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Interprofessional Collaboration in Inpatient Care

A case study at Skånes Universitetssjukhus (SUS)

by

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Abstract

There is an increased demand for managing the complex hospital organisations in which healthcare personnel operate within, which is even more so evident from today's healthcare crisis in Sweden. Since the World Health Organisation (WHO) emphasised the importance of interprofessional collaboration in 2010, research on this area has increased. However, much of the research considers only one actor, which is members of interprofessional teams, and thus misses the managerial context of other actors playing a major role for the collaboration. Therefore, this study aims to enhance the knowledge of interprofessional collaboration, both horizontally and vertically, and thereby create an understanding of how Team Members, Department Managers and Human Resource personnel collaborate by studying various barriers and facilitating factors. This study is conducted through a qualitative case study with 17 semi-structured interviews from these three actors within inpatient care at Skånes Universitetssjukhus (SUS). Findings suggest that the actors all have different experiences regarding both who carries the responsibility and what they are responsible for, in relation to the different barriers and facilitating factors. It also appears that undesirable communication, both horizontally and vertically, forms the basis on which these misunderstandings lay. However, it seems not to be a lack of willingness to collaborate and facilitate interprofessional collaboration that is the root cause, but rather a lack of time and resources. In relation to this, the organisational structures in the managerial streamline for different professions along with a very limited Human Resource Partner function working closely to the operational level of the departments, hinders proactive work, which impacts the interprofessional collaboration. In conclusion, this thesis concludes that communication is not a one-way path, but that there needs to be a responsibility within the organisation to create a well-functioning collaboration, which in turn could lead to better interprofessional collaboration. Finally, recommendations are given for future research areas that aim to optimise and deepen the understanding of all three actors, not least to strengthen the role of the Human Resource Function in the complex hospital environments.

Keywords

Interprofessional Teams, Interprofessional Collaboration, Collaboration, Barriers, Facilitating Factors, Support, Inpatient Care, Team Members, Department Managers, Human Resource Management

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1. Introduction

The world is becoming increasingly complex, and the landscape of healthcare is no exception with the merging technology advancements and escalating healthcare demands (Plsek & Greenhalgh, 2001). In Sweden, the crisis in healthcare has been a highly debated topic for several years, with the most prominent challenge being the shortage of beds. This challenge, in turn, is caused by the difficulties in keeping and staffing employees, leading to a shortage of both nurses and specialist doctors. Additionally, there is a lack of efficiency within the hospital which leads to difficulties in accompanying the right skills to the right jobs, i.e. making the best use of the healthcare resources (Dagens Medicin, 2024). During the writing of this thesis, members of the Swedish Association of Healthcare Workers have been blocking overtime and extra hours in an attempt to negotiate new collective agreements, with demands of a reduction in working hours, sustainable schedules and four weeks of uninterrupted summer vacation. This is an example of the consequences of today's healthcare challenges, where the Swedish Association of Healthcare Workers want to secure better working conditions for their members (Vårdförbundet, 2024; Torkelsson, 2024). Furthermore, the Human Resource Function plays a crucial role in facing these challenges since their focus lies in the relationship between the employer and the employee. More in depth, the Human Resource Function deals with employee's well-being and performance delivery, as well as having a strategic focus on how change can be managed (Wilkinson, 2022). In an era of great challenges within healthcare, it is important to remember that a collaborative relationship does not exclude actors operating on hierarchical levels higher up in the organisation, including the Human Resource Function (Leathard, 2003).

In 2010, The World Health Organisation (WHO) realised a "Framework for action on interprofessional education & collaborative practice" with the intention of improving global health outcomes through enhanced interprofessional education and collaborative practices. The aim with this framework is to encourage and enable a health workforce to work collaboratively across disciplines, leading to a more holistic, effective and sustainable health care system (WHO, 2010). Sweden is one of many countries which has adopted the practice of interprofessional collaboration due to the increased demand on ability to work in interprofessional teams (Ponzer et al. 2009). Furthermore, with the emerging importance of interprofessional collaboration, there has been extensive research and literature on this matter (see for example D'Amour et al. 2005; Leathard, 2003; McLaney et al. 2022; San-Martin-Rodriguez et al. 2005; WHO, 2010). However, there is less focus on how different actors, both on a vertical and horizontal level, collaborate to secure the efficiency of its execution and how these practices are supported.

1.1 Problem Statement

As mentioned in the introduction, there is a need for interprofessional collaboration in order to meet the demands of complex health care challenges (Plsek & Greenhalgh, 2001; Dagens Medicin, 2024). There is extensive literature on interprofessional education and collaborative practices within interprofessional teams (WHO, 2010), but there is lack of dimensions focusing on how actors operating on different hierarchical levels in the hospital organisation collaborate, and how this in turn affects the interprofessional collaboration. More in depth, focusing on only one actor, the members of interprofessional teams, is important for understanding interprofessional collaboration. However, this overlooks the context and dimension of the entirety of the healthcare organisation as its whole and how this ultimately plays a role in achieving interprofessional collaboration. Understanding and increasing knowledge about collaboration not only in the interprofessional teams, but between actors affecting these teams, is of uttermost importance with the complexity that inpatient care departments face (Cigna, n.d.).

1.2 Research Purpose

In alignment with the previous problem statement, the purpose of this study is to contribute to an increased understanding and knowledge about the horizontal collaboration between Team Members of interprofessional teams and the vertical collaboration between three actors; Team Members of interprofessional teams, Department Managers and the Human Resource Function. Furthermore, the purpose will be investigated by describing and analysing barriers and facilitating factors which affect the possibility to achieve interprofessional collaboration in inpatient care.

1.3 Research Question

Based on the above stated research purpose, this study will examine one main question by investigating three sub questions as follows.

How do Team Member, Department Managers and Human Resource Function collaborate in inpatient care?

a. How do Team Members of interprofessional teams experience barriers and facilitating factors influencing the interprofessional collaboration?
b. How do Department Managers of interprofessional teams experience barriers and facilitating factors influencing interprofessional collaboration?
c. How do the Human Resource Function view their support to Department Managers in facilitating interprofessional collaboration?

1.4 Delimitations

This study is limited to inpatient care departments within one area of operations at Skånes Universitetssjukhus (SUS) in Lund, Sweden. Furthermore, this study will exclude two departments within the area of operations due to limited access. This means that this study will investigate three out of five inpatient care departments within one area of operations. Furthermore, this study has included one Acting Director of Human Resources (Human Resource Manager), the Human Recourse Partner from the particular area of operations studied, three Department Managers from three different inpatient care departments within that area of operations and lastly, four Team Members from each department who are part of interprofessional collaboration. In addition, a minority of the professions working in the departments of inpatient care have a different managerial streamline, and thus a separate manager, from the rest. In this study, one doctor (of each department) who does not have the Department Manager as their direct manager will be included due to their significance in the interprofessional teams, which affects the interprofessional collaboration and the managerial streamline of all other professions (see Figure 1).

1.5 Outline of Thesis

Initially, an overarching introduction to the area of research is presented followed by an outline of the study's purpose and research questions. Thereafter, in chapter 2, a comprehensive review of existing literature of interprofessional teams, interprofessional collaboration and support from the Human Resource Function is presented. The next chapter, methodology, outlines the procedure from which the research subject was determined, along with a description of research context, research design and collection, data presentation and analysis, and a discussion about the overall quality of the study. Furthermore, chapter 4, presents the collected data, both in tables and in fluent text, to structure the material in an approachable manner, following the structure of chapter 2. Moreover, the presented data is discussed in relation to the theoretical framework. The following analysis and discussion in chapter 5, is structured in accordance with the research question where each subchapter aims to capture one research question. Finally, conclusions are drawn and suggestions for future research are being presented.

2. Theoretical Framework

This chapter will start by describing and defining the terms team, interprofessional teams and interprofessional collaboration, giving the reader a clear definition to core terms used in this study. The second subchapter dives deeper into additional factors to achieve interprofessional collaboration. Amongst them, this study has incorporated leadership, and more specifically distributed leadership, as a part of those factors to achieve interprofessional collaboration. The final chapter targets the support of the Human Resource Function. These three subchapters aim to give this study a fundamental base

to analyse and discuss interprofessional collaboration horizontally within teams, and vertically between the three actors, in relation to our research questions and research purpose. For clarification, all chapters (2.1, 2.2 and 2.3) will be analysed and discussed as barriers and facilitating factors throughout this study, as they all ultimately impact the interprofessional collaboration. Additionally, it is important to highlight that even though these different factors are divided into different chapters, and should be seen as interactive parts of a complex healthcare environment.

2.1 Team

Team is a broad term that differs from other types of groups, and it has been defined in a large variety of ways (Sandahl et al. 2017; Gilley et al. 2010). Sinclair (1992) defines a team as "*a distinctive class of group, which is more task-oriented than other groups, and which has a set of obvious rules and rewards for its members*", while Gibson et al. (2012) defines the term as "*a special type of task group, consisting of two or more individuals responsible for the achievement of a goal or objective*". Furthermore, aspects like identifiable boundaries differentiating people in the team from people outside the team (Larsen, 2003), complementary qualities (Katzenbach and Smith, 1993) and a clear outline of what a Team Membership constitutes (Harvey and Drolet, 2004) distinguish teams from other types of groups. The purpose of composing a team differs, but a common incentive is to, in one or another way, enhance productivity (Gilley et al. 2010).

Working in teams is one of the most effective forms of work, given the requirement that members of the team utilise the different expertise within the group (Cooke & Hilton, 2015). A comprehensive literature review shows that working in a team can advance decision-making, resource utilisation and goal alignment. Additionally, creativity, morale and leadership skills can be reinforced through this way of working (Gilley et al. 2010).

2.1.1 Interprofessional Teams

Teams can be arranged in various forms depending on the sector, and putting together professions form different disciplines in so called interprofessional teams is a common way to effectively organise health care teams (Comeau-Vallée & Langley, 2019). Functioning interprofessional teams have an understanding of how to utilise other Team Members' competencies, which gives them greater ability to solve problems with a high degree of complexity. Organising health care personnel into interprofessional teams can also reduce the financial burden for the organisation (WHO, 2010). In contrast to multidisciplinary teams, where professions from different disciplines work towards a common goal but make individual contributions, interprofessional teams work interactively throughout the process (Chamberlain-Salaun et al. 2013).

2.1.2 Interprofessional Collaboration

Interprofessional collaboration is a way for interprofessional teams to engage in practices that enable them to deal with an increasingly complex healthcare environment (D'Amour et al. 2005). The Team Members ability to collaborate with professionals from other disciplines affect the quality of care provided to patients (Comeau-Vallée & Langley, 2019). Furthermore, working in healthcare requires the ability to adapt and collaborate with different people due to, among other things, the constant change of team constellations. The maturity and constellation of a group have an impact on the group dynamic and the demanded leadership style. In relation to this, sustaining a functioning work dynamic, aligning goals and clearly defining visions in all settings are essential to executing a well-rounded job (Rahm-Sjögren & Sjögren, 2002).

WHO (2010) outlines that collaborative practice for health workers, including work in health care that has no direct connection to the clinical work, "*occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings*". In general, the effectiveness of interprofessional collaboration delivered by interprofessional teams is determined by their ability to share responsibilities among the members and their ability to ensure that everyone is involved in planning as well as decision-making (McLaney et al. 2022). Interprofessional collaboration requires that professionals respect and trust each other while collaborating (D'Amour et al. 2005), but also that there is good communication, clearly defined roles, a belief among the personnel of the benefits of interprofessional collaboration (San-Martin-Rodriguez et al. 2005), aligned goals, and that information is shared (Leathard, 2003). However, not only healthcare personnel in direct contact with patients are responsible for the quality of interprofessional collaboration, but also organisational factors (e.g. team resources, human resource management in terms of availability and qualification of managers, and managerial leadership and expertise) together with systemic factors (e.g. education systems and professional compensation) can hinder or facilitate interprofessional collaboration (San-Martin-Rodriguez et al. 2005).

WHO shed light on the importance of interprofessional collaboration in 2010 when a "Framework for Action on Interprofessional Education and Collaborative Practice" was issued, stating that many health care systems were fragmented, alongside ideas of how collaborative practice can be implemented in current systems to strengthen the actual systems, as well as improving patient care and safety. More in detail, collaborative practice can benefit health care personnel by, among other things, decreasing staff turnover, conflict among caregivers and hospital admissions and thereby reducing the cost of care (WHO, 2010). Additionally, Leathard (2003) discusses the phenomenon of interprofessional collaboration, pointing out that the aim extends throughout the entire organisation,

decreasing levels of stress while increasing efficiency, not only horizontally, but in between different vertical functions.

2.2 Achieving Interprofessional Collaboration

As explained in the introduction to this chapter, this specific subchapter aims to highlight different barriers and facilitating factors in achieving interprofessional collaboration, which stems from literature and theory researching interprofessional collaboration. However, this study has added the context of leadership and management, which aims to give further depth in analysing and discussing collaboration, but specifically to analyse and discuss the relation between the three actors: Team Members, Department Managers and Human Resource Function. The barriers and facilitating factors that will be brought up are: Leadership, Distributed Leadership, Building Professional Relationships, Knowing Each Other's Professions, Vision and Goal Alignment, and Communication.

2.2.1 Leadership

The term "leadership" has been around for decades yet there is not one single definition, instead, various definitions have emerged over time. For example, the traditional trait theories emphasise on charisma, intelligence or courage as traits of effective leadership whilst more behavioural theories focused on observable action and behaviours by leaders (Grint, 2010). However, more recent studies put emphasis on the relation between the leader and the follower, recognising the active agency of followers in shaping effective leadership (Sandahl et al. 2017; Bolman & Deal, 2017). According to Lundin and Sandström (2016), "*leadership is the ability to use their co-workers' gathered competence to effectively reach established goals*" (Lundin & Sandström, 2016), which aims to explain that leadership is accomplished once co-workers work together, creating a positive synergy to achieve their goals.

Apart from the various definitions of leadership, there are also different views on its relation to management, and many practitioners claim that there is a difference between the two (Bolman & Deal, 2017; Kotter, 2001; Sandahl et al. 2017; Lundin & Sandström, 2016). Kotter (2001) explains that management is coping with complexity while leadership is coping with change. They both have an accomplished agenda, however, they do so in different ways. Managing achieves its plan by organising and staffing, creating strategies to reach requirements, delegating responsibilities and monitoring implementation. Leadership, on the other hand, achieves its accomplishments by aligning people, creating a mutual vision by motivating and inspiring (Kotter, 2001). Lundin and Sandström (2016) aligns with this view, saying that there is a difference between a manager and a leader. Becoming a manager is a position given to someone from a superior, gaining legitimacy and mandate from them. A leader however, gets that same legitimacy and mandate from their subordinates. Thus,

great leadership is determined in the eyes of their followers. This is further discussed by Richards (2023), arguing that there is a difference between management and leadership, with management often being more focused on policies and procedures, whilst leadership provides direction and support. However, the two should be combined, and though they may be different, they are equally important.

Given the presentation of various literature above, this study adopts a perspective of leadership that aligns with literature which emphasises the critical role of followers acceptance and active agency. It will also put emphasis on leadership as an act to align people to achieve a set of goals. Additionally it will acknowledge the distinction between management and leadership, more precisely, being a manager or a leader. However, though they represent separate concepts, they should not be viewed in isolation but rather as complementary components, with leadership being an integrated part of management.

