difficult to have enough staff to work across teams. COVID-19 was explored as a barrier around how it has changed how services function and communicate with one another, alongside the sense of uncertainty around how the joint working will look in the future.

Discussion

The present research aimed to understand the experience of health care professionals working towards a collaborative care model, with an additional aim of understanding the effectiveness of the COM-B model as a framework for understanding these experiences. No previous studies have explored this area of research since the implementation of Wave 2 IAPT-LTC pilot sites. The COM-B model was mapped onto the four themes; ‘the culture of them and us,’ ‘can they see the value in it?’ ‘It wasn’t new to me’ and ‘joint working seen as costly vs. enabling.’ Barriers and facilitators around the participants’ capability, opportunity and motivation to engage in joint working were explored. It was found that the issue around sustaining joint working pathways could not be factored into the COM-B model and was therefore explored as a separate theme.

This chapter will explore the research findings in relation to each of the research questions, framed within the context of the COM- B model. Distinctions will be made between individual and systemic factors impacting on collaborative care within the constructs of the COM-B model . The implications for clinical practice, the study’s strengths and limitations, alongside recommendations for future research are further discussed. Finally, the main conclusions of the research are outlined.

Research question 1: What are the facilitators and barriers to joint working?

Capability

The construct of capability found individual factors to impact of collaborative care, including experience and knowledge held by professionals. It was found that prior experience of working across physical and mental health care settings and having knowledge and understanding of each other’s services facilitated joint working across teams. However, those without prior experience of working across teams reported this as being a barrier and that it created a divide in terms of fields of expertise. This supports previous findings by Knowles et al. (2013), who found that professionals maintaining barriers around physical and mental health expertise contributed to the theme of division. The findings also support Wozniak et al. (2015), who highlighted the importance of professional and personal qualities of those engaging in collaborative care as a facilitator.

However, the current findings can better make sense of this in relation to the levels of confidence that participants described due to this perceived lack of knowledge and experience. For example, not understanding medical terminology or not feeling familiar with medicalised settings directly impacted on mental health workers' confidence to work in a collaborative way. Carroll et al. (2021) also found that levels of confidence in working with LTCs were a barrier to therapists supporting patients with LTCs generally, which the current study both supports and provides further depth on around the implications for joint working specifically.

Opportunity

The need to work around barriers within the NHS was previously reported by Carroll et al. (2021) as important when it came to engaging patients within IAPT-LTC settings. Their findings suggest that a lack of flexibility in session frequency and location, alongside service level constraints due to increasing demands to meet targets, were all barriers to working effectively within the IAPT LTC pathway. These systemic level barriers were also found within the current study when applied to working collaboratively. However, the present study has evidenced that increased flexibility around diary management, alongside protected time within practitioner's diaries to work alongside physical health care professionals, seemed to be a helpful adaption which was given on a service level within *Time to Talk Health.*

Having a designated person to contact and being co-located with teams to provide joined up care were both found to be facilitating factors linked to physical opportunity. Both factors seemed to improve familiarity of staff and a sense of approachability through improved working relationships. These findings were supported by Kathol et al. (2010), who found facilitators around the delivery and sustainability of integrated care programmes to include the use of care managers to co-ordinate care, alongside the colocation of services. The national evaluation conducted after the implementation IAPT-LTC pilot sites (Clarke et al., 2018) identified limited space for co-location as a barrier to the integration of teams. The findings in the present study highlight the ongoing nature of this difficulty three years on and how barriers related to the COM-B construct 'physical opportunity' are systemic, needing to be addressed by those setting up joint working pathways, rather than individual barrier.

A culture of 'them and us' was found to impact on social opportunity to work effectively alongside one another. Practitioners felt that they were still working on two separate agendas with patients, with physical health professionals often being socialised to the biomedical model. Participants described the impact of societal stigma around mental health difficulties in creating a barrier to working alongside each other due to patient perceptions. Previous research supports these findings with a theme of separation between physical and mental health care teams and the importance of a culture shift to value integration by both professionals (Kathol et al., 2010; Wozniak et al., 2015) and patients (Knowles et al., 2015).

However, IAPT-LTC staff working within a physical health environment seemed to reduce these barriers for both staff and patients. This further highlights how increasing resources and improved planning around co-location at a systemic level can bring about change in how teams work alongside one another and the perception of patients. Carroll et al. (2021) provides support for this, finding that participants were more receptive to receiving psychological therapy when it was part of their hospital care as part of an MDT approach, further improving integration and reducing stigma. It was of interest that allied health professionals made up over half of the sample of health professionals within the study. This may have supported with integration once IAPT-LTC staff were co-located, due to their familiarity of working within multi-disciplinary teams (NHS, 2022). A recent literature review exploring allied health professionals' perceptions of collaborative care (Seaton et al. 2021) found a shared perception of themselves as members of a non-hierarchal interprofessional network. This was found to create a shared sense of respect and leadership, particularly when working in close proximity. Future research may benefit from exploring collaborative care between IAPT-LTC staff and specific groups of allied health professionals, rather than collectively as within the current study. This would enable further exploration around barriers and facilitators for joint working across different models of care.

Motivation

There were many factors that were found to impact on levels of motivation to engage in joint working which were both individual and systemic factors. These include levels of confidence to work collaboratively, how much value the practitioners could see in joint working and practitioner's expectations of one another. These factors will be discussed in more detail.

Practitioner's levels of confidence to engage in joint working was a key individual factor and found to be strongly related to the construct around capability, including previous experience of working across teams and knowledge of physical and mental health. These findings support Carroll et al.'s (2020) findings, which suggest a lack of knowledge around specific LTCs and their treatments impacted on therapists' confidence in communicating about and delivering LTC interventions. The current study therefore builds upon these findings to demonstrate that practitioners are also less motivated to engage in joint working as a result.

Having unrealistic expectations of one another was found to negatively impact on motivation levels to engage in joint working. It is important that communication between services is clear and that expectations of one another are transparent, to ensure that services can be provided in conjunction with one another, rather than having a sense of ownership by one party. This ties into the theme of 'we didn't deliver on what they had in their heads' as services having different expectations of one another was found to serve as a barrier to joint working. Daniel (2020) highlights the importance of a shared understanding of the provision of care from one another's services as key in the delivery of 'integration across teams.'

Health professionals' level of motivation to work collaboratively was positively impacted by feeling valued by their colleagues, which has been previously documented in terms of the importance of valuing a collaborative model of care and MDT working (Carrol et al., 2021; Daniel, 2020). Previous findings have shown that a stronger culture of collaborative care has been found to improve motivation to engage and therefore implementation fidelity (Kathol et al., 2010; Wozniak et al., 2015).

As part of the wider theme 'can they see the value in it?' the subtheme of 'don't take my role away' explored the perceived sense of threat experienced by physical health care staff which further impacted on levels of motivation to engage in joint working. This barrier had not been identified within the initial IAPT-LTC pilot evaluation, or within previous literature around collaborative care. Many of the physical health practitioners had developed aspects of their services to support psychological wellbeing and they were therefore fearful that collaborating with IAPT-LTC would threaten this element of their role. Daniel’s (2020) definition of integrated care as being either ‘integration within teams’ (for example, MDT teams) or ‘integration across teams’ (which would include joined up care between physical and mental health teams such as IAPT-LTC) may be helpful to better understand this finding. It is suggested that when integration across teams occurs, it is more likely that duplication of services could be offered which could explain the feared outcome by the physical health practitioners. This therefore offers further insight into how levels of motivation to engage in joint working may be impacted by this sense of threat to job role.

Overall, individual and systemic factors were at play around managing expectations of and valuing one another’s input, further contributing to levels of motivation to work collaboratively. At a systemic level, it was important to ensure that joint working pathways were set up with clear expectations of one another’s role, alongside placing value on joint working which then feeds into the culture and working model of the teams. On an individual level, it was important for clinicians to communicate and understand their roles when working collaboratively and levels of value placed on joint working were also influenced by beliefs and assumptions held by staff.

Summary

Overall, the current findings offer support for existing research around the barriers and facilitators into collaborative care. The national evaluation conducted after the implementation IAPT-LTC pilot sites (Clarke et al., 2018) identified strong leadership alongside effective supervision and training to facilitate IAPT-LTC pathways. The current study adds further depth to this through understanding moderating factors linked to capability, opportunity and motivation around engaging in collaborative care. The current research also captured the experience of health practitioners with a wealth of experience of working within/alongside IAPT-LTC for many years following implementation, of which the pilot evaluation was unable to offer. The novel findings around the barrier of a perceived threat to job role is considered later in the chapter as part of implications for practice, as it is important that this is given further thought around how to engage physical health practitioners and stakeholders.

Themes falling outside of the COM-B model

The current study found a key barrier to working towards a collaborative care model was the sustainability of joint working pathways. Previous research has found limited degrees of collaborative care being practiced and discontinuity amongst care managers when implementing a collaborative care model for those with diabetes and depression (Wozniak et al., 2015). This discontinuity was linked to staff turnover and the splitting of the case manager role across the locality, causing further difficulties around building trust and rapport. This highlights the importance of retention of healthcare staff due to the need for joint working pathways to be sustained and good working relationships to be built over time.

The current findings highlight the challenges around recruiting staff into IAPT-LTC services due to the perceived complexity of working with the client group, the level of training needed within the role to work with LTCs, alongside minimal incentives for staff to remain in their role. These challenges highlighted a key systemic issue around the recruitment and retention of staff which is particularly due to the rapid expansion of services that IAPT are currently undergoing. It has been documented that the recruitment and retention of qualified practitioners within IAPT services is a national problem

(Psychological Professions Network, 2021) and particular consideration from IAPT-LTC services is therefore needed around how to incentivise potential candidates.

The current study adds to the findings around sustainability of joint working in the current sociocultural context and impact of the COVID-19 pandemic. These factors therefore fall outside of individual and systemic barriers as previously discussed. Barriers included loss of contact with health care teams, re-deployment, a switch to remote working and additional pressures that the teams were placed under during the pandemic. The participants were interviewed during the months between the first and the second wave of the pandemic and therefore were able to reflect upon the challenges that have continued to adapt to throughout the year. The findings suggest that in the face of adversity, service priority shifts to that of their own needs, rather than upholding communications to support one another across teams. This further contributes to the theme of ‘them and us’ amidst the continually changing climate.

Research question 2: What are the facilitators and barriers to setting up joint working pathways?

The findings in relation to this research question provided a novel aspect to the study as previous research has not focused on barriers and facilitators in the early stages of setting up joint working pathways, particularly within IAPT-LTC settings since the implementation of second wave pilot sites.

Many of the themes were found to overlap with the barriers and facilitators that clinical staff faced once joint working pathways were in place. Individual factors including increased physical and psychological capability was found to facilitate the process of setting up joint working pathways with stakeholders. This was due to participants having worked in both physical and mental health care teams, and having previous experience of project work, which increased their confidence to do so. This supports previous findings that suggest previous training, implementation support and the personal qualities of those responsible for implementing the joint working pathways are predictors of success (Wozniak et al. 2015).

Similar themes around physical and social opportunity existed, with the same systemic barriers existing in the early stages of setting up the joint working pathways such as time pressures, lack of room space and cultural divides between physical and mental health teams. This is supported by previous research, highlighting the importance of co-location in supporting the implementation of joint working pathways (Kathol et al., 2010; Clarke et al., 2018). Having a key point of contact was equally found to be a facilitator in the process. The national IAPT-LTC evaluation of pilot sites (Clarke et al., 2018) identifed that teamwork, effective relationships among healthcare teams and strong networking and access to health psychology services all supported the development of pathways. All participants within the current study reported that building relationships with key stakeholders was essential in the implementation stages of setting up the joint working model, which also highlights the importance of individual factors to develop meaningful relationships in order to support implentation of pathways in the face of systemic barriers.

The main differences across the staff groups were found within the constructs of social opportunity and motivation which were both found to be systemic factors; directly impacted by stakeholders, including NHS England and local commissioning groups. A perceived lack of buy in from stakeholders and the top-down approach in working towards unrealistic targets and KPIs directly impacted on participants' confidence levels and motivation to engage in the process. There was a perceived lack of value in collaborative care as this did not inform any of the targets set by NHS England. The fact that teams were commissioned separately fed into many difficulties when working clinically around holding different waiting lists, being housed in different venues and having access to different record systems. Previous research has found that this makes a difference in being able to work collaboratively, with shared access to patient records and ease around the sharing of information across teams being a key facilitator in collaborative care (Kathol et al., 2010).

Furthermore, the findings from Carrol et al. (2021) demonstrated that there was a sense that LTC pathways were trying to 'fit' pathway models designed for people without LTCs. The current findings mirrored this, with feelings of frustration around system level barriers and unrealistic targets which were put in place for non LTC services. It is suggested that consideration at a system level is given to support further adaptions to the IAPT-LTC model at the implementation stages.

Overall, the experiences of those implementing IAPT-LTC pathways seemed to fit with the barriers and facilitators reported within previous research. However, the subtheme of 'don't take my role away' highlights novel findings within the current study which have not been documented within previous research. This subtheme captures both individual and systemic factors and has implications for practice, in particular for those services planning to implement joint working pathways. Furthermore, the possibility that colleagues and stakeholders may feel threatened could be considered at this early stage and allow an opportunity for them to be involved in decision making and planning in order to better engage them in the process. Finally, the COM-B model provides a framework to be able to better understand how the constructs of capability, opportunity and motivation interact to contribute to the implementation of the joint working pathways. This element of the research findings provides a novel aspect to the study and is further explored below.

Research question 3: To what extent can COM-B be used as an effective framework to explain these findings?

The COM-B model was largely found to be an effective framework for mapping out the barriers and facilitators found in working towards a collaborative care model. The COM-B model allowed the researcher to explore the findings in more depth, due to the interactions described between each of the components of capability, opportunity and motivation. The thematic map (Appendix J) demonstrates how the different constructs impact on one another and therefore provide a cyclical approach. Bi-directional relationships between increased levels of capability, opportunity and motivation bring about positive change in joint working and implementation of joint working pathways. There were multiple links between the constructs, which are further explored below.

The findings show overlap between the theme ‘it wasn’t new to me’ and the subtheme ‘we didn’t deliver on what they had in their heads’. Both identify the importance of having a good understanding of each other’s services to improve levels of capability and motivation to engage in joint working. For those working in senior positions, having a shared understanding with stakeholders, whilst also having understanding and experience of project work, overlapped these two themes. The theme ‘it wasn’t new to me’ was also directly linked to the subtheme of ‘don’t take my role away’. Health care professionals and stakeholders who demonstrated an interest in providing psychological support were more likely to feel threatened by *Time to Talk Health’s* input, further highlighting this as a barrier to collaborative working and setting up joint working pathways. ‘It wasn’t new to me’ was found to be linked to ‘joint working seen as costly vs. enabling’ as those who had increased opportunity to engage in joint working gained more exposure to doing so and therefore felt more familiar with their respective colleagues. This further instilled confidence to embark on future opportunities for collaboration.

‘The culture of them and us’ overlapped the constructs of social opportunity and reflective motivation. Participants reported working on separate agendas with patients which created barriers around social opportunity. However, feeling valued by one another fostered motivation to collaborate and work more holistically as a team by both clinicians and senior staff. The subtheme of ‘we didn’t deliver on what they had in their heads’ had a knock-on effect to levels of automatic motivation, with many participants describing feelings of frustration when policies and protocols of one another’s services did not align with their expectations.

These examples provide strong evidence for the use of the COM-B model as an effective framework to understand the barriers and facilitators to collaborative care. However, the COM-B model was limited in its ability to factor in the sustainability of joint working pathways over time. The Normalisation Process Theory (May & Finch, 2009) was previously explored as a theoretical framework which supports the identification of barriers and facilitators of interventions into everyday practice. It was considered that it may not lend itself to the current research as the joint working pathways were an established way of working within the team. However, the findings highlight a continued difficulty with sustaining joint working pathways which highlights the applicability of the constructs within NPT to the current research.

The constructs around ‘collective action,’ and ‘reflexive monitoring’ may have been particularly helpful additions to the COM-B model to further explore barriers around sustainability. These constructs explore agreements around how work gets done in relation to pre-existing or established processes, alongside an agreement around how to appraise the work and collaborative model.