Distributed Leadership.

Leadership has been recognised as an exchange between leaders and followers and with that, the distributed leadership has gained relevance. Bolden (2011) explains in his research that distributed leadership is not something "done" by an individual "to" others, it works through and within relationships rather than by individual action. Furthermore, distributed leadership has also emerged in health care research, as its imminent complex environments increasingly demands individuals to share responsibility and tasks, e.g. share leadership. There is also different research on vertically versus horizontally distributed leadership. The more common research is studied from a horizontal perspective, meaning the relation between individuals in the same hierarchical structure, for example in teams (Leach et al. 2021). Rahm-Sjögren and Sjögren (2002), explains this further, saying that a part of a manager's role is delegating responsibilities to members of the team enables employees to actively participate and lead different parts of the work.

However, research on vertical distributed leadership sheds light on the importance of leadership as a distributed function that exists between multiple layers of healthcare, i.e. executive staff (e.g. Administration), Clinical Managers (e.g. Department Managers) and Clinicians (e.g. nurses, pharmacists etc). Thus, dyads of distributed leadership can mitigate negative effects of in-group and out-group comparisons between different hierarchical groups and instead enable effective communication and performance (Leach et al. 2021).

2.2.2 Building Professional Relationships

When leading teams it is crucial to have some sort of established relationship with one another (Rahm-Sjögren & Sjögren, 2002). Building professional relationships can entail various things, where

building trust is one of them. As in any human relationship, teams in health care are no exception. An example of this is that in interprofessional teams, it is of major importance for members to trust someone of another profession that they have executed their task correctly or made a correct diagnosis. A key reason behind this is because of the nature of interprofessional teams, where boundaries of both knowledge and tasks are greater than in other teams (Chamberlain-Salaun et al. 2013). Thus, these teams need some sort of interdependence, meaning, creating a relationship of trustworthiness (Gregory & Austin, 2016). If this is achieved, studies show a greater likelihood of motivation and engagement, consequently achieving higher performance (Sifaki-Pistolla et al. 2019; MacLeod, 2015).

Building trust in interprofessional teams can be challenging, with barriers such as professional hierarchical cultures within health-care settings (Comeau-Vallée & Langley, 2019). However, dictating time and effort to training and educational programs which gives opportunities and incentives to address factors of trust building, such as addressing the need of different roles, conflict management and team briefings, ultimately helps boost effective interprofessional performance (Sifaki-Pistolla et al. 2019).

Furthermore, trust is the foundation on which other elements of relationship-building lays, not only within teams, but among key players in the organisation. If trust is not established, the cost of doing business can become consequently larger (MacLeod, 2015). However, it is not only about business. Building trust between managers and clinical workers is crucial for collaboration to be upheld, as this relationship is just as important for an effective healthcare delivery system. One way of doing so is by adopting clear expectations of each other's roles and measures of accountability, taking a proactive stance in the trust-building process. By communicating vertically, barriers can be identified to then work towards a resolution (MacLeod, 2015).

However, building professional relationships, thus building trust, is limited by the size of the team you are responsible for, and the more people in the team, the more relationships to maintain (Sandahl et al. 2017). According to Lundin and Sandström (2016), the number of relationships in one team can be counted with the equation N(N-1) / 2, with N being the leader. For example, this would mean that eight Team Members with one leader creates 28 relationships. Within the hospital, teams are often bigger than that and using this equation one can quickly understand that there are many relationships to handle (Lim et al. 2014).

2.2.3 Knowing Each Other's Professions

Another aspect of leading interprofessional collaboration is boundaries between professional titles. Understanding and respecting boundaries is important in interprofessional teams due to the fact that disciplinary logic differs from interdisciplinary logic (Kvarnström, 2009). Knowing each other's professions encompasses respecting and trusting each other's abilities, but also understanding one own's profession (Lindh Falk, 2017). Furthermore, collaborative competencies can enable a functioning collaboration within an interprofessional team. The first competency is about Team Members' ability to recognize and describe both others' and their own roles, as well as respecting boundaries. The second competency is to work together effectively in an interprofessional team, both clinically and on issues outside of direct care, such as improving policies or resolving conflicts. Lastly, the third competency relates to trust, which has been further discussed in section 2.3.1. In this competency, the importance of being open to learning from each other and accepting differences among professions, as well as tolerating misunderstandings, is highlighted (Hylin, 2010).

Kvarnstöm (2009) points out that there is a risk of individuals being silenced and excluded from operations if their skills and knowledge are not valued because of their profession. Additionally, difficulties in terms of conflicts and worsened patient care may occur if the boundaries are not clear and respected. The latter might be a greater challenge in health care where the caregivers are working in different collegial constellations and where the collaborative competencies have to be worked more frequently (Hylin, 2010). Furthermore, studies have shown that Team Members in interprofessional teams have a desire to protect their own profession. However, collaboration is most often enabled when there is a requirement for it, yet hierarchical orders among professions tend to interrupt and sometimes damage collaboration, especially in the setting of a hospital where social power primarily is given to doctors (Comeau-Vallée & Langley, 2019).

2.2.4 Vision and Goal Alignment

Explicitly agreeing upon concrete visions and goals is of utmost importance for successful interprofessional collaboration. The goals have to be formed collectively, and the outcomes have to be morally and ethically shared among everyone in the team (San-Martin-Rodriguez et al. 2005; Lundin & Sandström, 2016; Rahm-Sjögren & Sjögren, 2002). Furthermore, the leader is responsible for creating forums where questions about the expected work environment, purpose, values and ethical dilemmas related to patient care, can be raised. In those forums, it is important that the leader gives an overall direction for the group (Sandahl et al. 2017). However, willingness from the healthcare personnel to collaborate forms the basis for the possibility of creating a vision and aligning goals (San-Martin-Rodriguez et al. 2005). Conflicts regarding which goals to prioritise may occur, and in

those situations, it is especially important for leaders to facilitate discussions so that a common ground can be reached (Sandahl et al. 2017).

Worth mentioning is that shaping goals and visions is just one part of the process; maintaining them is another. Furthermore, Rahm-Sjögren and Sjögren (2002) outlines that each team has to explicitly define what they want to achieve, why they want to achieve it and how they are planning on achieving it. Taking maintenance of alignment seriously within the team can positively affect work satisfaction and the feeling of purposefulness among the personnel (Lundin & Sandström, 2016).

2.2.5 Communication

Communication in healthcare settings is a broad term encompassing the transaction of messages between people, where the sent message cannot be assumed to be the same as the received one. Furthermore, communication can be either verbal or non-verbal, and the latter plays an important role in the highly complex environment healthcare personnel operate in (Kourkouta & Papathanasiou, 2014). Communication in healthcare is crucial due to the harm it can cause patients if it is not efficient (Youngwerth & Twaddle, 2011). This thesis will be limited to address two factors related to communication that may be a barrier or a facilitating factor leading interprofessional collaboration: conflict resolution and sharing of information.

Sharing information is a key for building an effective team, and it includes verbal and non-verbal (Gibson et al. 2012) as well as formal and informal communication (Youngwerth & Twaddle, 2011). Not having access to the same knowledge within the team has a significantly negative impact on the ability to collaborate in the interprofessional team (Kvarnstöm, 2009), which points to the importance of creating a solid base of knowledge among the personnel, both when it comes to trust and interpersonal relationships (Lindh Falk, 2017; Leathard, 2003). Additionally, sharing of information needs to be actively worked on in order to be maintained (Leathard, 2003). Derry et al. (2005) points out that status within the group influences the amount of information individuals have access to, where those with lower status have access to less information than personnel with higher status. Furthermore, Abramson and Mizrahi (2003) highlight that information sharing can be especially challenging when profession-specific information needs to be conveyed to another profession. Also, lack of trust among personnel can make individuals withhold information, which in turn impacts the collaboration negatively (Mikles et al. 2018). While informal communication occurs in their everyday work where each individual has to take responsibility for sharing the information, it is the leader's role to facilitate formal communication and information sharing (Youngwerth & Twaddle, 2011). This can be accomplished by arranging meetings with the teams, and by doing so, interprofessional collaboration is facilitated (Rawlinson et al. 2020). Another matter to take into consideration is what type of information is being shared among professionals. Not only should one be limited to

information about the biomedical work (i.e. the direct patient care) but also opening up to dialogue about psychosocial information (e.g. the patient's family), that helps improve collaboration and decreases tensions between Team Members (Youngwerth & Twaddle, 2011).

Another dimension, as mentioned earlier, is conflict resolution. Conflicts in the workplace can occur for many reasons, for instance because of lack of respect for each other's professions and responsibilities, independent on whether the professionals belong to the same profession or not, or due to unclarity in who is the leader of the team (Comeau-Vallée & Langley 2019; Cullati et al. 2019; Folkman et al. 2018). Putting together teams whose members have a lot in common is often mistaken as a way of minimising the risk of conflicts that instead lead to groupthink (Gibson et al. 2012). However, even though diversity in terms of different professional backgrounds has shown to increase efficiency in a health care team, it may lay the basis for conflicts. Among other things, team dynamic, trust and mental health can be damaged by conflicts in the workplace alongside interprofessional conflicts risk having consequences for the patient care (Cullati et al. 2019). Furthermore, because of the consequences of care quality, it is important to develop support programs for conflict resolution (Cullati et al. 2019). A key aspect to successfully managing conflicts is through direct communication and active listening. It is the manager's role to act as a role model, making the involved people see their part of the conflict, and contribute to the solution (Rahm-Sjögren & Sjögren, 2002; Sandahl et al. 2017). Furthermore, if a manager does not act on conflicts it will stagnant the development for the team (Sandahl et al. 2017).

2.3 Support from Human Resource Function

This chapter aims to describe both the responsibility and mission of the Human Resource Function at SUS as well as factors which can operate as barriers and facilitators to achieve effective support from Human Resource Function to managers further down in the organisation, which in this study is Department Managers at inpatient care departments.

Human Resources has a large variety of definitions, but focuses on the relations between employer and employee at its root (Wilkinson, 2022). Furthermore, the Human Resource Functions mission within SUS is to "*support Region Skåne's managers in the task of managing and developing the business and directing the strategic development of Human Resource work in order to support Region Skåne's development. It also includes making the work for managers and employees more intelligible by providing service and delivering digital tools that facilitate personnel administration work. The Human Resource Function needs to be continuously developed and has a shared responsibility to ensure that the function is perceived as a well-developed professional support function that contributes to operational benefits*" (personal communication, 22 may 2024). In "Region Skåne's HR

plan 2023 with focus areas 2023-2025" (Region Skåne, 2023) the three main focuses are to create an attractive workplace, support employee development and to use competence in the right way. Additionally, in the role description for the Human Resource Function working within one area of operation at SUS it said, among other management based responsibilities, that "*Training and guidance of interventions in management and leadership development, change management, people management and career development*" (Skånes Universitetssjukhus n.d.). In addition to this, it is important to engage in proactive work to build and support a positive workplace that actively addresses employee concerns and needs. This is ever more important in the complex healthcare environment, where the hospital organisation not only needs to attract but also attain nurses, assistant nurses, doctors and other healthcare personnel (Khatri et al. 2017).

Watson Wyatt's Human Capital Index (2002) concluded a study that aimed to answer the question: can a company that manages its human capital affect their financial performance? The study conducted a human capital index (HCI) which confirmed that the answer is not only yes, but that the two closely correlate with each other. It further provided evidence that effective HR practises is the driving force behind financial success (Watson Wyatt's Human Capital Index, 2002). Comparing a hospital caring for sick people with an organisation pricing goods and services would be to contrast two vastly different environments (Rahm-Sjögren & Sjögren, 2002). However, there are similarities in facing significant financial challenges, which will ultimately affect the employees.

As mentioned throughout this chapter, collaboration, building relationships and sharing information is not only of great importance horizontally, e.g. within the same hierarchical structure, but also vertically, meaning in between actors of different parts of the organisation (Leathard, 2003; Rahm-Sjögren & Sjögren, 2002; Gibson et al. 2012). As Leathard (2003) mentions, there are many challenges for managers to facilitate a well established structure for collaboration, but one very important aspect is to adopt a mindset of learning from the people you manage. This means, being able to be both a leader and a follower, which aligns with the more recent research within leadership and distributed leadership (Bolden, 2011). The collaboration is only as effective as the willingness of different actors, including Human Resource Managers, to facilitate that collaboration by providing the needed support. A fully collaborative relationship does not exclude those of "higher" hierarchical positions of an organisation. Actually, a management structure which is very top-down heavy is more likely to limit mid-or senior level managers to gain important knowledge about what is happening on the operating level (Leathard, 2003).

2.4 Chapter Summary

This chapter has displayed key concepts of this study, introducing and defining the terms team, interprofessional team and interprofessional collaboration. It further gives an explanation of the multivarious definitions of leadership, distinguishing the term from management and emphasises on the distributed leadership which is evidently recognised within healthcare. The chapter then highlights the importance of building professional relationships and creating trust among personnel, knowing one's own and others professions and responsibilities, explicitly agreeing upon goals and visions, sharing of information both formally and non formally, and handling conflicts in a desirable way to achieve interprofessional collaboration. Lastly, the chapter shed lights on the importance of the Human Resource Functions role in supporting interprofessional collaboration and work proactively.

3. Methodology

This chapter aims to explain the methodology used in this study. It begins with an overview of the preparatory research conducted in advance to gain a comprehensive understanding of the research setting before formulating research questions. Thereafter, the research context is described to provide a deeper understanding not only of inpatient care in general but also of the area of operation, the interviewees and their interrelations. Furthermore, a more in-depth description of the procedure for research design, data collection and data analysis is presented. The last two subheadings aim to describe how qualitative data is ensured, along with some limitations of the study.

3.1 Preparatory Research

Prior to this thesis work, several interviews were conducted to gain a comprehensive understanding of the complexity inherent in a hospital organisation. A lot of time and effort were invested in this phase of the process to identify a research subject of value that could contribute to the continuous development of the people working at the hospital and, in turn, benefit the patients.

Starting with contacting acquaintances working at the hospital and sending emails to people working within the area of interest led to a conduction of nine preparatory interviews. The interviewees were doctors, nurses within interprofessional teams, Department Managers of interprofessional teams and Human Resource Personnel in order to get a variety of perspectives. The interviews were unstructured but tried to get answers to (1) what their everyday work looks like, (2) how the organisation is structured and (3) their relationship with other actors. In further explanation, when interviewing one actor (Team Member, Department Manager or Human Resources Function), we asked about their relationship with the other two actors. These interviews, initially with our contacts and later through referrals to other individuals, ultimately provided us with an understanding of structural matters, as well as collaborative and managerial issues.

After narrowing down this study to one area of operation, a phone call to the Human Resource Partner for that specific area was made regarding possibilities of conducting a study. The Human Resource Partner then facilitated contact with the Department Managers for the inpatient care departments, who in return facilitated contact with members of interprofessional teams. In addition to the preparatory interviews, we conducted investigations into previous research on the subject. This preparatory phase enabled the formulation of research questions that were not only relevant but also suited to the given timeframe.