As previously discussed, the NPT is particularly effective for research that is aiming to develop, implement and evaluate complex organisational innovations such as collaborative care. Therefore, the constructs that can support us to understand the *continued* implementation and evaluation of the pathways would have been a helpful addition to the study.

Practical implications and recommendations

As a result of the study's findings, there are several recommendations for healthcare professionals and service providers within the NHS to support the development of joint working pathways within IAPT-LTC services. Given the bidirectional links between the constructs within the COM-B model, it is suggested that bringing about change in one area of the model will have a positive impact on the other areas, further increasing engagement in collaborative care practice. Michie (2012) describes interventions associated with each of the COM-B constructs that aim to bring about behaviour change. Those elements that may be helpful to apply to the current findings are discussed below, whilst outlining whether the implications for practice are on an individual or systemic level.

Capability: Education, training, enablement.

Interventions aimed at reducing barriers related to individual factors could include the provision of cross-disciplinary training. This may support the upskilling of practitioners and support professionals to increase their knowledge base around physical and mental health concepts. Providing this training across teams may support a shared understanding and sense of integration and connectedness, rather than this training being sourced externally and being delivered to teams in isolation from one another. Training around the importance of integration and the provision of formal processes and procedures around how teams work alongside one another as part of the joint working pathways will enable practitioners to work more effectively.

Limited support is provided by Haas et al. (2011), who found that cross-disciplinary training improved levels of knowledge and receptiveness to collaborative care amongst domestic violence and child welfare workers. However, there has not been any research into this approach within the context of supporting patients with LTCs to the researcher's knowledge.

Motivation: Modelling

Interventions to reduce barriers associated with individual factors impacting on motivation could include opportunities to shadow colleagues who are already integrated with other teams. This would positively reinforce staff to want to engage in joint working and improve confidence in doing so. A recent study carried out by Monroe et al. (2021) found reciprocal shadowing across inter-professional team members was associated with a significant improvement in communication, collaboration, role understanding, team process and patient centred care. This research was conducted amongst a sample of health care professionals including nurses and physicians which provides good transferability to the current study.

For those setting up joint working pathways, it is important that there are members of the team who have had prior experience of project work and service development. This could provide shadowing opportunities, as well as a source of confidence and motivation to others. This was particularly important for participants within the current study, given that they reported there to be no previous working models or examples of service development in the field to use as a prototype.

Opportunity: Incentivisation, environmental restructuring, enablement

Practitioners need to be incentivised to support the recruitment drive as part of the IAPT-LTC expansion, therefore interventions to increase opportunity to engage in joint working should be targeted at a systemic level. Incentives could be considered financial, related to career development opportunities, or increased job satisfaction. The Psychological Professions Network (2021) supports this by encouraging service providers to allow staff to develop specialisms within their role, becoming a recognised 'champion' in a specific area. This would enable the learning of new skills, such as project management, whilst also developing a sense of ownership in their work. Participants anecdotally reported that some IAPT services provide financial incentives through rewarding a higher banding of pay for PWPS working with LTCs; however, this has not yet been documented within best practice guidance.

For joint working to be effective, there needs to be the resources for practitioners to be embedded within heath care teams. This may only be possible if services are restructured to better support co-location and provide further flexibility to enable joint working. Integrated care systems (ICSs) describe new partnerships between organisations that meet health and care needs of communities across the UK through joint budgets (NHS, 2021). Integrated care systems aim to remove divisions between physical and mental health and their service providers through better co-ordination and sharing of resources (NHS England & NHS Improvement, 2021). Integrated care systems are confirmed as part of the NHS long term plan, with government aiming to implement statutory ICSs from April 2022 (NHS, 2021). Considering the current findings, this is a timely development for the re-structuring of health and care partnerships. Future research should therefore aim to explore the extent to which ICSs reduce these systemic barriers and improve opportunity for collaborative care.

Strengths and limitations

To the author's knowledge, this was the first piece of research to explore the barriers and facilitators to collaborative care amongst health professionals working within and alongside IAPT-LTC services. Participants represented a range of professions within *Time to Talk Health* (IAPT-LTC) and across physical health care teams, alongside capturing the experiences of those responsible for setting up joint working pathways. However, there were limitations in terms of the sample which meant that experiences of some of the population may not have been captured. Although the researcher adjusted the recruitment process to invite all clinical members of *Time to Talk Health* staff to take part regardless of the amount of joint working they engaged in, only those health care professionals who were known to be working alongside the service were identified to send invitations to. Within the interviews, there was a theme linked to psychological capacity, around the lack of knowledge of other health care services, including *Time to Talk Health* being a barrier to joint working. It is therefore likely that there are many health professionals who are not aware of *Time to Talk Health* and therefore not working closely alongside the psychological therapists. This unknown population of professionals was inaccessible to the researcher and this methodology may have therefore affected the findings from the study, which may have provided greater insights into the barriers to engaging in joint working amongst those engaging in very little of it.

Seventy-seven percent of workers within the NHS are women, with men only representing 11% of clinical roles within nursing and health visiting (NHS Digital, 2018b). This is reflected within the current study, with only 3 male participants taking part out of the sample of 21. However, research has suggested that a lack of gender representation across healthcare professions could potentially lead to mismanaged, ineffective and segmented inter-professional care (Bell et al., 2014). Wider demographics of the participants including their age, ethnicity and sexuality were not captured by the researcher, which limits the findings in identifying unheard voices in the data (Connelly, 2013).

Another limitation of the research includes the design of the study, as this may have limited what was found within the data. One to one interviews may reflect what the participants felt comfortable to tell the researcher as a colleague (Duncombe & Jessop, 2002). It was noticed that those interviews that gained richer data were with those with whom the researcher has strong working relationships, and this may have been due to how comfortable both the participant and researcher felt within the process and reacting to each other. Focus groups may have provided deeper information through an exchange of ideas with more than one colleague (Wellings, Branigan & Mitchell, 2000) and may have provided observable data about the nature of communication between staff members, which may have been valuable for the research topic, around the nature of collaboration (Farnsworth & Boon, 2010).

A final limitation to consider is around the analysis of the results. The researcher used a mixed approach, using an inductive analysis initially to identify key themes, followed by a deductive approach to map the constructs of the COM-B model onto these themes. This deductive approach could be considered reductive in nature and may not align with the exploratory nature of qualitative research, which is said to usually adopt an inductive approach (Soiferman, 2010). In addition, a deductive approach may also misalign with the researcher’s epistemological approach as a contextualist and ontological approach as a critical realist (Trochim, 2006). However, it was considered that this approach was successfully implemented within previous research which is key to the current study (Carroll et al. 2020). It was also important to explore the effectiveness of the COM-B model as this provided a novel element to the study. It was therefore considered that a mixed approach was appropriate to adopt for the current study, which also allowed for an inductive analysis to take place initially.

A particular strength of this study is the fact that the findings were collected within the context of an established IAPT-LTC setting. The joint working model had therefore been established and put in place over the past four years, which differs from existing findings providing data based on a trial within a routinely delivered IAPT service (Coventry et al., 2014; Knowles et al., 2015). The high level of reflexivity practiced throughout the course of the planning and implementation stage of the study discourages impositions of meaning by the researcher and therefore promotes high levels of validity (Willig, 2013).

A particular strength of using the COM-B model lies in its ability to account for the bidirectional links between the constructs and the overlap between the themes. The framework also enables the development of practical interventions that can be implemented within NHS services to increase engagement with joint working; for example, the model tells us that increasing levels of capability and opportunity amongst staff will then also increase their levels of motivation to bring about changes in practice.

Future research

Whilst the current study provides an important insight into the barriers and facilitators associated with setting up joint working pathways and collaborative working within IAPT-LTC services, further research could help increase understanding and inform future service level interventions.

The researcher sought to explore the experiences of those in managerial positions who were part of setting up the IAPT-LTC model and developing joint working pathways. Although this bought a novel element to the research, only four participants were recruited as part of this subsample. It is therefore important that future research aims to further explore the experience of those setting up joint working pathways due to the small sample included within the current study. Further, there is anecdotal evidence that other IAPT-LTC services do not operate as a separate team to their colleagues working with non-LTC patients. It may be worthwhile replicating this study within a range of IAPT settings to better understand the barriers and facilitators to collaborative care across services which have developed their pathways very differently. This would also provide further insight into systemic barriers associated with different models of care within IAPT-LTC services.

Allied health professionals made up over half of the sample of those in physical health care teams, with only one GP taking part in the research. Future research should aim to explore differences in individual factors which may contribute to levels of motivation and perceived capability to work collaboratively within different roles, as this was explored collectively within the current study.

Considering the sociocultural impact of COVID-19, there was uncertainty around how services would establish a ‘new normal’ and the write up of the current study has taken place whilst COVD-19 continues to have an impact upon health care practice. It is therefore recommended that future research looks to explore new ways of collaborative working, which are likely to both retain some of the new practices learnt from working through the pandemic and restore old ways of working.

Conclusions

IAPT-LTC services were part of the 5 years forward plan for primary mental health provision and have been developed across the country following many early implementer sites in 2016 (National Collaborating Centre for Mental Health, 2018). Integration with physical health care teams is an important part of this development. Although previous research has explored therapists’ perceptions of challenges related to the uptake and engagement with therapy in LTCs (Carroll et al., 2021), to the author's knowledge, the experiences of health professionals working towards a collaborative care model have not been explored specifically within previous research. The current study therefore builds upon these findings by exploring the barriers and facilitators to collaborative working as part of the IAPT-LTC pathways.

Current findings therefore address a gap by understanding the barriers and facilitators of collaborative working through the COM-B model. The study highlights novel findings around the perceived sense of threat around loss of job role amongst physical health care clinicians. When services are planning to implement new working pathways, this will be important to consider, ensuring that all stakeholders are considered in decision making around joint service provision. The current findings also highlight the need for further consideration to be given at a system level around targets and adaptions put in place for IAPT-LTC sites. This would further support and validate the need for collaborative working at the implementation stages.

Constructs around capability, opportunity and motivation were found to overlap and provide an understanding of the bidirectional links between the constructs. This further provided evidence for the use of the model as a potential framework for understanding health professionals' experiences of collaborative care and the experience of senior staff in setting up joint working pathways.

However, the need to sustain joint working pathways was a key theme, in the context of ongoing challenges around retaining staff and sociocultural factors including the impact of COVID-19. Therefore, the model may benefit from an evaluative construct to fully explore sustainability of organisational innovations such as IAPT-LTC pathways. Further research would therefore benefit from piloting a framework which considers COM-B constructs and constructs from NPT to allow us to better understand collaborative working within IAPT-LTC services from an individual and organisational perspective.

31,366 words

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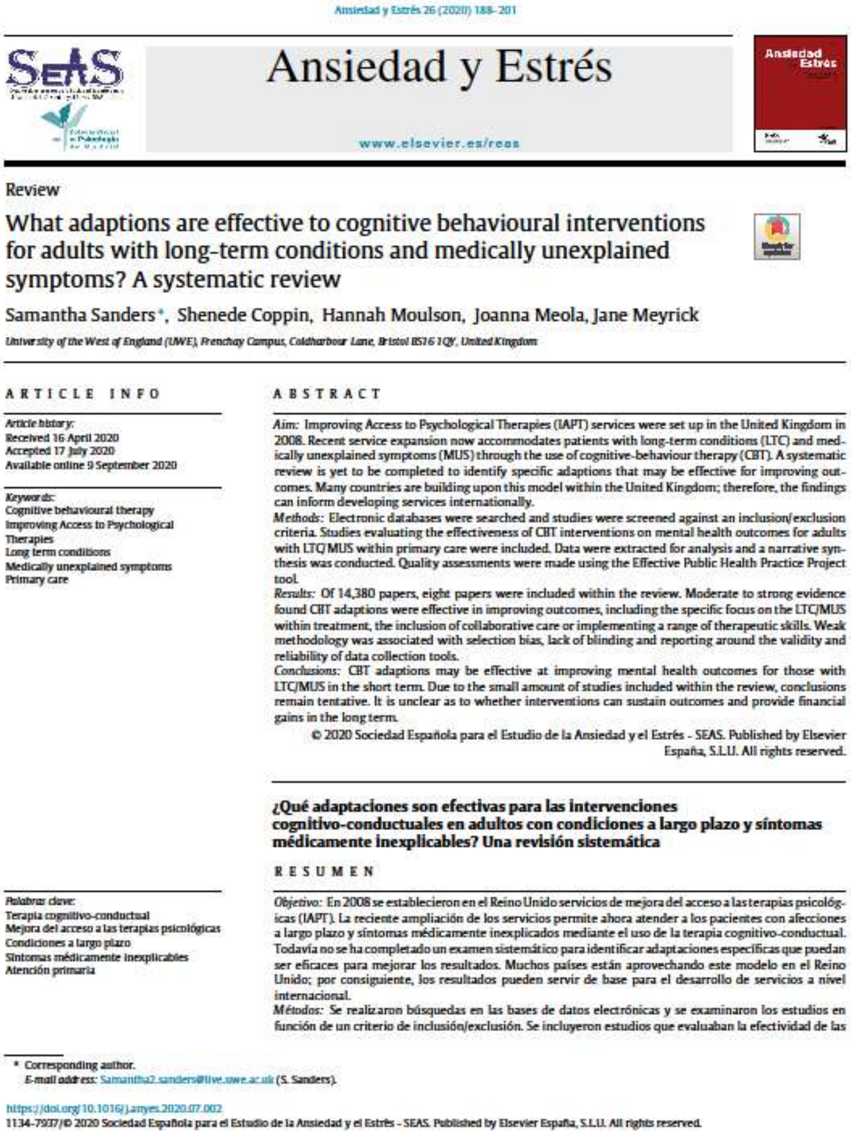
Appendices

Appendix A: Systematic Review (linked PDF)



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Review

What adaptions are effective to cognitive behavioural interventions for adults with long-term conditions and medically unexplained symptoms? A systematic review

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ABSTRACT

Aim: Improving Access to Psychological Therapies (IAPT) services were set up in the United Kingdom in 2008. Recent service expansion now accommodates patients with long-term conditions (LTC) and medically unexplained symptoms (MUS) through the use of cognitive-behaviour therapy (CBT). A systematic review is yet to be completed to identify specific adaptions that may be effective for improving outcomes. Many countries are building upon this model within the United Kingdom; therefore, the findings can inform developing services internationally.
Methods: Electronic databases were searched and studies were screened against an inclusion/exclusion criteria. Studies evaluating the effectiveness of CBT interventions on mental health outcomes for adults with LTC/MUS within primary care were included. Data were extracted for analysis and a narrative synthesis was conducted. Quality assessments were made using the Effective Public Health Practice Project tool.
Results: Of 14,380 papers, eight papers were included within the review. Moderate to strong evidence found CBT adaptions were effective in improving outcomes, including the specific focus on the LTC/MUS within treatment, the inclusion of collaborative care or implementing a range of therapeutic skills. Weak methodology was associated with selection bias, lack of blinding and reporting around the validity and reliability of data collection tools.
Conclusions: CBT adaptions may be effective at improving mental health outcomes for those with LTC/MUS in the short term. Due to the small amount of studies included within the review, conclusions remain tentative. It is unclear as to whether interventions can sustain outcomes and provide financial gains in the long term.

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¿Qué adaptaciones son efectivas para las intervenciones cognitivo-conductuales en adultos con condiciones a largo plazo y síntomas médicamente inexplicables? Una revisión sistemática

Palabras clave:
Terapia cognitivo-conductual
Mejora del acceso a las terapias psicológicas
Condiciones a largo plazo
Síntomas médicamente inexplicables
Atención primaria

RESUMEN

Objetivo: En 2008 se establecieron en el Reino Unido servicios de mejora del acceso a las terapias psicológicas (IAPT). La reciente ampliación de los servicios permite ahora atender a los pacientes con afecciones a largo plazo y síntomas médicamente inexplicados mediante el uso de la terapia cognitivo-conductual. Todavía no se ha completado un examen sistemático para identificar adaptaciones específicas que puedan ser eficaces para mejorar los resultados. Muchos países están aprovechando este modelo en el Reino Unido; por consiguiente, los resultados pueden servir de base para el desarrollo de servicios a nivel internacional.
Métodos: Se realizaron búsquedas en las bases de datos electrónicas y se examinaron los estudios en función de un criterio de inclusión/exclusión. Se incluyeron estudios que evaluaban la efectividad de las

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Appendix B: Interview guide

Interview Guide

Can you tell me a bit about your role within the NHS?