3.2 Research Context

SUS is, like any other hospital, a huge and complex organisation, with 12 000 employees within 100 different professions (Skånes Universitetssjukhus, n.d.). There are 19 areas of operations which contain varying constellations of both inpatient care departments, outpatient care departments and patient facilities (see Appendix 4). Inpatient care is the opposite to outpatient care, in which the patient is admitted to a hospital department. This requires the department to be staffed 24 hours of the day and Team Members need to interactively collaborate, i.e. take part in interprofessional collaboration (Cigna, n.d.). Further, each area of operations has one Human Resource Partner who serves as the operating member of the Human Resource Team.

As mentioned in chapter 1.4, this study is limited to three departments of inpatient care within one area of operations. Thereby, this study has conducted interviews with two employees from the Human Resource Function: the Human Resource Manager and the Human Recourse Partner from the particular area of operations studied. Along with this, interviews are conducted with three Department Managers from three different inpatient care departments within that area of operations, and four Team Members from each department who are part of interprofessional collaboration. One member of each team, the doctors, does not operate under the same Department Manager as the rest of the Team Members, but because they are members of the interprofessional team as well as part of the interprofessional collaboration, they were interviewed to add further dimensions to the purpose of this study. The structure of the interviewees position in the organisation can be understood by referring to Figure 1.

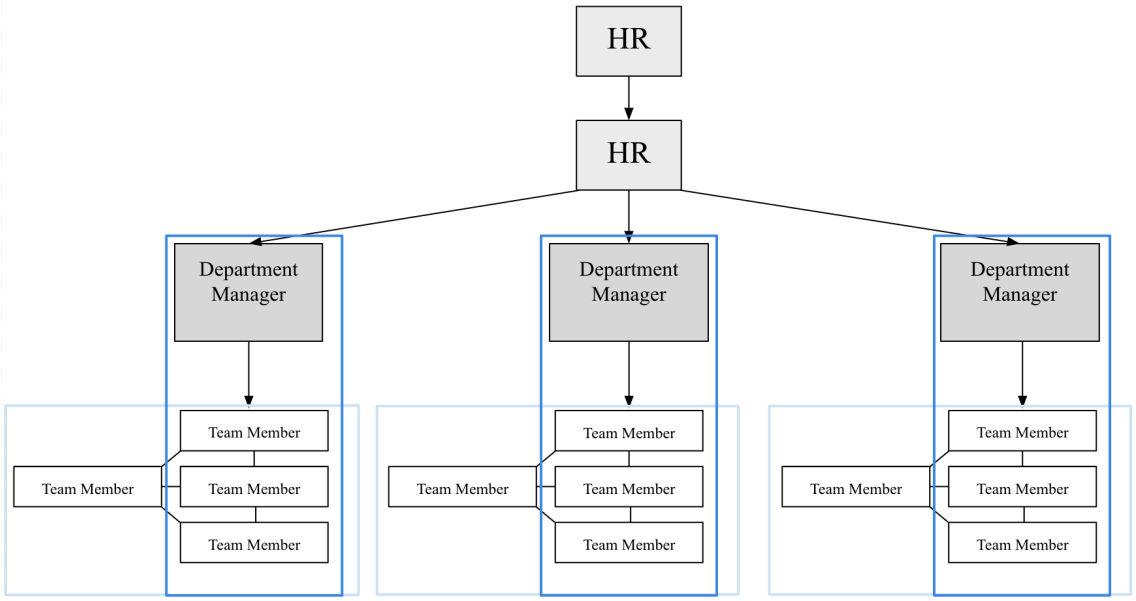

Figure 1. Organisational Scheme of Selected Interviewees.

3.3 Research Design

This study has employed a qualitative research method, gathering data from 17 interviews with Human Resource Functions, Department Managers and Team Members of interprofessional teams in inpatient care departments within one area of operations at SUS. The sampling was (1) goal-oriented and (2) snowball-based. Goal-oriented sampling means that the sampling is based on what is relevant for the research question (Bryman, 2011), while snowball sampling means that researchers make contact with people who are relevant to the study and let them help facilitate contact with additional relevant people (Bell et al. 2022). The population is around 960 employees within the selected area of operation. The goal-oriented sampling entails a selection of personnel that fit into the predetermined purpose of the study, i.e. a certain amount of personnel with a certain profession or a certain manager (see details in Figure 1). Therefore, a snowball sampling was made where the Human Resource Partner facilitated contact with Department Managers, who in turn facilitated contact with Team Members of interprofessional teams. The Human Resource Manager was contacted separately. Furthermore, it is important that the study has a representative sample of the population (Sekaran & Bougie, 2020). This study selected four Team Members from each interprofessional team, the corresponding Department Manager of each department, the Human Resource Partner responsible for those departments and, lastly, one Human Resource Manager. This way, the study sampled a small yet representative group of personnel, reflecting the reality of inpatient care departments in this area of operations.

The approach to this study is deductive, as data was collected and then analysed in relation to previous research on barriers and facilitating factors affecting the possibility to achieve interprofessional

collaboration (Bell et al. 2022). However, the perspective of the Human Resource Function had limited, to almost no previous research. Therefore the theoretical framework has been conducted both from information given by the Human Resource Function at SUS but also from interviews with Team Members and Department Managers, when asked about their relationship and perception of the Human Resource Function. Therefore, the study stays deductive, however, the support from the Human Resource Function, is more exploratory.

The qualitative research strategy was further found to be of most value, since it tends to focus on words rather than numbers and can create an understanding of how individuals interpret their social world (Bell et al. 2022). As further mentioned by Bell et al. (2022), when applying a qualitative research approach, theory and research questions often emerge from a collection and analysis of the data. Therefore, this study, as mentioned in chapter 3.2, adopted a thorough preparatory research to gather information from various parts of the hospital to generate realistic research questions which stems not only from theory but also from collection of data.

3.4 Data Collection

To get an in-depth understanding of interprofessional teams, one organisation was studied, which according to Sekaran and Bougie (2020) conforms to a case study. Furthermore, the chosen data collection method was semi-structured interviews. Semi-structured interviews can be structured in advance in terms of content, i.e. creating an interview guide, but an important part is to let the interviewee be flexible and interpret the questions. The researchers are allowed to ask questions that are not mentioned in the interview guide if it relates to something the interviewee has said (Bryman, 2011). Additionally, semi-structured interviews may entail an introductory phase, where there is room to present oneself, present the purpose with the study, ask for permission to record the interview, and other practicalities. This may be followed by “warm-up questions” that helps the interviewee get comfortable answering further questions, and further exploratory questions and follow-up questions that enable the researcher to gain nuance and a complete understanding to the given answers (Sekaran & Bougie, 2020). The interviews in this study have, in accordance with the literature, been based on an interview-guide with predetermined questions. The outline differs slightly between Team Members and Department Managers due to their distinctive roles within the organisation (see details in Appendices 1 & 2). The interview-guide for the Human Resource Function has some questions that are based on the same content as for Team Members and Department Managers, but the majority of the questions builds upon its own content and answers the interviewees gave during the interview due to the limited theory (see details in Appendix 3). The interviews with the Human Resource Function also became more unstructured than the other interviews, meaning that we (the researchers) went away from the prepared material and, instead, asked spontaneous questions, or let the respondent

freely comment on different themes. What was done is what Sekaran and Bougie (2020) calls unstructured interviewing.

Furthermore, all interviews started with an introductory phase consisting of a presentation of ourselves (the researchers), a presentation of the research subject and the purpose with the interview, a question about permission to record and transcribe the interview, and general information about what anonymity entails. Thereafter, some general questions about themselves in relation to their role at the hospital were asked, partly so that the interviewee would feel safe with us (the researchers) to further give transparent answers, and partly so that we (the researchers) would gain a greater understanding for the organisation and the people working there. Moreover, the exploratory questions related to content in our theoretical framework, and follow-up questions were primarily based on what the interviewee said, and secondly things that were either written in the theoretical framework or things that were believed to be beneficial for fulfilling the purpose of the thesis. Notably, not all questions were asked in the same order during all interviews, instead, the answers from the interviewees steered the conversation towards one question or another. However, it was ensured that all participants received all predetermined questions.

All interviews, except for the two interviews with the Human Resource Manager and the Human Resource Partner via videolink on Teams, were conducted in reality at the hospital. Sekaran and Bougie (2020) as well as Bell et al. (2022) emphasise that there are both advantages and disadvantages for face-to-face and non face-to-face interviews. Conducting the interview in reality enables the researcher to notice non-verbal cues from the respondent, while it can also make the respondent uncomfortable and hesitate the anonymity. Non face-to-face interviewing on the other hand can create greater comfort for the respondent. Because of this, the majority of interviews were held in person and the interviews held online took this into consideration, being more attentive to secure comfortability. Lastly, to gain a broader understanding of who the 17 interviewees are, see Table 1 and 2 below. The information has been anonymized to protect the respondents.

Profession	**Amount**
Pharmaceut	3
Doctor	3
Assistant Nurse	3
Nurse	2
Medical Secretary	1

Table 1. List of Professions Amongst the Team Members.

Nr.	Interviewee	Department	Time at department
Human Resource Function			
#1	Human Resource Manager	-	2 years
#2	Human Resource Partner	-	5 years
Department Managers			
#1	Department Manager	A	3 years
#2	Department Manager	B	1 year
#3	Department Manager	C	3 years
Team Members			
#1	Team Member	A	2 years
#2	Team Member	A	22 years
#3	Team Member	A	3 years
#4	Team Member	A	2 years
#5	Team Member 5	B	6 years
#6	Team Member 6	B	2 years
#7	Team Member 7	B	1 year
#8	Team Member 8	B	3 months
#9	Team Member 9	C	11 years
#10	Team Member 10	C	1 year
#11	Team Member 11	C	1 month
#12	Team Member 12	C	24 years

Table 2. List of Interviewees.

3.5 Data Presentation and Analysis

After collecting data in the form of audio recordings, all files were transferred to a USB stick. The USB stick was then used to run an Artificial Intelligence program from OpenAI called Whisper, which transcribed all interviews. Furthermore, managing a large amount of unstructured data, both in terms of transcripts and other notes, can be challenging and there are almost no established rules for how to analyse it. However, one way to analyse qualitative data in a flexible way is through thematic analysis, where patterns and themes are identified in the collected data (Bell et al. 2022; Sekaran & Bougie, 2020). The transcriptions were coded manually to identify themes based on how often a

statement that could be related to the theoretical framework recurred as well as on similarities and differences between the respondent's answers. The Empirical Data (chapter 4) was structured in accordance with the interview guides, mirroring the structure of the Theoretical Framework (chapter 2). Under each heading, findings from the coding are documented, first in a table to get an overview of the most prominent themes, and then in text to add nuance and depth to the answers presented in the table. Thereafter, in the analysis (chapter 5), one research question at a time is analysed and discussed under each main heading, where empirical data is combined with different parts of the theoretical framework. The analysis and discussions made in chapter 5 then form the basis for the conclusions drawn.

3.6 Ensuring Quality of Research

It is essential to establish a high quality of research, and three ways to do so is by ensuring validity, reliability and that no biases have impacted the results of the research. Validity refers to whether the study is investigating what it claims to investigate, and reliability measures how consistent and stable the results are. The meaning of validity and reliability can depend on the type of research being conducted. In qualitative research, both validity and reliability can be divided into internal and external dimensions. Internal validity refers to whether the results align with the collected data, while external validity refers to whether the results can be generalised to other settings. Furthermore, internal reliability refers to the degree of agreement regarding the data among several researchers, while external reliability focuses on the possibility of conducting a similar study in the future and replicating consistent results (Bell et al. 2022; Sekaran & Bougie, 2020).

Internal validity has been secured by systematically documenting findings along the way, basing the questions in the interview-guide on previous research, and being transparent about how and why every step in the process was taken. The method section and the introduction to all chapters function as guidance for this type of transparency. Another way through which internal validity is captured is through consistently reviewing data and looking for support for conclusions in more than one part of the data, but also by asking the respondents open-ended questions. Quality of the external validity, on the other hand, is enhanced by interviewing a larger amount of personnel within fewer departments, rather than vice versa. Moreover, the inclusion of personnel on various levels in the organisation and with different professions and managers, contributed to a more generalisable picture of interprofessional collaboration within inpatient care.

Furthermore, we (the researchers) assessed the data individually before structuring the empirical results and analysis, which contributes to a legitimate external reliability. The external reliability was enhanced by providing information about the research object to minimise risk of misunderstandings,

and by adapting the interview-guide depending on whether it was a Team Member, Department Manager, or someone from the Human Resource Function that was the interviewee. External validity has, on the other hand, been secured by executing an extensive review of existing literature, consequently narrowing it down to a relevant theoretical framework within the thesis.

Biases refers to defects in the data that may be caused by the interviewer, interviewee, or factors from the surrounding. The occurrence of biases can be caused by lack of trust from the interviewee, minterpretations, or non-verbal gestures from the interviewer that makes the respondent act in a certain way (Sekaran & Bougie, 2020). This study has minimised biases through several measures, one of which is establishing awareness about the risks associated with biases. Trust was built by ensuring anonymity, introducing ourselves and by beginning with open questions that were simpler in nature. Misinterpretations were avoided by taking notes, using the same words as the respondent, and minimising non-verbal gestures through awareness and maintaining a natural facial expression. Moreover, the study has a representative sample, which mitigates the risk of selection bias. All interviewees were allowed to answer general questions about their perception of key factors for achieving interprofessional collaboration before questions based on what previous research says about these factors were asked.

3.7 Limitations

The sample size of 17 interviews was limited due to the given timeframe, which in turn impacts the external validity, i.e. the generalizability of the study (Bell et al. 2022). SUS is a large and complex organisation, and if more interviews would have been conducted, the generalisability would have been higher. Moreover, although there were specifications regarding which professions and how many members from each profession should be interviewed, there was a limitation due to the fact that it was the Department Manager who facilitated contact with which Team Members who could be interviewed. We (the researchers) tried to conduct both a diverse and representative selection in each department to the extent possible, by having conversations with the Department Managers. The sample turned out to be diverse in terms of age and gender, even though some modifications regarding the time spent at the department would have been made if we (the researchers) had chosen the interviewees ourselves. Having greater diversity in terms of length of time at the department would generate an even more accurate result, even though there are respondents representing different lengths of employment.

The data could have been collected in other ways than semi-structured interviews and thereby give different results to the research questions. Semi-structured interviews are a great tool for providing flexibility for the respondents at the same time as the predetermined questions assures that the

interview is compatible with the theoretical framework. However, the interviews were not equally long, ranging from 40 to 50 minutes, which may impact how much the interviewees had time to elaborate, and thereby also affect the results. Furthermore, to make the respondents comfortable in the interview setting, all interviewees were conducted in their native language, swedish. Although it generated trustworthy answers, there are still risks associated with translation errors. To minimise this risk, we (the researchers) peer-reviewed each other's translations and adopted an approach where the essence of what a respondent said is presented instead of solely relying on a direct translation of a single word.

Another aspect to consider is that all research presented in the theoretical framework is conducted in countries other than Sweden, where this thesis is conducted. The study collects data based on human opinions which could affect the accuracy of the study. Furthermore, reality is more complex than the research can capture, which creates a risk that conclusions are drawn from overly simplified versions of reality. However, the analysis (chapter 5) and the conclusion (chapter 6) capture the complexity by combining theories, statements and research questions to provide an accurate picture of reality.