- What does your role entail?
- What types of patients do you work with?
- How do you support patients with managing their LTC?

What does the term ‘collaborative care’ mean to you?

- If you were to describe collaborative care to a friend, how would you explain it?
- How do you think this relates to your work?
- Is it important to you?
- Is important for your patients? Why or why not?

How you work with other professionals/ IAPT staff outside of your team?

- How much time do you spend working with other professionals?
- In what settings/situations do you work with other professionals?
- How do you find working with other professionals?

Have you found there to be any benefits from working with other professionals outside of your team?

- Why do you think that?
- Can you give me an example of that?
- What do you think colleagues within your team would say are the benefits?

Have there been any difficulties with working with professionals outside of your team?

- What do you think got in the way?
- What would have made this/the situation better?
- Have you/your team tried to overcome these difficulties?
- What happened?

What do you think the barriers are to joint working?

- Are there differences in expectations? Cultures? Behaviours between teams?

What are the facilitators to joint working?

- Anything that promotes joint working? Encourages it? Helps adherence?

Can you tell me how you find communication with professionals outside of your team?

- Is there anything that has made this easier/worse?
- Can you give me an example?

What do you find are the challenges of treating people with physical-mental health comorbidities?

- Do you think physical or mental health is prioritized when treating a long-term condition?
- What do you think should be the priority?

Have you been involved in setting up pathways for joint working?

- If yes, can you tell me about the process of doing this?
- How would you describe this model of care?
- How did you find trying to set this up?
- Who else was involved?
- Were there any challenges?
- Looking back on this is there anything that you would do differently, why?

Did implementing this model of care change the way you/clinicians within your teamwork?

- or change how care was delivered?
- How do you think this model of care has impacted on patients?

How would you like joint working to look in the future?

- What needs to be overcome for this to happen?
- What gets in the way currently?

Anything else you would like to say or any final thoughts?

- Anything that I haven't asked which is important to you?

Appendix C: Patient information sheet- Redacted due to personal information

Appendix D: Table to show application of quality criteria (Adapted from Tracy, 2010)

Criteria for quality (end goal)	**Means, practices, and methods of achieving quality criteria.**	**Application of criteria to this study**
Worthy topic	The topic of research is relevant, timely, significant, interesting	The current research project demonstrates high levels of relevance due to its implications for clinical practice. IAPT-LTC services are a new development within the NHS, making the project timely. There is limited research around health professional's experience of collaborative care within IAPT-LTC, further highlighting the current projects significance and potential interest to stakeholders.
Rich rigor	The study uses sufficient, abundant, appropriate, and complex • Theoretical constructs • Data and time in the field • Sample(s) • Context(s) • Data collection and analysis processes	Theoretical constructs grounded in the field of Health Psychology were applied to the current study (COM-B). Twenty-one participants were interviewed from a range of professional backgrounds which supported the collection of rich and meaningful data. The researcher ensured transparency around the methodology and data analysis process by providing a detailed description.
Sincerity	The study is characterised by self-reflexivity about subjective values, biases, and inclinations of the researcher(s), transparency about the methods and challenges	The researcher ensured that they were reflexive throughout the process of the research study which was also documented within the write up. Particular attention was paid to the researcher's influence and biases and the researcher ensured that this was also discussed with the research team.
Credibility	The research is marked by thick description, concrete detail, explication of tacit (non-textual) knowledge, and showing rather than telling, triangulation or crystallisation, multivocality, member reflections	Cross checking of coding with the research team was carried out for two transcripts. Themes were also cross checked with the research team. The researcher ensured that the findings included relevant quotes from participants to illustrate themes.

Resonance	The research influences, affects, or moves particular readers or a variety of audiences through aesthetic, evocative representations, naturalistic generalisations, transferable findings	The researcher conducted in-depth, situated analyses of contexts so that the reader is able to apply or transfer the findings to their own situation, in a way that is meaningful to them. The findings from the research resonate with other settings of clinical practice engaging in collaborative working.
Significant contribution	The research provides a significant contribution: conceptually/theoretically, practically, morally, methodologically, heuristically	The findings from the research provide recommendations to overcome barriers to collaborative working. These recommendations are theoretically grounded in the COM-B model. The findings further provide critique around the use of the COM-B model and suggestions for future developments of the model and future research in the field. The findings of the research are of clinical significance for the future development of IAPT-LTC services which is still undergoing across the UK.
Ethical	The research considers procedural ethics, situational and culturally specific ethics, relational ethics, exiting ethics	Ethical consent was obtained by UWE and HRA. The researcher ensured transparency when considering relational ethics throughout the write up.
Meaningful coherence	The study achieves what it purports to be about, uses methods and procedures that fit its stated goals, meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other	The researcher considered the method and design of the research to ensure that the aims and objectives would be met. The researcher met with the research team at all stages of the project to achieve meaningful interconnection throughout the research.

Appendix E: HRA approval (linked PDF)- - Redacted due to personal information

Appendix F: UWE ethics approval (linked PDF)- - Redacted due to personal information

Appendix G: Indemnity insurance- Redacted due to personal information

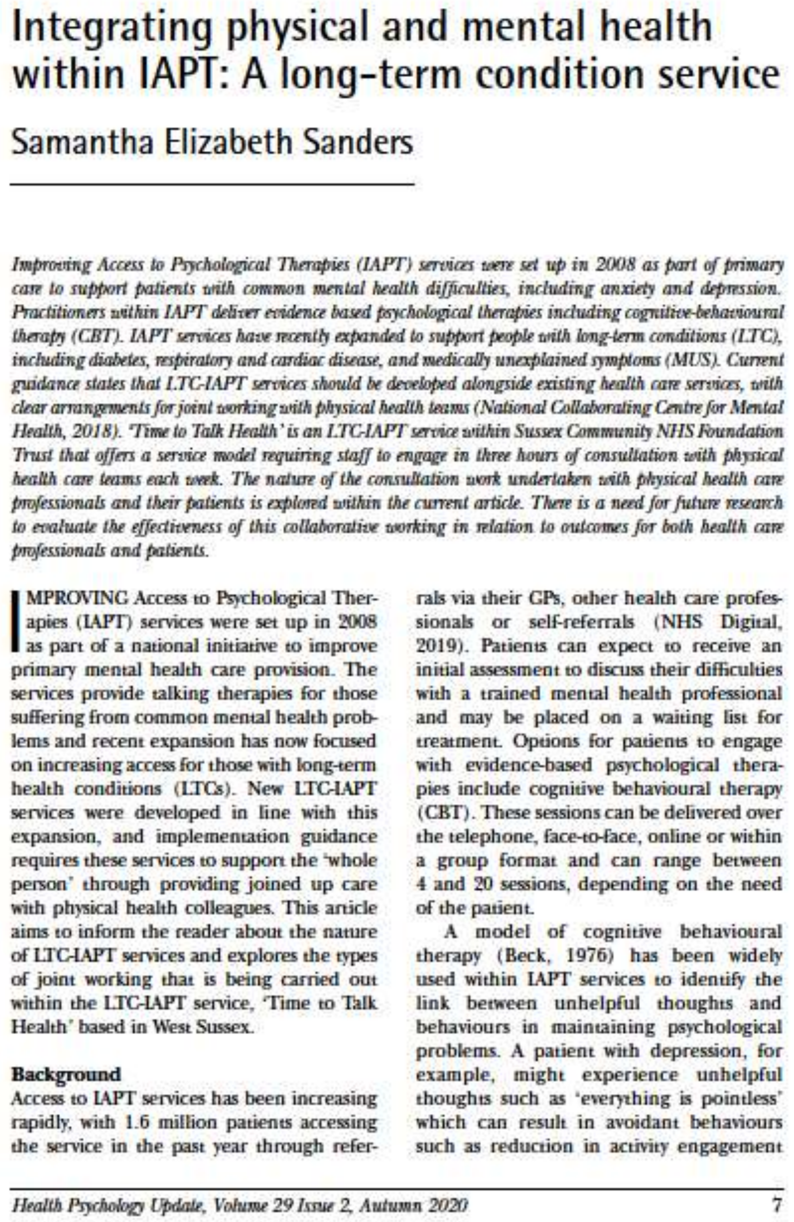
Appendix H: Verbal consent log

To be completed by the person receiving consent.
File in the Study Master File

Participant Name	Participant ID	Have you received a copy of the PIS confirm version number and date with participant]	Have you read it and understand it?	Do you have any questions?	Have your questions been answered satisfactorily?	Do you agree to being audio recorded?	Do you agree to participate?	Name of **Investigator r**eceiving consent	Signature of **Investigator** receiving consent

Consent log. V1.0. 06/08/20 ref: 286458

Appendix I: Health Psychology Update publication (linked PDF)



Integrating physical and mental health within IAPT: A long-term condition service

Samantha Elizabeth Sanders

Improving Access to Psychological Therapies (IAPT) services were set up in 2008 as part of primary care to support patients with common mental health difficulties, including anxiety and depression. Practitioners within IAPT deliver evidence based psychological therapies including cognitive-behavioural therapy (CBT). IAPT services have recently expanded to support people with long-term conditions (LTC), including diabetes, respiratory and cardiac disease, and medically unexplained symptoms (MUS). Current guidance states that LTC-IAPT services should be developed alongside existing health care services, with clear arrangements for joint working with physical health teams (National Collaborating Centre for Mental Health, 2018). 'Time to Talk Health' is an LTC-IAPT service within Sussex Community NHS Foundation Trust that offers a service model requiring staff to engage in three hours of consultation with physical health care teams each week. The nature of the consultation work undertaken with physical health care professionals and their patients is explored within the current article. There is a need for future research to evaluate the effectiveness of this collaborative working in relation to outcomes for both health care professionals and patients.

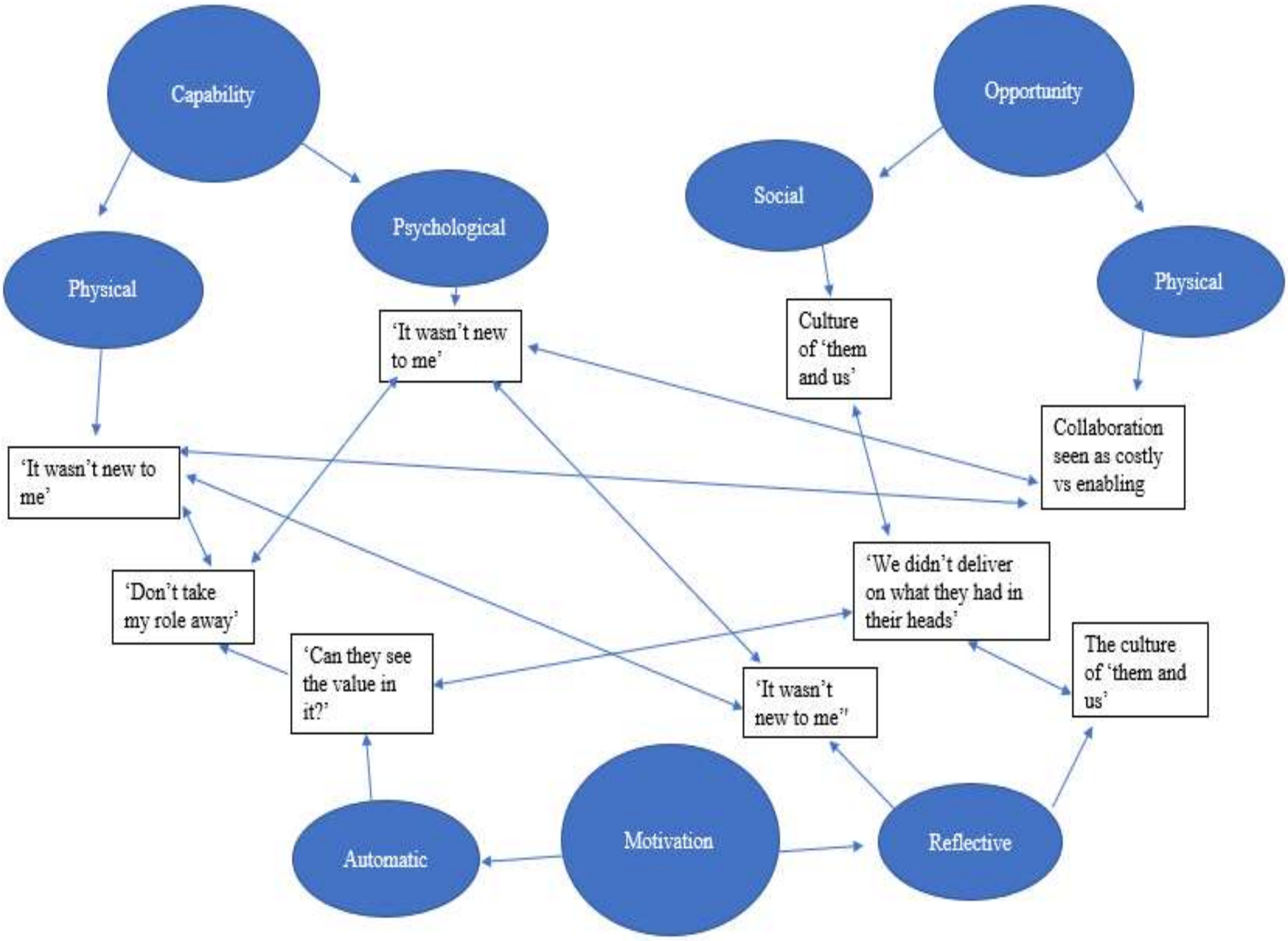
IMPROVING Access to Psychological Therapies (IAPT) services were set up in 2008 as part of a national initiative to improve primary mental health care provision. The services provide talking therapies for those suffering from common mental health problems and recent expansion has now focused on increasing access for those with long-term health conditions (LTCs). New LTC-IAPT services were developed in line with this expansion, and implementation guidance requires these services to support the 'whole person' through providing joined up care with physical health colleagues. This article aims to inform the reader about the nature of LTC-IAPT services and explores the types of joint working that is being carried out within the LTC-IAPT service, 'Time to Talk Health' based in West Sussex.

Background

Access to IAPT services has been increasing rapidly, with 1.6 million patients accessing the service in the past year through referrals via their GPs, other health care professionals or self-referrals (NHS Digital, 2019). Patients can expect to receive an initial assessment to discuss their difficulties with a trained mental health professional and may be placed on a waiting list for treatment. Options for patients to engage with evidence-based psychological therapies include cognitive behavioural therapy (CBT). These sessions can be delivered over the telephone, face-to-face, online or within a group format and can range between 4 and 20 sessions, depending on the need of the patient.

A model of cognitive behavioural therapy (Beck, 1976) has been widely used within IAPT services to identify the link between unhelpful thoughts and behaviours in maintaining psychological problems. A patient with depression, for example, might experience unhelpful thoughts such as 'everything is pointless' which can result in avoidant behaviours such as reduction in activity engagement