3.8 Chapter Summary

This chapter has outlined how this thesis was approached and realised. The processes started with unstructured interviews with personnel working at the hospital to identify a relevant research project, followed by narrowing down the study to SUS, one specific area of operation, three inpatient care departments, and the various actors (Team Members, Department Managers and Human Resource Function). The qualitative case study was conducted using semi-structured interviews based on interview guides - one for each actor. The anonymous interviews were transcribed and then coded manually to identify relevant themes, which were in turn interpreted in relation to the theoretical framework. The chapter also discusses how validity and reliability were ensured, followed by a discussion of biases and limiting factors of the study.

4. Empirical Results

This chapter will display the empirical data collected from the 17 semi-structured interviews. To keep the anonymity of interviewees, they will be referred to in accordance with Table 2, which does not include the profession of the interviewee. The data will further be displayed thematically in accordance with both the theoretical framework, the interview guide and answers from the interviews, starting with teams and interprofessional collaboration, then moving forward to other barriers and facilitating factors to achieve interprofessional collaboration. As mentioned in the introduction to chapter 2, views on teams and interprofessional collaboration will also serve as barriers and facilitating factors. Initially, the data is introduced in tables to identify commonly recurring themes

during the interviews, giving a visual display of both Team Members and Department Managers insights on these themes. As the Human Resource Functions acts as a supportive role, with interviews that differ from the rest, their data is displayed in a different table corresponding to relevant themes from their interviews.

Additionally, some questions were only asked to one actor and in that case, the columns associated with the actor not asked, are marked grey. Finally, it is important to understand that the tables should be understood in collaboration with the associated text, which further explains specific information and statements given from the interviewees. Also, as explained in the introduction to chapter 2 (theoretical framework), even though the barriers and facilitating factors are displayed in different chapters, they are to be seen as interactive parts to the complex healthcare environments.

4.1 Interprofessional Teams and Collaboration

No.	*Barriers and/ or Facilitators*	*Team Member (#)*	*Department Manager (#)*
1	Team Member: Believes oneself is part of one/ several interprofessional team(s) Department Manager: Believes one is leading one/ several interprofessional team(s)	#1, #2, #3, #4, #5, #6, #7, #8, #9 #10, #11	#1, #2, #3
2	Believes the interprofessional collaboration is generally well functioning	#1, #2, #4, #5, #6 #7, #8, #9, #10, #11	#1, #2, #3
3	Believes the size of the team(s) is good in relation to achieving effective team collaboration	#1, #4, #6, #7 #8, #9, #11, #12	#3

Table 3. Barriers and Facilitating Factors Regarding Interprofessional Teams and Collaboration.

Team and Team Size.

All Team Members except from #12 believed that they were part of an interprofessional team, who said that they were "*...kind of everywhere*". Team Member #2 mentioned that working in inpatient care is highly teamwork-intensive and that "*...it never really becomes well functioning around the patients if we (the team) do not work as a team... You have to see the patient from different angles*". Furthermore, Team Member #3 believes they work in interprofessional teams even though they are differently physically placed when they do not treat a patient. Additionally, all Department Managers stated that they were leading one or several interprofessional teams, even though Department Manager #3 emphasised that they are managing some professions but not others. Regarding the professions they are not managing, they said: "*I am not formally their manager. But I often involve them. Or often*

involve them in decisions. So I inform them if anything is happening in the department. Because they need to know that too".

Regarding who is viewed as part of the team, Team Member #7, Team Member #10 and Department Manager #2 believe that the whole department is a team working with the patients, while Team Member #4, #6 and #8 view the team as several smaller teams that give care to patients. Department Manager #3 highlighted that the department can be seen as one team, as well as several teams within the same department. Moreover, Team Member #6 and Department Manager #1 did not see the doctors as part of the team, and Department Manager #1 thinks it is a big challenge to create a functioning interprofessional collaboration when the doctors' managers have another agenda. In addition, Department Manager #1 and 3 saw the physiotherapists and the occupational therapists as consultants, rather than as part of the team. Department Manager one commented: "*I often forget them. And I get some criticism for that*".

Efficiency of Interprofessional Collaboration.

Team Members #3 and #12 said the interprofessional collaboration is completely dependent on who they are working with and how well they are communicating. Furthermore, Team Member #6 said: "*I think that it works well. It is the doctors who are sometimes a bit far away. They often run their own race. But the rest of the team. Absolutely*", Team Member #5 said that "*You notice when you have doctors who are here (at the department) maybe only for a week, to cover someone else, who may not be familiar with the routines, then it stops in the wheel, but when you have experienced doctors and nurses, it goes very smoothly*". Department Manager #1 highlighted that they think the doctors tend to do their own thing, but that they think it is a matter of how health care is organised. Moreover, Department Manager #3 mentions that the hierarchy is not as prominent anymore and Department Manager #1 experiences a decrease in hierarchies based on status, even though they do not believe they have actively contributed to this change.

4.2 Achieving Interprofessional Collaboration

This chapter aims to display data targeting the different barriers and facilitating factors in achieving interprofessional collaboration, and is further displayed in accordance with the theoretical framework: Leadership, Building Professional Relationships, Knowing Each Other's Professions, Vision and Goal Alignment and finally, Communication. As an introduction, this chapter will display the answers to two very open questions asked to all interviewees: (1) What are (according to you) key factors in achieving interprofessional collaboration and (2) What are (according to you) key factors in leading interprofessional collaboration. These answers are displayed in visual figures, giving a clear overview of frequently mentioned key factors on both questions.

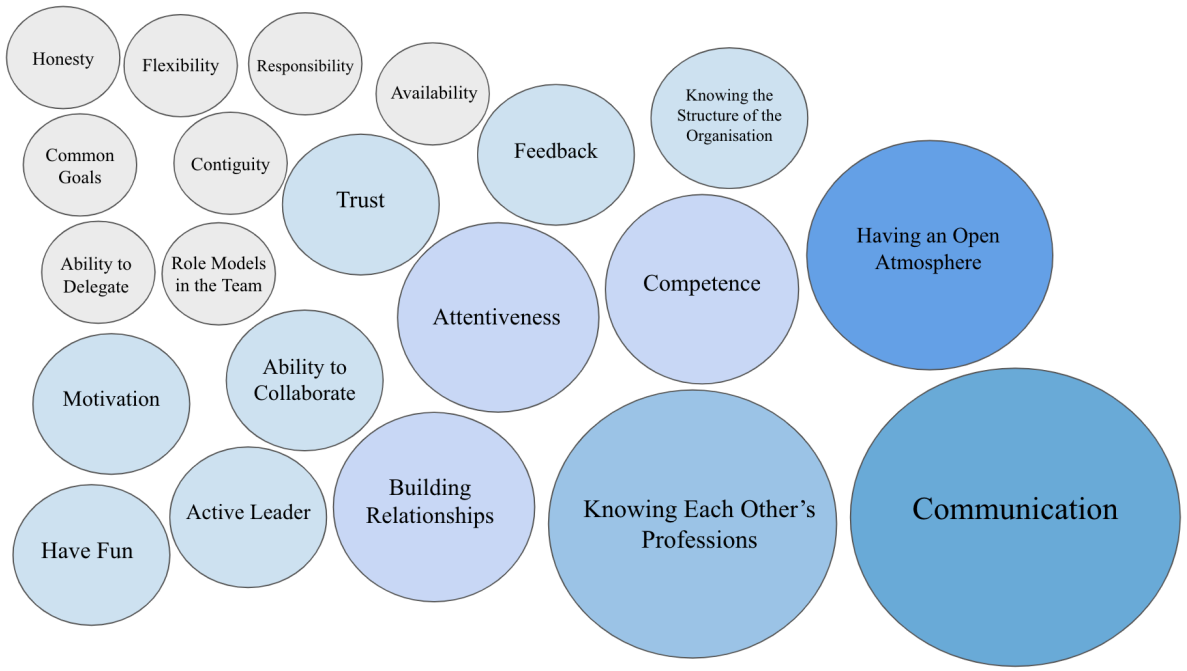

Figure 2. Perceived Key Factor(s) for Achieving Interprofessional Collaboration According to Team Members, Department Managers and Human Resource Function (visual).

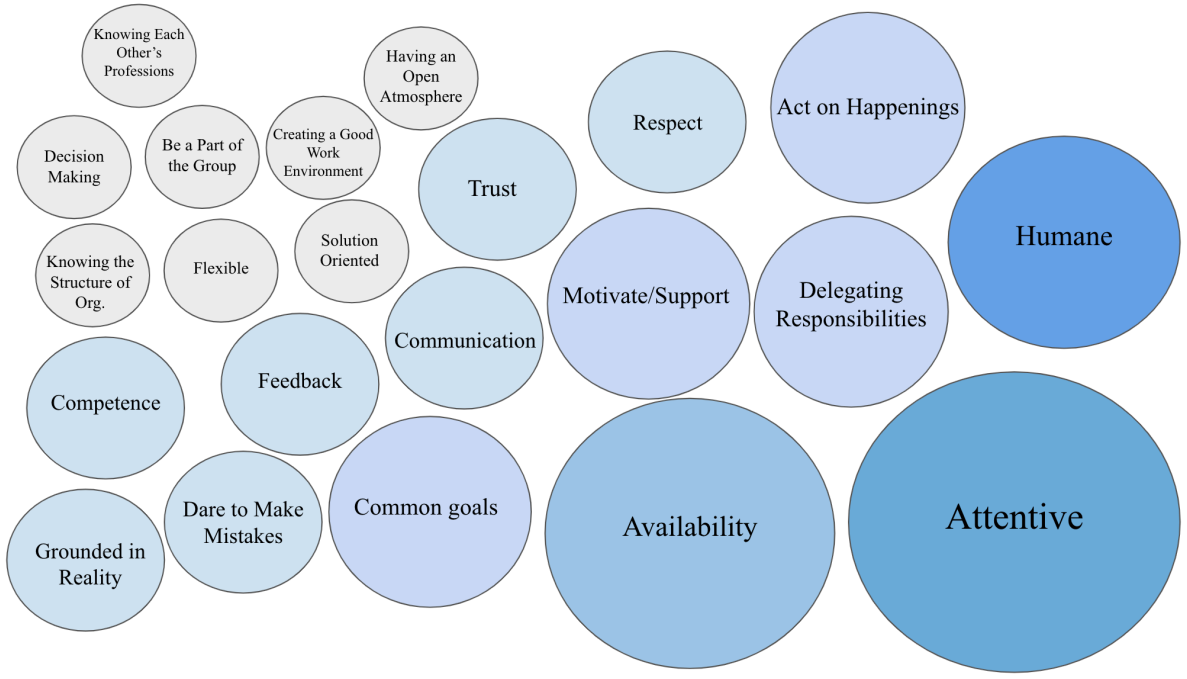

Figure 3. Perceived Key Factor(s) for Leading Interprofessional Collaboration According to Team Members, Department Manager and Human Resource Function (visual).

4.2.1 Leadership

No.	*Barriers and Facilitating Factors*	*Team Member (#)*	*Department Manager (#)*
1	Believes there is a difference between leadership and management	#1, #2, #3, #4, #5, #6, #7, #8 #9, #10 #11	#1, #2, #3
2	Team Members: Believes the Department Manager delegates responsibility to Team Members Department Managers: Believes oneself is delegating responsibilities to members of the Team Members	#1, #4, #5, #6, #7 #9, #10, #12	#1, #2, #3
3	Believes Team Members should take active action in a leadership role		#1, #3, #2
4	Believes there is a shared responsibility among Team Members	#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12	
5	Believes there is an opportunity for Team Members to take more responsibility if desired	#1, #2, #5, #6,	#1, #2

Table 4. Barriers and Facilitating Factors Regarding Leadership.

Difference between Leadership and Management.

All respondent, except from Team Member #12, believes there is a difference between leadership and management. The overarching answer was that someone can be a manager, but not every manager is a leader. In the same way, someone can be a leader without attaining a manager position. Team Member #2 said *"You can be a manager but the worst leader in the world"*. Another said "*My spontaneous thought is that leadership does not only happen at the manager level. Especially within interprofessional teams, there needs to be collaboration which requires more people to lead*" (Team Member #9). Further, some interviewees (Team Member #1 and Department Manager #1, #2, #3) said that the two roles often include different tasks. Department Manager #3 said "*The managerial role is about making decisions, while the leadership role is to realise and implement them"*. Department Manager #1 said "*Management is more static, like approving salaries for example. A leader needs to align the Team Members and facilitate the decisions*". Another Team Member said that "*A manager might only tell people what to do, while a leader sees themselves as part of the team and tries to get everyone towards the same goal*" (Team Member #1). However, this is not always very easy to do. There are a lot of difficult and "boring" tasks that need to be done (Team Member #9). They further said, *"I mean, it is not like there is ever a situation where someone comes in and says "Oh, we have just received a contribution of 100 million crowns that you can use however you want!". The reality does not look like that. It is about whether we can facilitate more hospital beds, patients or nurses"*

Delegating Responsibilities and Opportunities to Take Active Action.

Regarding delegation of responsibilities, Department Manager #1 explained that they have "*... created islands of leadership positions throughout the department*", because at first, every single question or concern was asked to them, which was not sustainable. They further elaborated that *"... this enables concerns to be filtered before it reaches me*". Likewise, Team Members #1, who operates at the same department, said that "*Department Managers delegate a lot, and I receive a lot of feedback*". This person also said that they have "*... been able to be a part of developing the role*". Others also expressed that it becomes a given in interprofessional teams, as there is a structure to follow. For example, both Team Member #3 and #12 expressed that nurses often take on a leading role due to their hierarchical positioning in relation to assistant nurses. However, this is not viewed by everyone. One person said that there is a delegation of tasks, but it is often to the same people (Team Member #4). The same person said that there is not really an opportunity for everyone to take more responsibility if desired - *"There is too much hierarchy*". Another Team Member of a different department said similarly that *"Yes there is opportunity, however, it is a bit limited depending on which profession*" (#5).

There is further a display for the importance of having opportunities to lead and delegate. Team Member #2 said "*I think it is very important to align people and get everyone onboard by delegating tasks and responsibilities*". In contrast, Department Manager #2 expressed that there is an opportunity to take on more responsibility and thus a leading role, however, *"... there have been some issues getting people to have the drive to do so"*. As seen in column three in the table, it is important for all Department Managers that Team Members take active action in taking a leading role upon them. Department Manager #3 said, *"There is a natural hierarchy in hospital settings since what the doctor prescribes is what the nurse needs to do and what the nurse prescribes is often what the assistant nurse needs to do"*. Department Manager #1 expressed that they believe their job is to create conditions for Team Members to be part of developing their roles further.

Shared Responsibility among Team Members.

As seen in the table, every Team Member believes there is a shared responsibility amongst them, however, in different ways. The majority of the answers shed light on the different professions, saying that there is a shared responsibility but that it is more so within your specific profession, and therefore lets you know what you are responsible for (Team Member #3, #6, #8). One further stressed the importance of this, saying that if the boundaries get too blurred out it can impact the collaboration and create conflict. They said, *"It is better to know what you are supposed to do. Like, you are doing that and I am doing this."* (Team Member #12). Further, the different positions and hierarchies between professions can create conflict as some professions would put themselves "above others" (Team Member #4). The different professions also seem to create informal leaders, often between a nurse and

assistant nurse (Team Member #11). Others stressed the importance of the shared responsibility due to the interprofessional collaboration, and that you need to take responsibility to step up but also that the Department Manager should motivate their employees to do so (Team Member #9, #11).

4.2.2 Building Professional Relationships

No.	*Barriers and Facilitating Factors*	*Team Member (#)*	*Department Manager (#)*
1	Experiences a professional relation to colleagues, i.e. Team Members and Department Managers	#1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12	#1, #2, #3
2	Believes there is trust amongst colleagues	#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12	#1, #2, #3
3	Believes oneself is actively building trust amongst Team Members		#1, #2
4	Believes trust is built over time	#1, #2, #3, #6, #8	#3
5	Believes trust depends on the person	#1, #2, #3, #5, #6, #8, #9, #10, #11, #12	#3
6	Believes trust depends on the profession	#1, #2, #4, #5, #6, #11	
7	Believes there is engagement and motivation in the interprofessional team	#1, #2, #3, #4, #5, #6, #7, #8, #9, #11	#1, #2
8	Believes motivation is created amongst Team Members	#5, #7, #8, #10, #11	#1, #2
9	Believes motivation is created through the Department Manager	#1, #2, #4, #6, #9, #11	#1, #2

Table 5. Barriers and Facilitating Factors Regarding Building Professional Relationships.

Professional Relationship to Colleagues.

Department Manager #1, in contrast to the other two Department Managers, actively chose to become the manager of a department where they had not worked before. Department Manager #1 further elaborated on this, criticising how the healthcare sector often appoint someone that has been a part of the team to become the Manager, which makes the job very difficult - *"Then you have pre-assumptions, relationships and other things that you can not just overlook or brush off. And if you do, those you are responsible for will hate you"*. Department Manager #2 answered yes to the question of professional relationships but said that it is hard with some coworkers since they have been part of

their team before. Team Member #10 believes it requires a fundamental understanding and respect of each other's professions to create a well established relationship. Team Member #8 said that it can sometimes become a bit difficult since some professions tend to stick to themselves due to the nature of their professions and because they do not operate at the Department at all times - *"Then it would be to build relationships in the lunchroom during lunch I guess"*.

Trust Amongst Colleagues and How it is Built.

As seen in question number three, four and five in the table, the majority of respondents believed trust depends on the person, and this correlates to both question five and six. For example, Team Member #2 said that it takes time to build trust, and that it is not only a matter of a degree. They said, *"I mean, that is good, but you need to be able to apply what you have learned"*, which indicates how trust has a lot to do with the person. Others also agreed to all three questions and that it is a mix of things (Team Member #1, #6). Every respondent arguing that trust depends on the profession, also said that it depends on the person (Team Member #1, #2, #4, #5, #6, #11). Team Member #11 said that it is important to get to know each other to gain trust, but also that there needs to be an understanding of each other's professions. Team Member #5 said *"If someone starts to doubt themselves, then I doubt them too"* which affects the trust building based on the person.

So, every respondent arguing that trust depends on the profession, also said that it depends on the person as stated above. However, not every respondent that said trust depends on the person agreed it also depends on the profession (#3, #8, #9, #10, #12). Team Member #12 said *"Just because you have worked together for a long time does not mean you have to trust them. It is a lot about chemistry"*. Team Member #9 said *"It has a lot to do with motivation and engagement from the person"*. Additionally, Team Member #3 said *"It is important to have time with each other. I do not really know what those of a profession that does not belong to this department do"*. Lastly, Department Manager #1 and #2 agreed that they are actively building trust amongst their Team Members. Department Manager #2 said that it is important to communicate and make sure they meet their Team Members and show availability.

Motivation and Engagement in the Team and How it is Created.

The final questions regards motivation and engagement within the team, where all Team Members agreed except Team Member #12 who said it has disappeared and that it might be due to the "new way" in healthcare, where people jump between hospitals or departments, which impacts the sense of community. They said, *"I have a little short time here and then I will try something new and then I will try something new again. So you do not get involved at all like you did before. You do not get a sense of "this is my department"*. The sense of community was mentioned by other Team Members, who also said it is important to have common goals (Team Member #6, #8). Team Member #5 said it

is crucial to have respect for each other and each other's professions at the workplace. In addition, both Department Manager #1 and #2 argued that they build trust by communicating. Department Manager #1 said that it has a lot to do with trust, and that if you feel as if you do not have mastered a task you have to feel safe to be able to express that.

Some Team Members who argued Department Manager plays a great role in creating motivation said delegating responsibilities and sharing goals can have a great impact (Team Member #1, #2, #9). Team Member #2 said "*It is important that members get responsibilities delegated to them but also to get an insight into each other's professions"*. Department Manager #2 further said *"It is important as a Department Manager to create a clear common vision"*. Team Member #11 also mentioned that "*It is important to have a realistic workload"*.

4.2.3 Knowing Each Other's Professions

No.	*Barriers and Facilitating Factors*	*Team Member (#)*	*Department Manager (#)*
1	Believes there is a respect for Each Other's Professions	#2, #3, #5, #7, #8, #9, #11	#1, #2
2	Believes the level of respect depends on the person	#1, #3, #5, #9, #12	
3	Believes the level of respect depends on the profession	#4, #12	
4	Believes understanding others professions is built over time	#1, #2, #3, #4, #6, #7	
5	Believes Department Managers are allocating time and resources to increase the understanding of other professions	#6, #9, #10	#1, #3

Table 6. Barriers and Facilitating Factors Regarding Knowing Each Other's Profession.

Respect for Each Other's Professions and Hierarchies.

Some of the Team Members who expressed that the personnel have respect for each other's professions, gave examples of situations where the respect sometimes gets lost. For Instance, Team Members #5 expresses that confusion can appear when newly graduated doctors enter the department and do not know exactly what their responsibilities are. Additionally, Team Member #5 thinks it is especially important to help each other in inpatient care where the tempo is high. Furthermore, Team Members #5 and #12 experience that professions are not being listened to by doctors because they view themselves as superior.

Other Team Members (#6, #12) do not believe that there is respect for each other's professions. Both of them believe the lack of respect is caused by the inherent hierarchy. Team Member #1 highlighted that the hierarchy is the cause of an indesirable working environment. Team Member #6 answered the question about if there is a respect for each other's professions by saying "*I guess it is the doctors who are sometimes a bit far away. Often running their own race. But the rest of the team. Yeah, absolutely*" and Team Members #12 also think it is a matter of hierarchies. Furthermore, Team Member #10 agrees that the way they are working is governed by hierarchy, but does not see it as an obstacle as long as it does not create conflicts. Department Manager #1 also discusses hierarchies, but from another angle. Team Member #11 agrees, saying that a working hierarchy does not have to be something negative. Moreover, Department Manager #2 does not agree that there is a hierarchy within the department and expresses that they have a well functioning collaboration with the doctors.

Why (not) Respect for Each Other's Professions.

Team Members #1 and #3 both highlight that there is a hierarchy, but that is not the main cause for lack of respect. Instead, they believe it depends on the person. Team Member #3 mentions that respect for boundaries can be exceeded if the other person is not trusted. Contrary to the opinions presented, Team Member #4 expresses that respect for each other's professions is connected to one's profession. They said, "*Rather, a little more upwards, so to speak... I have a lot of respect for doctors and so on. Whereas doctors... may not have respect for one…*". Additionally, half of the Team Members (#1, #2 #3, #4, #6, #7) believes that respect is something that has to be built over time as you get to know the person better.

Time and Resources Allocated by the Department Manager.

Team Members #2 and #11 do not think the Department Manager is allocating time and resources to facilitate an understanding of each other's professions. However, both of them mention that doctors are, in some cases, permitted to shadow a nurse during the introduction. This is something Team Member #10 would like to have but did not get, even though Team Member #10 is satisfied with the resources allocated. Additionally, Team Member #6 says that they were told to be part of another profession's APT meetings (workplace meeting, i.e. meetings with some, or all, professions and the responsible manager) but "*... it was cancelled because there was a very big shortage of health care personnel that day*". The same Team Member also believes that, even though the APT meetings are a forum to work with this, they are instead created in everyday work life.

Team Member #1 and #10 got a role description from the Department Manager during the introduction that they were then able to further develop, which both of the Team Members appreciated. Team Member #4 think enough resources are allocated on this matter, Team Member #9 believes that the Department Managers might have an ambitions to work with questions on the topic

but that there is no time but during the APT meeting and Team Member #12 says that "*Yes, we have so called planning days as it is so nicely called*" where we talk about those things, but then says that the Department Manager is not acting on it. Department Manager #1 tries to create a safe environment at the workplace, but they believe it is hard to engage Team Members that are not working under them.

4.2.4 Vision and Goal Alignment

No.	*Barriers and Facilitating Factors*	*Team Member (#)*	*Department Manager (#)*
1	Believes it is important to have common goals	#2, #6, #7, #8 #9, #11	
2	Believes it is not important to have common goals	#3, #5 #10	#1
3	Believes there are common, explicit goals	#2, #4	#1, #2, #3
4	Believes there are common, implicit goals	#1, #3, #7, #8, #9, #10	#1, #3
5	Believes there are goals specifically for the department	#1, #9	#1, #3
6	Believes goals derive from the top management in the organisation	#1, #2, #4, #5, #8, #9, #11, #12	#1, #2, #3
7	Believes there is a possibility to impact common goals	#3, #4, #12	
8	Believes the Department Manager plays an important role in facilitating common goals, i.e. if the Department Managers are doing it or not	#1, #3, #4, #7, #10, #12	#2

Table 7. Barriers and Facilitating Factors Regarding Vision and Goal Alignment.

Importance of Having Goals.

Interviewees who thought that common goals are important had different views on why that is. For instance, Team Members #7 rate this as important as there are many professions involved in the collaboration, thus things can go wrong if they are not working towards the same goal. Team Member #11 thinks it is essential to have an overarching goal, while more detailed goals are irrelevant. The same Team Member experiences that detailed goals tend to be "false" and that they just exist for the sake of it. The interviewees who found common goals unnecessary also had different views on why that is. For example, Team Member #5 and Department Manager #1 simply could not see the purpose of having common goals. However, the Department Manager thought that each Team Member should have individual goals related to their work, and that personnel with the responsibility of developing the organisation should have goals related to its continuous development. Bringing some nuance,

many interviewees mentioned patient oriented care as a focus. They did not view it as a goal, but rather as the essence of their everyday work (Team Member #1, #2, #4, #5, #8, #9, #10, #12 and Department Manager #1, #2, #3).

Explicit/ Implicit Goals and Department Specific Goals.

Three Team Members (#2, #4, #6) recognize that there are explicit goals. However, none of them know what the goals are or where they can be found. Team Member #5 believes that there are no overarching goals at all but admits that other professions might have goals within their specific profession, or alternatively, that some have individual goals. Furthermore, Department Managers #1 and #2 brought up in their interviews that goals, both department specific and more generic goals, tend to be inaccessible for Team Members. Department Manager #2 believed it is even harder to convey the message to Team Members in inpatient care and that too much emphasis is placed on the actual goal, rather than the process. In line with this, Department Manager #3 mentions that there are goals, both overarching from SUS and department specific, but that many Team Members do not know about them.

Regarding implicit goals, one Team Member (#1) and the Department Manager from the same Department (#1) mentions that their department specific vision and mindset is to become the best department in Sweden. They both point out that it is not a goal they have a plan or strategy for, but rather something that permeates the way they work and treat each other at the department. Other Team Members (#6, #7, #8, #9, #12) view their goals as something implicit that no one talks about, but that everyone is aware of. For instance, Team Member #6 said that "*You can set implicit goals for the day, but I do not think it is possible to set bigger goals that last in the long run*", Team Member #12 talks about it as an overall "approach" rather than a "goal", and Team Member #8 said "*The working environment should be desirable*, meaning that each employee has to contribute to the vision.

More in depth, departmental goals exist according to Department Managers (#1, #3). Department Manager #3 mentioned having a "*high knowledge level*" as the department's goal. Team Member #8 said that they have never seen any clearly outlined department goals, and that this might lead to concerns within the group. Additionally, several Team Members (#5, #7, #10, #12) explicitly mentions that there are no department goals, while another Team Member (#2) thinks there might be goals but that they do not know about them. Another Team Member (#11), who works at one of the departments but is not subordinate to the Department Manager, expresses that there might be goals that they did not know about since they do not really belong to the department.

Goals Derived from the Top Management in the Organisation.

The previous mentioned goal about patient-oriented care derives from top management. Based on the empirical data, Team Members and Department Managers share the perception of top management setting very broad goals that are difficult to understand. Two interviewees (Team Member #8 and Department Manager #1 expressed that they find the goals very "*fuzzy*", and Department Manager #1 elaborated on this by stating that it becomes even fuzzier as it moves higher up in the organisation. Department Manager #3, expresses that it hard to choose which goal are relevant and then make those goals applicable to a specific department, and Department Manager #2 expressed that there are so many goals on different levels in the organisation that it is hard to convey the message to the Team Members. The last mentioned Department Managers said that "*It becomes so diffuse and it can be quite difficult to grasp or understand (for Team Members)*" and that the consequences might be lack of motivation. In addition, they mention that time during meetings with other managers is not primarily prioritised to align goals.

Furthermore, some Team Members expressed strong feelings about the goals coming from the top management in the organisation. Team Member #2, for instance, expressed that "*These things that the region comes up with, their fancy words, they mock people*" and that the goals do not mirror how the top management acts themselves. Team Member #9 stated, in accordance to Team Member #2, that the goals are unrealistic and that a top manager once came to the department and said that it would be "*... wonderful if we could have empty (care) places at some point*", which they perceived as detached from reality. In addition, Team Member #12 declares that SUS has a goal of being centred around the patient. However, they admit that there are a lot of other goals, but Team Member #12 do not care about them since they find them unnecessary. Moreover, in contrast to the opinions expressed by some interviewees in the previous paragraph, some Team Members (#1, #11) expressed that there are some concrete saving targets coming from the top management that at least Team Member #1 is working with on a daily basis. Yet, Team Member #1's perception is that the saving target is a directive, rather than a goal.

The Department Manager's Role in Facilitating Common Goals and The Team Members Possibility to Impact Common Goals.

Two interviewees, Team Member #5 and #8, actively expressed that they do not think common goals are facilitated by Department Managers. Some other Team Members highlighted areas for improvement, for instance Team Member #9 who thought that the Department Managers are focusing too much on goals regarding patients, and too little on goals regarding the personnel. Hence, Team Member #7 expresses that the morning meetings function as a great forum for Department Managers to lead the group towards that specific day's goal. Additionally, Team Members #1, #3 and #4

consider the Department Managers to facilitate common goals through APT meetings and by creating new routines to improve performance.

Department Manager #2 experiences that they have to take full responsibility for facilitation because there is no support from higher instances. Both time and resources are limited, which creates difficulties in delivering the desired facilitation of common goals. Furthermore, three Team Members (#3, #4, #12) believe they have the possibility to impact common goals. Team Member #4 perceives the goals to derive from a top management level but that they can still have an opinion and Team Member #12 sees the APT meetings as an opportunity, to some extent, to express opinions.

4.2.5 Communication

No.	*Barriers and Facilitating Factors*	*Team Member (#)*	*Department Manager (#)*
1	Believes everyone has access to the same information	#1, #3, #4, #5, #6, #7, #8, #9, #11, #12	#1, #2, #3

Table 8. Barriers and Facilitating Factors Regarding Sharing Information.