Appendix J: Thematic map



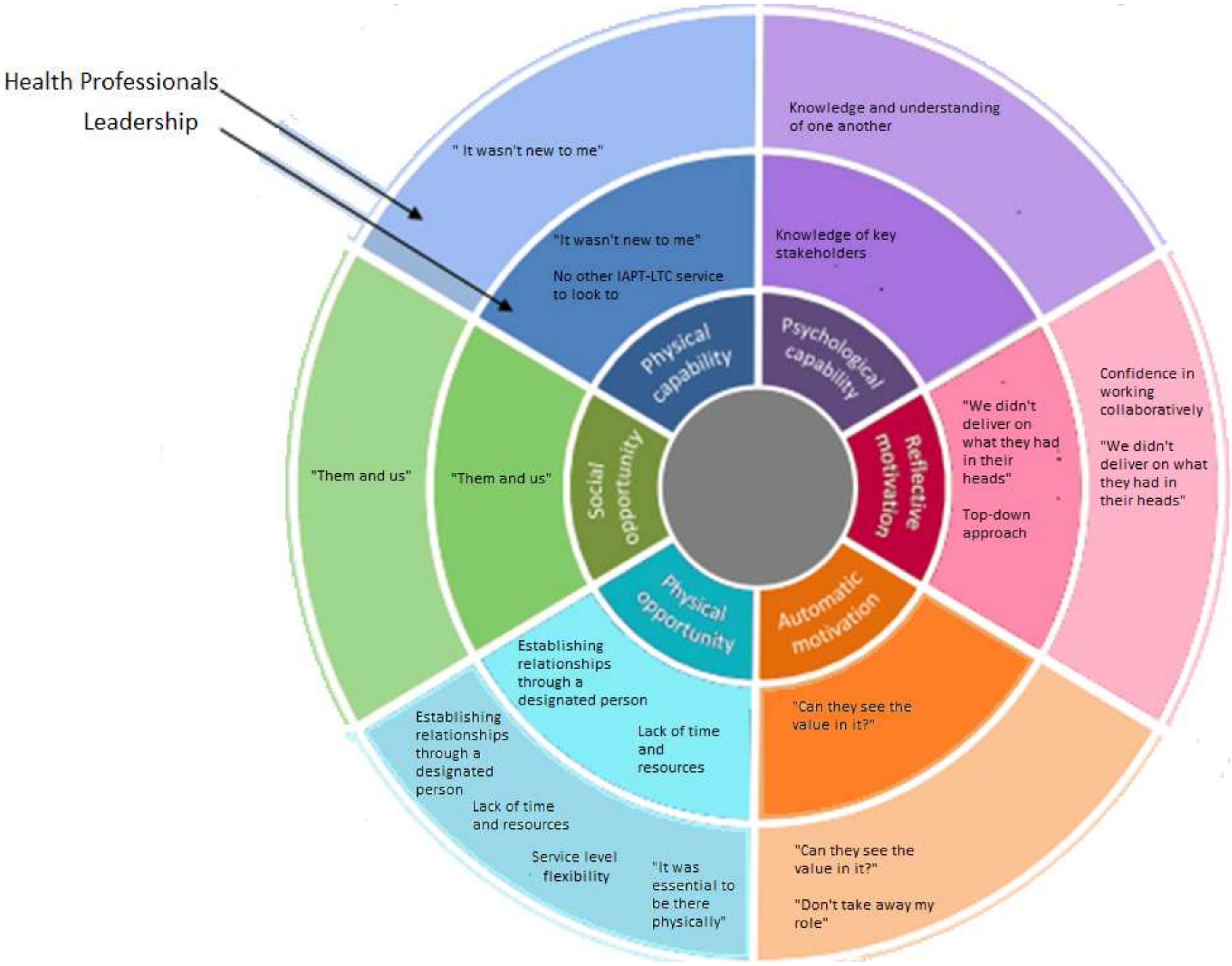
Appendix K: Theme development

Stage 1: Themes in black, developed into themes in blue

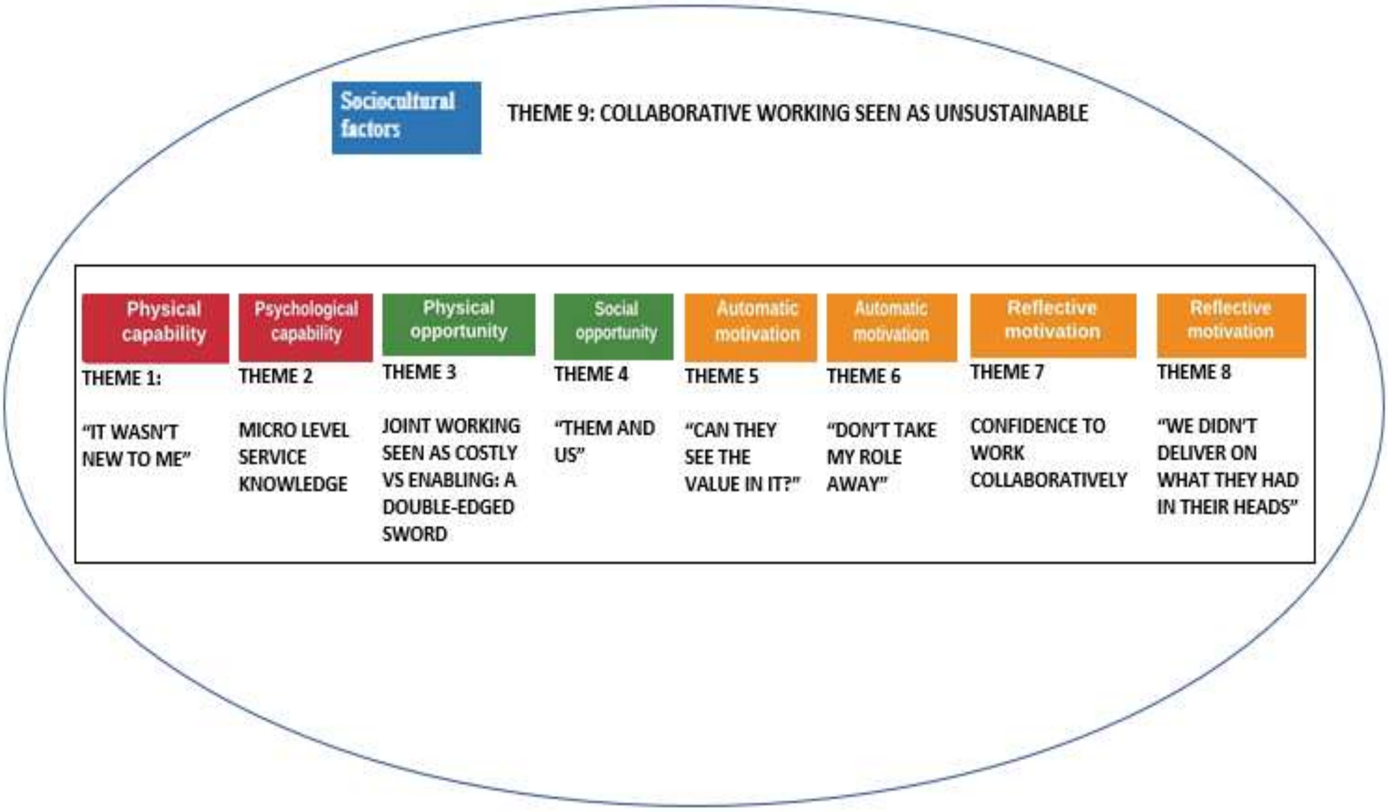
COM-B constructs	Clinical Staff	Leadership
Capability		
Physical	Previous experience of working within different job roles increasing sense of physical capability. "It wasn't new to me"	No previous working model as reference to support development of new pathways "We had no other IAPT LTC service at which to look to"
Psychological	Knowledge and understanding of other services increasing psychological capability. "Them understanding who we are"	Knowledge of key stakeholders facilitating development of pathways. "Knowing the key players in the system"
Opportunity		
Social	Culture of 'them and us' impacting on joint working "Them and us"	Culture of 'them and us' impacting setting up joint working pathways. "Them and us"
Physical	Having a key point of liaison supports joint working "Establishing relationships through a designated person" Colocation improving the visibility of staff and joint working. "It was essential to be there physically" Service flexibility needed to enable joint working "We were a little more flexible" Lack of time and resources impacts on ability to engage in joint working "We have a real difficulty with practicalities"	Having a key point of liaison supports the development of joint working pathways "Establishing relationships through a designated person" Lack of time and resources impacts on ability to develop joint working pathways effectively "We have a real difficulty with practicalities"
Motivation		
Automatic	How valued feels staff feel by colleagues and stakeholders impacts on motivation. "Can they see the value in it?"	How valued staff feel by colleagues and stakeholders impacts on motivation "Can they see the value in it?"