Ten Team Members believe, more or less, that everyone has access to the same information at the department. Team Member #2, who did not believe the statement to be true, highlighted that things can go wrong early on because, even though they have access to the same information in the journals, the understanding of what doctors have written will most likely differ. They have a desire that more time would be released so the doctors could explain the written information. Additionally, some interviewees (Team Member #2, #4) believe the main communication streamline is made through informal communication, while some other personnel (Team Member #11 and Department Manager #1) believes that the main communication streamline is made through formal communication. Furthermore, regarding informal communication, Team Member #11 said that most of the shared information is through journals or, more or less, organised meetings. Team Member #2 highlights that it would be purposeful to formalise the communication further because they get interrupted in their everyday work when it is too informal.

Team Member #5, even though they considered the information to be shared among everyone, said that information sometimes tends to go from one part of the streamline to another, missing some professions even though they needed the information to execute a well rounded job. Team Member #6 also thinks the sharing of information is overarchingly good, however, sometimes decisions are being made that their profession does not know about until the decision is realised, which may breed tensions in the team. Also Team Member #8 gives their perspective, saying that the human factor may

play a vital role in why information does not always reach out to everyone and why tensions within the team are created. Besides, Team Member #1 comments that they have observed that some doctors expect members from other professions to do things without them communicating it. The same Team Member adds that it is not always obvious what the doctors expect, and that irritation from the doctors may appear if what was expected is not executed.

Another quote from Team Member #2, explaining how they perceive the information to get stuck within one professional category, was "*But when a patient comes here, if they are admitted urgently, the nurses talk to each other and report. And the doctors talk to each other and report. And it is not obvious that there's a flow between the professional groups*". Furthermore, Team Member #5 commented that everyone has access to the information via email but that there is no time to read it. Team Member #12 expressed that meetings, as well as email, are the main channels of communication and that it is functioning well. Instead, they believed that things may get lost between different professions in the everyday job. Furthermore, Department Manager #3 said that some professions are better at sharing information than others. They also said, "*Sometimes it is about what you are interested in as well*" and "*It is not always lack of time, actually I think some of it is actually lack of interest*". Moreover, Department Manager #2 made a statement in accordance to Department Manager #3's statement. They also think everyone has access to the same information but that not everyone takes the time, or even have the habit, of reading their emails. They also mention that sharing information is even more challenging in a 24/7 organisation, and that lack of communication can cause frustration.

No.	*Barriers and Facilitating Factors*	*Team Member (#)*	*Department Manager (#)*
1	Believes the Department Manager has an ability to manage conflicts	#1, #3, #5, #6, #7, #8, #9, #10, #12	#1, #2, #3

Table 9. Barriers and Facilitating Factors Regarding Conflict Resolution.

All three Department Managers declare that they have an ability to manage conflicts, which a majority of the Team Members (#1, #3, #5, #6, #7, #8, #9, #10, #12) agree with. More in depth, Department Manager #2 believes there is an open atmosphere that allows the Team Member to question things. Department Manager #3 highlighted the Team Members responsibility in being able to manage conflicts themselves. However, the same Department Manager makes it clear that Team Members can always approach them if needed. Furthermore, Department Manager #1 believes it is harder to manage conflicts that are rooted in the person, than conflicts that are rooted in someone's performance. In addition, Department Manager #1 and Department Manager #2 have different perceptions on anonymity in conflicts. Department Manager #1 do not allow personnel to report

conflict anonymously since that disables them to talk it through, while Department Manager #3 mention that they just implemented anonymous channels to report conflicts since they believe this enables more people to raise conflicts with them.

Team Member #4 is unsure whether there is functioning support regarding conflicts. Team Member #11 expresses that they believe it is important to have someone to turn to if needed while, at the same time, they express that they do not know whom to turn to because no one has told them. Team Member #3, on the other hand, believes the Department Manager is aware of tensions and "*... is there, understands, and wants to solve the problem*" if needed. However, Team Member #3 also mentions that there sometimes is a lack of time which disables discussions about apparent conflicts. Both Team Member #8 and #10 believes, in line with Department Manager #3, that Team Members must be able to solve conflicts themselves, but that Department Managers have a responsibility to give support if needed. Department Manager three said "*"It is important that they (Team Members) can handle a conflict without my presence or if someone misbehaves… since I am not here all the time, for example during the evening or weekends"*. Team Member #8 adds that "*A lot is up to you. You have to show that you need that support. No one comes and asks if you need help*" if a conflict arises. Additionally, another aspect is about why conflicts arise. Team Member #5 mentions that conflicts can appear because of language barriers or of different point of views between personnel that have worked for a long time and newer personnel. Team Member #8 and #10 gave another answer saying that they believe conflict often arises due to lack of respect for each other's professions. Team Member expresses a lack of support from the Human Resource Function in situations where it has been needed.

4.3 Support from Human Resource Function

As mentioned in chapter 3.2, the term Human Resource Function refers to both the Human Resource Manager and the Human Resource Partner. Otherwise, the two will be referred to as either the Human Resource Manager (#1) or the Human Resource Partner (#2).

No.	*Barriers and Facilitating Factors*	*Department Manager (#)*	*Human Resource Function (#)*
1	Believes one is leading one/ several interprofessional team(s)	Answers already displayed, see chapter 4.1	#1
2	Believes one has an idea of how the collaboration is functioning in the interprofessional teams		#1, #2

3	Believes the number of people within the area of responsibility is good in relation to providing good support	Answers already displayed, see chapter 4.1	
4	Believes there is a difference between leadership and management	Answers already displayed, see chapter 4.1	#1, #2
5	Believes, to some extent, that the Department Managers has a responsibility to lead interprofessional collaboration without support		#2
6	Believes the collaboration between Department Managers and Human Resource Function is desirable to some extent	#3	#2
7	Believes the Human Resource Function has enough insight into the interprofessional collaboration to give the needed support	#3	#2
8	Believes the Human Resource Function participates in proactive work		
9	Experiences a professional relation to colleagues, i.e. Department Managers and Human Resource Function	#3	
10	Believes there is support from Human Resource Function is case of conflict	#1, #3	

Table 10. Barriers and Facilitating Factors Regarding Support from Human Resource Function (Department Managers and Human Resource Function).

No.	*Barriers and Facilitating Factors*	*Team Member (#)*	*Department Manager (#)*	*Human Resource Function (#)*
1	Considers oneself to have a good idea of what the Human Resource Function does	#1, #9, #12	#1, #3	

Table 11. Barriers and Facilitating Factors Regarding Support from Human Resource Function (Team Members and Human Resource Function).

Leadership, Leading Interprofessional Teams and Perception of Interprofessional Collaboration.

The Human Resource Manager believes they indirectly lead an interprofessional team saying, "*When we have developed the teams... they have been distributed on the basis that the Human Resource Partner is the group of Human Resource Personnel we have most of... So they are like the keystone… Then we have the administrators… Then when it comes to the strategists and negotiators, there are not enough of them to cover all the teams"*. The Human Resource Partner, on the other hand, believes they do not lead an interprofessional team in any way saying "*It is purely operational, so to speak*" and that they were not part of that. Additionally, the Human Resource Partner highlights that their, and

the Department Manager's role, is being an employer representative, and further mentions that doctors are not part of the team. Furthermore, both interviewees answered both yes and no on the question regarding their perceived idea of the function of the collaboration within the interprofessional teams. The Human Resource Partner said mostly no because they do not see the daily work, but only get in contact with the teams if an errand about a conflict is being raised. The Human Resource Manager said, "*One challenge we have in our organisation today is that we have different managers"*, and that different professions report to different managers. The Human Resource Partner also highlighted the difficulties with having different managers for different professions that are working interactively. In addition, the Human Resource Partner said: "*You have to listen, a lot of times you have to listen. I am the bridge between them (Department Managers) and the union*".

Regarding their view on management and leadership in relation to each other, both of them agree that there is a difference. The Human Resource Partner said, "*Being a manager or a leader is not the same thing… I do not witness the managers in their leadership daily. I do not know how they perform it but I can perhaps draw conclusions based on where there is more staff turnover*", while the Human Resource Manager said that management is more about formalities while leadership may come in various forms, such as self-leadership and competence development.

Area of Responsibility and Proactive Work.

The Human Resource Manager believes they must work on making the organisation more equal, meaning that some Human Resource Partners are responsible for a lot more people than the Human Resource Partners in other areas of operation. Moreover, they said, "*After all, we are an extremely large organisation and we have quite big differences even between our areas of activity*", further explaining that the support can differ depending on what the resources look like and that the turnover rates of Human Resource Partners has been high the last few years. Furthermore, the Human Resource Manager believes they have initiated several projects and that "*... the vision is that you should get a clearer, more equal support as well as managerial and leadership development over their lifetime as a manager and leader in our organisation*".

The Human Resource Partner believes Department Managers often forget that they represent the employer. They also mention that they believe themselves to have responsibility for too many people in order to provide good support. They said, "*You know I manage 36 managers on my own…*". Additionally, they said, "*I wish I had more room for proactive work. 99 percent, well maybe not, 95 percent of my mission is very much reactive... I do not really have time, everything is done afterwards*". When further asking if more Human Resource personnel within the areas of operation would satisfy their need of working more proactively, the Human Resource Partner said "*It should be two people in this VO (area of operation). At the same time, there must always be a recipient for an*

Human Resource delivery. But if there is no time and resources in the organisation to work on it, it does not help to have two Human Resource Partners. The solution lies rather in the organisation. There is no lack of interest, they (Department Managers) are just so focused on the operational work that there is no time left". Additionally, they say that "*... it gets boring in the long run. When you are constantly putting out fires*". Furthermore, Department Manager #1 highlights that first line managers had a lot of questions in which they did not get an answer to about the, at the time occurring, blockade until 40 minutes before it came into force, even though they have known about it for 14 days. Furthermore, the Department Manager highlighted that "*... they (the Human Resource Function) do not work proactively, they work only reactively*" and "*Information comes late... the Human Resources Function should be a sounding board, not a one-line communication that appears when it suits*".

Quality of Support and Insight.

The Human Resource Manager mentions that they need to find another way to coordinate the Human Resource Function and the Financial Function so that people in the whole organisation, including the Department Managers, are making better financial decisions. The same interviewee said that they "*to some extent*" still have a diffuse image about where different functions have different focus areas. The Human Resource Partner expects the Department Managers to lead interprofessional collaboration without support to some extent, but said that it is also a matter of hierarchies and accessibility because the Human Resource Function does not have the mandate to do some things. The Human Resource Partner, on the other hand, believes that Department Managers are not contacting them due to lack of time. The Human Resource Manager believes the collaboration is built on expertise and an ability to build relationships. Furthermore, they believe that relationship building is based on communication, trust and knowledge. Additionally, the same respondent said they believe the Human Resource Partners have the best conditions to deliver messages and information to a greater extent of people within the organisation. Neither Department Manager #1 or #2 believes that the collaboration between the Human Resource Function and the Department Managers is desirable. For instance, both of them highlight that information about the, by then, ongoing blockades have not reached them. Department Manager #1 do not experience any support, but would prefer it. However, the Department Manager does believe that there is support in case of serious conflicts. Additionally, Department Manager #2 mentioned that "*Most often it has been that you need to seek help yourself. It has never been that someone has just seen that I need help. It is not something that comes automatically, and maybe you should not expect it to, but if you are completely new to a profession, you might still get more help than you ask for*", and goes on to mention that the Human Resource Function expects new Department Managers to manage their role in the same way as those who have been in that role for many years. In contrast, Department Manager #3 believes that the collaboration is functioning, and that they answer their questions rapidly regarding formalities such as legal regulations and conflicts that have arised at the department.

Regarding the Human Resource Function's insight into interprofessional collaboration and their ability to provide good support, the Human Resource Partner mentions that they have enough insight, but their visibility in the organisation is governed by the need for support. However, they mention that it is not natural for Team Members to contact them and that there must be a purpose if more visibility is to be organised. The Human Resource Manager said, "*I do not think they need to be so present in the business…walking on the department floors. I do not think that is necessary*". Instead, they believe that it is important that the Department Manager has a good relation to the Human Resource Function so that they can talk in favour of the Human Resource Function to their Team Members. Furthermore, both interviewees from the Human Resource Function mention that the only time they are visible is solely when a difficult situation has appeared. Furthermore, Department Managers had a different view on the question regarding if the Humans Resource Function should be more visible, where Department Manager #2 said "*Absolutely, and I also think that perhaps it would be good to be more transparent with what they are actually working on ... what am I responsible for, what can you ask of me*". The same Department Manager said, "*I still have difficulty with the boundaries, where can I get help and who can I get help from?*". In addition, Department Manager #1 does not believe that the Human Resource Function has insight in the operational work and would suggest them to be visible once a month in the organisation where topics like labour law and sick leave are being discussed, so that resources can be deployed in time. Department Manager #3 expresses that they have a good idea of what the Human Resource Function does, and Department Manager #1 said that they know what they do but that it is not enough.

Team Member's Perception.

Out of twelve Team Members, eight explicitly mention that they have no idea what the Human Resource Function is doing, one mentions that they know what they are doing, and three have a narrow idea. To give some examples of what Team Member who did not know what the Human Resource Function does, Team Member #2 said, "*I just get pissed off when I have contact with the Human Resource Function*", Team Member #3 said, "*I have no idea. Sounds scary, almost dangerous*". The one Team Member (#1) who believed they knew what the Human Resource Function is doing, also said that they have gotten the desired support when needed. Two of the Team Member (#5, #9) somewhat knows what the function is doing and said it could be beneficial if the Human Resource Function was more visible in the organisation.

4.4 Chapter Summary

This chapter has identified that most Team Members perceive themselves as part of interprofessional teams, however, with differing perceptions and definitions of team boundaries. Department Managers

all agreed upon leading such teams, however, not without managerial challenges, with some professions having a different managerial streamline. Additionally, the interviewees expressed that there is a difference between management and leadership, stating that management entails more "hard skills", such as approving salaries, coordinate Team Members and other administrative labour, whilst leadership entails more "soft skills", creating a sense of community with a common vision and goal. The efficiency of the interprofessional collaboration is heavily impacted by how well they have established a relationship of trust within the team. Doctors often tend to be perceived as "outsiders", not only because they operate on a different managerial streamline, but also because they do not tend to stay at the same department for as long as other Team Members, or because they often operate more by themselves. However, their different professions does not per say seem to be the major issue in relation to either trust or understanding each other, but instead, it seems to depend on the person. Furthermore, there is an overall perception that goals at the department derive from top management, which makes them difficult to understand and thus unnecessary, according to both Team Members and Department Manages. Likewise, a majority of both Team Members and Department Manages all express that they share information, further mentioning having access to journals and administrative work which regards the patients. There also seems to be a shared perception about conflict resolution, although with varying answers, where some feel that they know who to turn to in case of conflict, while others do not.

Lastly, the empirical data elaborates on the Human Resource Function as a support to the interprofessional collaboration. It is evident that both the Human Resource Function and the Department Managers express a lack of time to engage in proactive work and that there is an undesirable communication between them. Despite the Human Resource Function having a central role in support to Department Managers, they have difficulties finding time to be visually present at the operational level of the organisation, i.e. in this case, the inpatient care departments. Further, the empirical data shows different perceptions of the Human Resource Function's role, where Department Managers question how effective or important they are, as they are perceived as disconnected from reality. There also seem to be a disparity regarding who carries the responsibility to ultimately provide facilitation for achieving interprofessional collaboration.

5. Analysis and Discussion

This chapter aims to capture the purpose of this study by analysing and discussing the empirical data in relation to the theoretical framework. To ensure this, the first three subchapters (5.1, 5.2, 5.3) aim to analyse and discuss one research question each, following the same order as in chapter 1.3:

a. How do Team Members of interprofessional teams experience barriers and facilitating factors influencing the interprofessional collaboration?

b. How do Department Managers of interprofessional teams experience barriers and facilitating factors influencing interprofessional collaboration?
c. How do the Human Resource Function view their support to Department Managers in facilitating interprofessional collaboration?

All of these above-mentioned subchapters will initially analyse and discuss how the specific actors in that chapter describe who they believe are part of, or not part of, the interprofessional team and interprofessional collaboration. This is followed by analysing and discussing different barriers and facilitating factors in an integrative manner, finding themes and connections between them. These connections are structured in the most satisfactory way possible, attempting to mirror a very complex and intertwined healthcare environment. Additionally, the analysis and discussions in chapter 5.1, 5.2 and 5.3 is what creates the basis for the main research questions to be answered "How do Team Member, Department Managers and Human Resource Function collaborate in inpatient care?" which in turn is captured in chapter 5.4.

5.1 Team Members

Interprofessional Teams.

Most Team Members (excluding one, #12) acknowledge their role in an interprofessional team and understand the importance of teamwork for enhancing efficiency, reflecting consensus to literature that effective teamwork boosts productivity (Gilley et al. 2010). Despite this agreement, deeper inquiries into team composition and collaboration revealed diverse and conflicting views. While some Team Members viewed the entire department as one large team, others perceived it as segmented, with smaller more profession-centric teams within the department. For example, a large number of Team Members expressed that they did not see the doctors as part of the team, which could be worrisome, as this could undermine the importance of integral trust and respect needed when they ultimately need to collaborate and give care to the same patients (D'Amour et al. 2005). This could furthermore impact the planning and decision-making process, as they risk to not align with each other, which is essential for interprofessional teams to function (McLaney et al. 2022). Furthermore, as the empirical data reveals, Team Members expressed in varying ways that doctors can be "far away" from the rest, or that they often change departments due to their differing organisational structure at SUS. This is an additional organisational implication which ultimately affects the interprofessional collaboration (Leathard, 2003). On the contrary, one of the doctors expressed that it can be difficult to get to know everybody at the department and feel part of the team, because they often sit and operate by themselves. Then saying that relationships are often built in the lunchroom. Maybe, one has to take into consideration that doctors themselves might not be responsible for the difficulties of being seen as part of the team, but that it rather has to do with managerial implications.

Additionally, it might be the responsibility of other Team Members as well to include doctors, making them feel part of the team to ultimately build relationships and enhance interprofessional collaboration (Larsen 2003; D'Amour et al. 2005).

Leadership, Common Goals and Motivation.

According to many practitioners, there is a difference between leadership and management (Bolman & Deal, 2017; Kotter, 2001; Sandahl et al. 2017; Lundin & Sandström, 2016). The empirical data strengthens this view, as every interviewee except one agreed that leadership and management are two different things. Furthermore, management is traditionally considered to entail "hard skills", focusing on policies and procedures (Richards, 2023) but also creating strategies, organising and planning, while leadership achieves its accomplishments by aligning and inspiring people, creating a mutual vision (Kotter, 2001). Both Team Members and Department Managers seemed to agree with these differences, however, in contrasting ways. For example, Team Member #1 said, *"A manager might only tell people what to do, while a leader sees themselves as part of the team and tries to get everyone towards the same goal"*. Additionally, literature reveals that there is not only a difference between management and leadership, but consequently between a manager and a leader. Lundin and Sandström (2016) argues that someone is given the role of a manager from their superior, but that a leader contrastingly gets their legitimacy from their subordinates. Team Member #2 pinpointed this, saying that *"You can be a manager but the worst leader in the world"*. What can be said about Team Members' views on leadership and management, is that they all seem to have pretty strong and sharp opinions, not only emphasising the difference, but on the importance of leadership attributes (see Figure 2 & 3). However, when going further into the interviews, diving deeper into the contingencies of the department, the leadership attributes seemed to be missing. This in turn implies that there might not be the type of focus on leadership that they ultimately want and need. This became evident when we asked them about other barriers or facilitating factors.

Interestingly, having common goals was not one of the most important factors discussed by Team Members either for leading or achieving interprofessional collaboration even though, according to Lundin and Sandström (2016), *"leadership is the ability to use their co-workers' gathered competence to effectively reach established goals"*. Similarly, literature states that having clearly defined goals is of major importance for successful interprofessional collaboration (San-Martin-Rodriguez et al. 2005; Rahm-Sjögren & Sjögren, 2002). What is further interesting is that the data reveals some contrasting opinions about common goals depending on the context of the interview. When asked about drive and motivation, some Team Members expressed that having common goals is important to have a sense of community and motivation, and likewise, other Team Members believed common goals are important for the Department Manager to facilitate in order to create engagement. However, when explicitly asked about the importance of goals on its own, only half of the Team Members believed it is

important. Those who did not think it was important explained that they did not see the point, as the overarching goal at the hospital is to secure patient care, and that it is rather something given, not something that has to be portrayed in some goals. Similarly, those who expressed that there are explicit goals at their department interestingly did not know what those goals were. Conclusively, it is safe to say that there seems to be some belief in having common goals, however, that belief gets diminished when goals are too abstract and far away from everyday operations. This in turn implies poor communication of goals deriving from the top management.

Those who highlighted that there were implicit goals had different views on what they were. At one department, one Team Member explained that there are no set goals with clear strategies, but a vision and mindset to become the best department in Sweden, which then permeates the way they work together at the department. Members of other departments viewed implicit goals in various ways, one stating that "*You can set implicit goals for the day, but I do not think it is possible to set bigger goals that last in the long run*". Other Team Members talked about "approaches" and expressed that the approach is to have a good working environment in order for each employee to take responsibility and contribute to the vision, again which was not clearly defined. According to (San-Martin-Rodriguez et al. 2005; Lundin & Sandström, 2016; Rahm-Sjögren & Sjögren, 2002), goals have to be both morally and ethically shared amongst everyone in the team. Given the empirical data stated above, this would understandably be hard to achieve when not only the goals per say seem to differ, but even the perception of what a goal is and what it means. This in turn can give rise to conflicts because there is no established alignment between Team Members, which ultimately affects the overall motivation at the department.

San-Martin-Rodriguez et al. (2005) says that creating goals and visions relies on the willingness of healthcare personnel to collaborate. From the empirical data, the lack of willingness seems to derive not from lack of motivation, but lack of understanding. This is something that the leader plays an important role in establishing (Sandahl et al. 2017). The leader should create forums where questions about the experiences, values and dilemmas can be raised and additionally, there needs to be an overall direction for the group to know the purpose of their goals. They should also explicitly define what they want to achieve and how (Rahm-Sjögren & Sjögren, 2002). Again, from the empirical data, this is not done according to the Team Members. When asked to elaborate, the answer to this instead seems to stem from lack of time and financial resources. As one Team Member said, *"I mean, it is not like there is ever a situation where someone comes in and says "Oh, we have just received a contribution of 100 million crowns that you can use however you want!". The reality does not look like that. It is about whether we can facilitate more hospital beds, patients or nurses".* Another said that it would be *"... wonderful if we could have empty (care) places at some point"*. Again it seems to be a lack of willingness and interest from Team Members to have established goals. However, it is not

surprising as many Team Members struggle to see the purpose and meaning with the goals in their everyday work. Maybe, a suggestion would be to not only create patient-centric goals, but personnel-cetric goals, targeting the Team Members directly and thus increasing motivation as they would feel more seen and heard. This was also expressed in the empirical data from Team Member #9.

Adding further context to this, Team Members were also asked about where the goals derive from, with the majority answering that it comes from the top management, where patient-centred care is one of them. Additionally, they all seemed to share the perception that goals from the Top Management are very broad and difficult to understand. The further up in the organisation, the harder it is to understand. It even provoked some Team Members as it does not align with their reality. Team Member #2 expressed "*these things that the region comes up with, their fancy words, they mock people*". Another said that some of them feel more like directives rather than goals. Here, the Department Managers play an important role, according to the empirical data. One Team Member suggested that morning meetings and APT meetings should be utilised to better facilitate understanding of the common goals.

Motivation, Distributed Leadership and Sharing Responsibilities and Hierarchies.

Theory states the importance of distributed leadership in healthcare due to its complex environments which demands collaboration and sharing responsibilities (Leach et al. 2021). The empirical data strengthens this view, and it seems to affect not only collaboration but the motivation in the team. The majority of Team Members agreed that the Department Manager delegated responsibilities to them and stressed that having an opportunity to take more responsibility plays an important role in aligning people and creating motivation. However, there were some contrasting answers when addressing who is responsible for the creation of that motivation and "taking responsibility". On the one hand, some Team Members believe that the distributed responsibility often goes to the same people, which could impact aligning people and thus creating a lack of motivation.

Delegating responsibilities is a part of a manager's role to enable employees to actively participate and lead different parts of the work according to (Rahm-Sjögren & Sjögren, 2002). Furthermore, other research shows that if there is an established interdependence there is a greater likelihood of motivation and engagement (Sifaki-Pistolla et al. 2019; MacLeod, 2015). However, only four out of twelve Team Members believe there is room to take more responsibility if one wants to. This could again be explained due to the fact that responsibility is only given to the same people, along with perceived hierarchies between the professions. One Team Member said that it is difficult to take on more responsibility because "*There is too much hierarchy"* which then creates boundaries to take opportunities to lead or take on new tasks. Team Members further said, because of these boundaries,

each profession has its given tasks and roles. It becomes a bit “given” what you are supposed to do and one would then not take an active role as that might step over someone else, creating tensions and possible conflicts. Conclusively, due to the hierarchical settings it is even more important for the Department Manager to play an active role in delegating responsibility, and actively mitigate those hierarchies. This way they ensure that personnel in lower hierarchical positions will also feel an interdependence and motivation.

Knowing Each Other's Professions, Building Trust, Motivation and Professional Relationships.

Knowing each other's professions is crucial to achieve interprofessional collaboration (Kvarnström, 2009; Hylin, 2010). When the Team Members were asked about how to build established relationships and trust among each other, knowing, respecting and understanding each other's professions was mentioned various times. This aligns with theory stating that the interprofessional teams demand these factors due to the inherent nature of specific boundaries of professions (Gregory & Austin, 2016). Interestingly though, the majority of Team Members expressed that trust in each other's professions depends on the person rather than the profession. As expressed in the empirical data, every respondent arguing that trust depends on the profession also said it depends on the person, but not the other way around. The reason behind this, the empirical data reveals, has to do with the chemistry of the person you work with, the motivation or engagement from a specific person or lastly - that it takes time, as it takes time to get to know someone and thereby trust them in their profession. One Team Member expressed, “*If someone starts to doubt themselves, then I doubt them too”*. The answers found regarding the need for time to understand each other's profession poses some challenges, as time is significantly limited in inpatient care. This becomes increasingly challenging as the nature of interprofessional collaboration in inpatient care involves working in various team constellations and where doctors often do not stay at the same departments.

Knowing Each Other's Profession, Sharing Information and Conflict Resolution.

With the previous discussion in mind, it could be difficult to create a relationship between Team Members and doctors at the department. According to theory, hierarchical cultures can be barriers in health-care settings, especially when social power primarily is given to doctors (Comeau-Vallée & Langley, 2019). This furthermore connects to respecting each other, both as a person and profession (D’Amour et al. 2005, Comeau-Vallée & Langley 2019; Cullati et al. 2019; Folkman et al. 2018). When Team Members were asked about respect for each other's professions, a large number of Team Members said there is respect but that it differs, for example, it creates some problem when newly graduated doctors arrive at the department without knowing exactly what they are responsible for. Other Team Members mentioned that the inherent hierarchies harms the respect, and again, that the doctors are a *“bit way away”* and *“running their own race”*. Some also expressed that they are not listened to by doctors as they see themselves as superior. However, other Team Members said that yes,

there is hierarchy, but that it does not have to become a problem as long as it does not create conflict, there is established respect and clearly defined roles. What can be said about this is that it is not the hierarchies per say that seems to be the problems, which theory emphasises (Comeau-Vallée & Langley, 2019), but that again it depends on the person, not the profession, and the understanding and respect of each other. This relates back to theory which states that in order for collaboration to be achieved, there are some competencies that need to be enabled, one of them being the ability to recognise and describe both others and their own role. It is also important to be open to learning from each other and accepting differences among professions (Hylin, 2010). As described above, according to the empirical data, when people are unsure what they are responsible for or who to turn to, in combination with a person who does not invite someone to help, it creates tensions and conflicts in the group. This became further evident when Team Members were asked about why they believe conflict occurs. One said it can appear due to language barriers between professions or between people who are new and who have worked for a long time, which emphasises the lack of shared information and knowledge.

Having clear boundaries further seems to sometimes be a challenge when there is lack of communication. Communication and sharing information is crucial for building an effective team, especially in highly complex environments (Kourkouta & Papathanasiou, 2014) and not having access to the same information can have impact, both on the group and their performance (Youngwerth & Twaddle, 2011; Kvarnstöm, 2009). On the notion of understanding each other's professions, Team Members expressed, when asked about shared information, that even though everyone has access to the same information it is sometimes not clear what it means. For example, there is a desire for more time to actually understand what the doctors mean in their journals. Similarly, another Team Member said that information is shared by everyone, but that it tends to go from one streamline to another, missing some professions on the way. Another said that their perception is that doctors often expect things from the other Team Members without actually communicating it. This further creates irritation as it is not always obvious what they expect. Additionally, information is updated and maintained, however, the streamline of communication, meaning who to turn to when in need of specific information is not. This aligns with the discussion about understanding each other's professions. A lot of things at the departments are to be “given”, and not much time is spent creating and maintaining an understatement.

Sharing information needs to be actively worked on in order to be maintained (Leathard, 2003) and status in between groups can influence how information is being shared, often for professions further down in the established hierarchy (Derry et al. 2005). From the discussion above, it seems like there is an overall agreement that everyone has access to the same information in some way, however, the answers seem to only imply communication regarding administrative information for example about

patients. What does not seem to be clearly communicated are the needs and, at times, dissatisfactory opinions about factors that could facilitate interprofessional collaboration and understanding of each other. The communication is thereby not only a problem in relation to hierarchies and managerial streamlines, but is actually much broader than the Team Members might embrace. Communication is not only about their collaboration to secure patient-care, it is about their collaboration as a team, which entails communicating about different needs to achieve interprofessional collaboration.

Facilitating Shared Information, Communication and Conflict Resolution.

A highlighted question is who carries the ultimate responsibility for facilitating interprofessional collaboration. As with creating motivation, theory states that it is a leader's role to facilitate formal communication and information sharing (Youngwerth & Twaddle, 2011) which could be done through meetings with the team (Rawlinson et al. 2020). When Team Members were asked if they believe time is allocated to understand each other's professions, only three out of twelve answered yes. It is evident that there does not seem to be a solidified answer to how one should learn their new job. Throughout their employment, it also seems to differ. Some got a role description from the Department Manager which they have been able to be a part of developing. Another said they were supposed to be part of someone else's APT meeting once but it got cancelled due to lack of health care personnel that day, and further said that these APT meetings are forums which could be utilised to enable understanding and communication, but instead it is created in everyday life. Other Team Members also had opinions on these meetings, one of them saying that it is more so time set because it has to be there, but that the Department Manager is not acting on things anyways. Another said that there might be an ambition but no time during them.