	Perceived sense of threat to job role impacting on motivation	
Reflective	Therapist's confidence impacting on levels of motivation to engage in joint working "It is hugely driven by a lack of confidence" Teams having different expectations of each other's roles. "We didn't deliver on what they had in their heads"	A top-down approach from commissioners impacting on motivation in the process of setting up joint working pathways "High scrutiny from NHS England" Stakeholders having different expectations of joint working pathways. "We didn't deliver on what they had in their heads"

Stage 2: Themes mapped onto COM-B model across health professionals and leadership



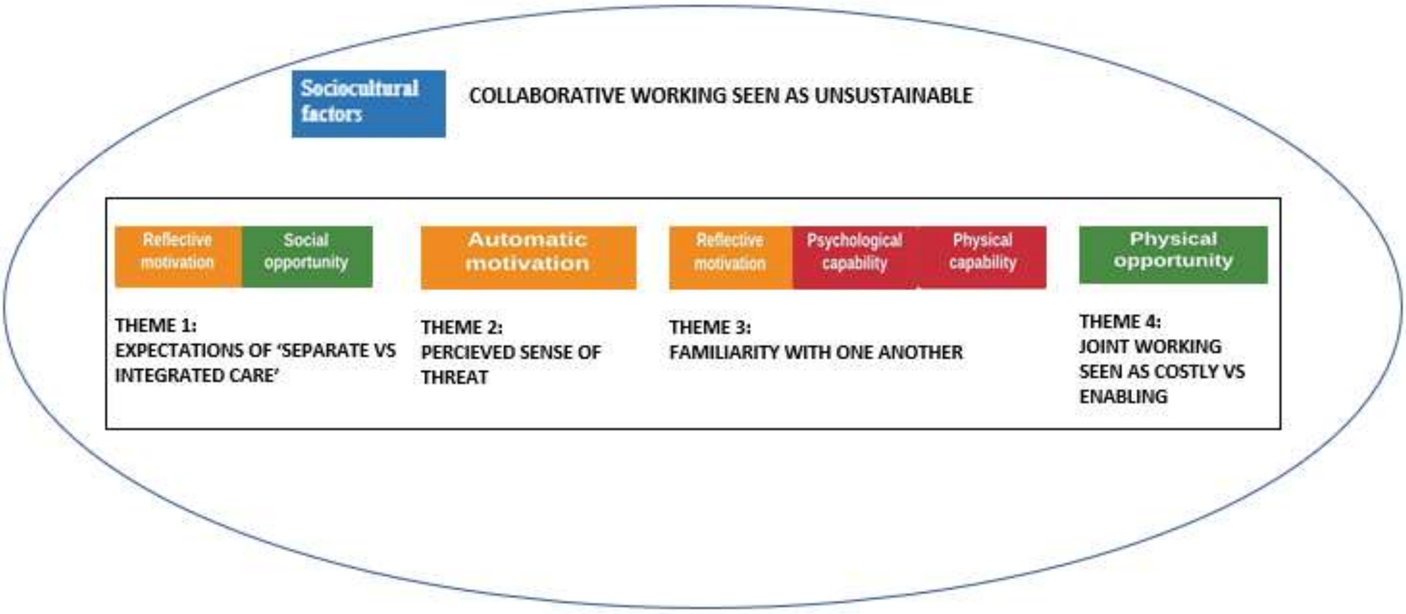
Stage 3: Themes considered concurrently for health professionals and leadership



Sociocultural factors — THEME 9: COLLABORATIVE WORKING SEEN AS UNSUSTAINABLE

Physical capability	Psychological capability	Physical opportunity	Social opportunity	Automatic motivation	Automatic motivation	Reflective motivation	Reflective motivation
THEME 1:	THEME 2	THEME 3	THEME 4	THEME 5	THEME 6	THEME 7	THEME 8
"IT WASN'T NEW TO ME"	MICRO LEVEL SERVICE KNOWLEDGE	JOINT WORKING SEEN AS COSTLY VS ENABLING: A DOUBLE-EDGED SWORD	"THEM AND US"	"CAN THEY SEE THE VALUE IN IT?"	"DON'T TAKE MY ROLE AWAY"	CONFIDENCE TO WORK COLLABORATIVELY	"WE DIDN'T DELIVER ON WHAT THEY HAD IN THEIR HEADS"

Stage 4: Themes condensed with multiple subthemes. COM-B constructs mapped onto themes, rather than themes mapped onto multiple constructs



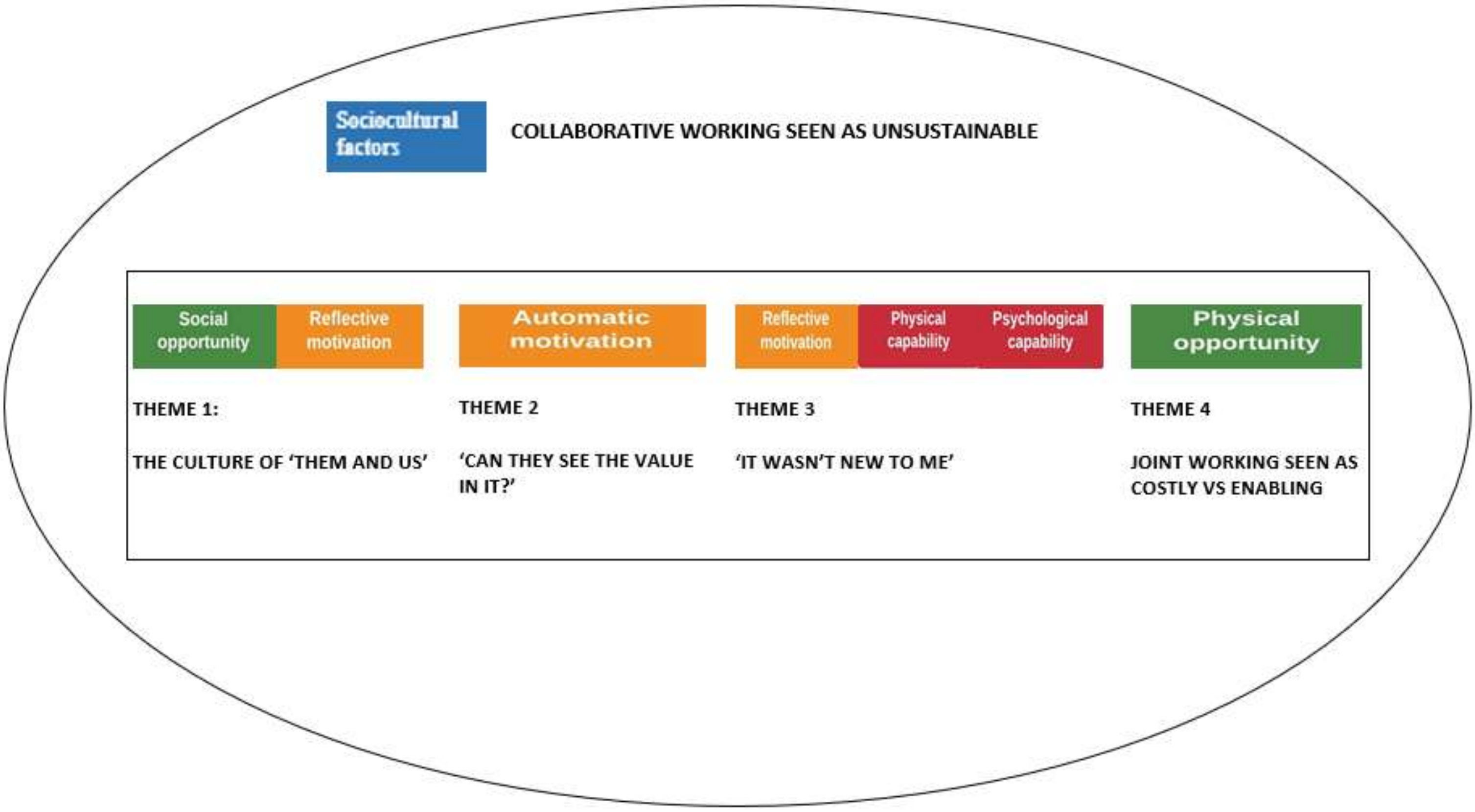
1. Expectations of 'separate vs. integrated' care
   Subthemes of
   Them and us
   We didn't deliver on what they had in their heads

2. Perceived sense of threat
   Subthemes of
   Can they see the value in it?
   Don't take my role away

3. Familiarity with one another
   Subthemes of
   It wasn't new to me
   Micro level service knowledge
   Confidence to work collaboratively

4. Joint working seen as costly vs. enabling

Stage 5: Themes and subthemes further condensed



Theme 1: The culture of ‘them and us’

Subtheme: ‘We didn’t deliver on what they had in their heads’

Theme 2: ‘Can they see the value in it?’

Subtheme: ‘Don’t take my role away’

Theme 3: ‘It wasn’t new to me’

Theme 4: Joint working seen as costly vs. enabling