What can be said about the above stated paragraph, is that sharing information is evidently important yet seems to be difficult to facilitate in an efficient and structured way. Team Members answers on shared information are largely differentiating, not only between departments but between Team Members own perceptions within the same departments. There is reason to argue that with this importance, especially when profession-specific information needs to be conveyed (Abramson & Mizrahi, 2003) it needs to be given actual time and not just created in everyday life, as there seems to be very differing opinions on what that information actually is. However, there is an obvious lack of time at the department. Therefore, if the time they actually have was allocated towards APT meetings to open up dialogue about other things, such as psychological information, this could improve collaboration and decrease tensions within the team (Youngwerth & Twaddle, 2011). Maybe then, this could spin the wheel, enabling the creation of strong communication between Team Members without massive time allocation.

5.2 Department Managers

Interprofessional Teams and Leadership.

Boundaries between who is in the team and who is not is an important aspect when it comes to defining teams (Larsen, 2003). All three Department Managers believe they are leading one or several interprofessional teams, even though they show ambiguity regarding who is considered part of the team and who is not - both in terms of size and professions. One Department Manager viewed the whole department as a team while another viewed teams as either the whole department or smaller constellations working with the patients within the same department. Comeau-Vallée and Langley (2019) further highlights that working across professional boundaries in interprofessional teams is an effective way to organise teams in health care. Based on the empirical data, one Department Manager believes that doctors are not part of the interprofessional teams, and two of them believe the physiotherapists and the occupational therapists are consultants, rather than part of the team. Department Manager #1 even said: "*I often forget them. And I get some criticism for that*", and Department Manager #3 said, "*I am not formally their manager. But I often involve them. Or often involve them in decisions. So I inform them if anything is happening at the department. Because they need to know that too*". Interestingly, all Department Managers believe they are leading interprofessional teams even though two of them exclude some professions (doctors, physiotherapists and occupational therapists) that work with the same patients at the same department. This ambiguity might affect the quality of care since it depends on the Team Members ability to collaborate (Comeau-Vallée & Langley, 2019) and this, in turn, is affected by the leaders ability to align people (Kotter, 2001). More in depth, if Department Managers are not including some professions in their definition of interprofessional teams, but still claim that they are leading one or several interprofessional teams, this means that they only lead some members of the actual collaboration with the patients.

Goal Alignment, Communication, Conflict and Motivation.

As stated earlier, it is important to have common goals and visions that have been agreed upon explicitly (San-Martin-Rodriguez et al. 2005; Lundin & Sandström, 2016; Rahm-Sjögren & Sjögren, 2002). Further, It is up to the leader to motivate and create a mutual vision (Kotter, 2001) as well as creating forums where direction for goals can be pointed out and discussion take place (Sandahl et al. 2017). The empirical data shows that one Department Manager explicitly expressed that they do not believe it is important to have common goals but instead, to have individual goals. Yet, the same Department Manager expressed that they have an implicit vision of becoming the best department in Sweden. Another Department Manager expressed that *"It is important as a Department Manager to create a clear common vision"* and the third Department Manager said that an implicit goal was to have a *"high knowledge level"* at the department. None of them expressed that it is important to have

common goals, which goes against previous research (San-Martin-Rodriguez et al. 2005; Lundin & Sandström, 2016; Rahm-Sjögren & Sjögren, 2002). However, all of them had an aspiration of giving the best possible patient care every day, even though it was a given to them. It might be that health care personnel have explicitly agreed upon things, but not framed them as "goals". Viewed from another angle, a potential risk is that all Department Managers see "common goals" as unnecessary because they fail to recognise that goals only for the day could also be beneficial to have.

Furthermore, all of them agreed that there are explicit goals which derive from top management. They also believe that the goals are too broad and difficult to understand. Department Manager #1 mentioned that the higher up in the organisation the goals derive from, the "*fuzzie*r" they get. The other two Department Managers agreed and expressed their awareness of difficulties in conveying goals to be accessible for Team Members. At the same time, Sandahl et al. (2017) mention the importance that leaders facilitate discussions about common goals to avoid conflicts, but only one out of three Department Managers believe they do so. The fact that they are not facilitating these kind of discussions may lead to tension between Team Members, impacting patient-care negatively. In addition, it is a challenging task for a manager to facilitate discussions around goals they themselves find fuzzy and undefined. One of the Department Managers also highlights the risk of Team Members losing motivation due to the goals inaccessible nature. Additionally, Rahm-Sjögren and Sjögren (2002) underscore the importance of explicitly defining what the goals are and how the team wants to achieve, maintain and practically work on it continuously. Since this is not done, there is a risk for the personnel to lose motivation and purposefulness, just as Lundin and Sandström (2016) mentioned. Department Manager #2 also mentions that goal alignment is not a prioritised topic in meetings with other managers because of limited time and resources, and that too much is emphasised on the actual goal instead of the process of getting there.

Based on what has been said, lack of motivation among Team Members appears, according to the data, to be caused by unclear communication from top management, which in turn makes Department Managers unable to convey the goals effectively to the Team Members. In this case, deficiencies in communication impacts goal alignment and motivation negatively as well as it creates risks of conflicts to arise. Department Managers are expected to motivate and facilitate goals for Team Members but, at the same time, they have a hard time understanding goals deriving from the top management. This points to poor communication not only from Department Managers to Team Members, but also from the top management to the Department Managers. In turn, misunderstandings due to poor communication may lead to tensions, or even conflicts, among personnel at the same level as well as at different levels within the organisation.

Leadership, Distributed Leadership, Sharing Responsibility and Motivation.

As stated in chapter 5.1, many researchers claim that there is a difference between management and leadership (Bolman & Deal, 2017; Kotter, 2001; Sandahl et al. 2017; Lundin & Sandström, 2016), which all three Department Managers answered in accordance with. Department Manager #3 said, "*The managerial role is about making decisions, while the leadership role is to realise and implement them"* and Department Manager #1 said, "*Management is more static, like approving salaries for example. A leader needs to align the Team Members and facilitate the decisions".* Interestingly, Department Manager #1 was the only manager who integrated their leadership practices into everyday work with Team Members, as revealed in other parts of the interviews. This raises the question if Department Managers are able to actually realise their theoretical knowledge about leadership. If not, this could impact Team Members' possibility to trust them, which could lead to a decrease in motivation.

Furthermore, Richards (2023) mentions that becoming a manager is a title given to you, whereas becoming a leader is something you achieve by getting legitimacy from your followers. One of the Department Managers expressed that they actively chose not to manage a team they had been part of before. The other two Department Managers have worked at the Department before they got promoted. It could eventually be more challenging to gain trust when your colleges all of a sudden have to relate to you in a new way. As Department Manager #1 mentioned, "*Then you have pre-assumptions, relationships and other things that you can not just overlook or brush off. And if you do, those you are responsible for will hate you*". Department Manager #2 confirmed this issue saying that they have experienced the challenges with building new, different relationships as soon as they became a manager. Conclusively, there seem to be issues gaining legitimacy as a leader if you have been someone's colleague and Team Members before. This could pose challenges in gaining the trust and respect needed to facilitate interprofessional collaboration at the department.

One part of the manager's job is to delegate responsibilities to subordinates (Rahm-Sjögren & Sjögren, 2002) and this vertically distributed leadership enhances performance as well as communication, instead of reproducing negative in- and out group effects based on hierarchical orders in the organisation (Leach et al. 2021). Every Department Manager believed they delegate responsibilities. Department Manager #1 mention that they have "*... created islands of leadership positions throughout the department*" and that *"... this enables concerns to be filtered before it reaches me*". Furthermore, all three Department Managers believed that Team Members should take active action towards the leadership role, however, only two of them believed there is an opportunity for Team Members to actually do so. Additionally, Department Manager #3 highlights that there are opportunities for Team Members to take on the leadership role but that this is not done due to lack of drive and motivation. Another reason for this, is due to lack of knowledge of who is responsible to do so. This in turn could

lead to no one taking on the leadership role, and thereby negatively affect the collaboration and patient care. In addition, the maturity and constellation of a group have an impact on the group dynamic and as stated before, the constellations are changing regularly in inpatient care. These changing group constellations demand a leadership style that can be efficient accordingly (Rahm-Sjögren & Sjögren, 2002). However, the Department Managers, as mentioned, say they do not have time to execute leadership. Having a Department Manager who almost solely focuses on management, can affect the ability to build professional relationships with Team Members and, in turn, disadvantage interprofessional collaboration. Therefore, it is even more important that the distributed leadership is functioning so that the Department Manager can be unburdened. In inpatient care, there is an even higher need for more time to execute and adjust the leadership style depending on the setting, due to their ever changing group constellations and 24 hours a day operation.

Sharing Information, Knowing Each Other's Professions, Hierarchies and Trust.

McLaney et al. (2022) points to the importance of sharing responsibilities, involving everyone in decision-making and planning to effectively achieve interprofessional collaboration. Furthermore, sharing information, both verbally and non-verbally, is key for achieving effective collaboration (Gibson et al. 2012; Kvarnstöm, 2008). All Department Managers believe that everyone has access to the same information, but two of them believe the Team Members are equally investigated in taking part of the information. Department Manager #3 expresses that, "*Sometimes it is about what you are interested in as well*" and "*It is not always lack of time, actually I think some of it is actually lack of interest*", and Department Manager #2 believes it is more challenging making sure that everyone has access to the same information in inpatient care, where the departments are open 24 hours a day. Youngwerth and Twaddle (2011) give prominence to the leaders role in facilitating information sharing. Not making sure that all Team Members have access to the same information might affect the collaboration negatively because it makes it more difficult to align Team Members. However, the lack of sharing information, thus lack of communication, is grounded in lack of time. Therefore, it is instead the lack of time that primarily needs to be dealt with for Department Manages to be able to align Team Members in a desirable way through information sharing.

Social power in healthcare is primarily given to doctors and this can create a damaging hierarchy that impacts the collaboration among Team Members. Furthermore, hierarchical orders can aggravate building professional relationships, and more precisely building trust (Comeau-Vallée & Langley, 2019). The solution according to Sifaki-Pistolla et al. (2019) is to dictate time and address the need for building trust, differentiating roles and conflict management. Department Manager #3 underscored that the hierarchy is not as prominent now as it has been earlier in history, and that personnel are more involved in decision-making. Department Manager #1 also expressed a decrease of the hierarchies based on status. However, none of the Department Managers expressed that they have actively

facilitated discussions about the hierarchies. This suggests that a cultural shift may be the underlying reason for better trust among healthcare personnel, rather than something the Department Managers have actively facilitated. However, if Department Managers would actively work on decreasing tensions based on hierarchies, the collaboration would most certainly benefit from it. In addition, if trust is built, motivation among Team Members will also increase (Sifaki-Pistolla et al. 2019; MacLeod, 2015). This shows how one change in the organisation can affect other factors that also, in this case positively, impact interprofessional collaboration.

Conflict, Trust and Knowing Each Other's Professions.

Creating trust among the personnel is a way of building professional relationships and it is especially important in interprofessional teams where boundaries, both in terms of knowledge and tasks, are greater than in other teams (Gregory & Austin, 2016). Lindh Falk (2017) further explains that knowing each other's professions encompasses trust, respect and understanding your own and someone else's profession. Only two out of three Department Managers believed that there is a respect for each other's professions but none could comment on how they actively work on building it. Moreover, only two Department Managers highlighted the importance of creating a sense of trust for the professions they are managing. In addition to this, one Department Manager believes it is hard to engage people of some professions that do not formally have them as their manager. It poses a risk of disrupting trust when the Department Managers do not successfully manage to involve all professions in the relationship building. This in turn, affects the ability to build respect for each other and might lead to tensions in the team.

Adding to the previous paragraph, trust can be damaged by conflicts (Cullati et al. 2019). One Department Manager expressed that *"It is important that they (Team Members) can handle a conflict without my presence or if someone misbehaves… since I am not here all the time, for example during the evening or weekends"* which also could be interpreted as a way of delegating leadership and responsibilities. However, Cullati et al. (2019) highlights the importance of developing support programs for conflict resolution to not damage the quality of care. It is also important to actively listen (Rahm-Sjögren & Sjögren, 2002; Sandahl et al. 2017). One Department Manager's solution to this was to create an anonymous channel to report dissatisfaction. However, another Department Manager did the complete opposite, stating that they do not allow anonymous reports regarding conflicts as this disrupts transparency and accountability. The latter implies direct communication and active listening which in turn can more easily resolve conflict with those it impacts. Ultimately, having forums for communication can mitigate conflict but also build trust between Team Members and Department Managers.

Kvarnström (2009) mentions a risk of individuals being excluded from the group if their profession is not respected, which leads to worsened patient care. Hylin (2010) adds to this, saying that knowing each other's professions can be especially challenging when Team Members frequently work in different team constellations, which is the everyday environment in inpatient care. Furthermore, hierarchical orders based on lack of respect for each other's professions can disrupt the collaboration (Comeau-Vallée & Langley 2019). Based on the empirical data, one Department Manager does not believe there is an hierarchy, and another Department Manager believes that "*There is a natural hierarchy in hospital settings since what the doctor prescribes is what the nurse needs to do and what the nurse prescribes is often what the assistant nurse needs to do*", clarifying that it does not exclusively have to be something negative. However, they still mention that there is some kind of hierarchy. Given this information, the hierarchical settings seem not to be the primary issue, but rather the person behind a profession which creates difficulties when there is high rotation of teams and Team Members. Therefore, it is of major importance to establish relationships of trust and respect among the personnel to secure interprofessional collaboration. If done successfully, the hierarchies might even facilitate clear roles and understanding.

5.3 Human Resource Function

Interprofessional Teams and Leadership.

Interprofessional teams are teams consisting of people from different professions that are working interactively (Comeau-Vallée & Langley, 2019; Chamberlain-Salaun et al. 2013). In this thesis, operational healthcare personnel, i.e. Team Members are considered to be part of the interprofessional team, which were also outlined during the interviews. However, the Human Resource Manager answered, on the question that examined whether they believe themselves to lead an interprofessional team, that "*When we have developed the teams... they have been distributed on the basis that the Human Resource Partner is the group of Human Resource Personnel we have most of... So they are like the keystone… Then we have the administrators… Then when it comes to the strategists and negotiators, there are not enough of them to cover all the teams"*. This implies that they do not really see themselves as the main supporting funcion, instead, there are other more operational Human Resource Functions that carry that responsibility for the interprofessional teams. The Human Resource Partner, on the other hand, answered no to this question and added, "*It is purely operational, so to speak*", emphasising that they are too far from the Team Members operating in direct contact with patients, and that instead, other managers are responsible for leading the interprofessional teams.

Adding to the previous paragraph, the Human Resource Manager, working further from the operational personnel, seems to have associations with interprofessional teams that are distant from operational work. In contrast, the Human Resource Partner could more easily see that there is a

manager between the Human Resource Function and the interprofessional teams, and therefore did not view themselves as a leader of one or several interprofessional teams at all. Interestingly, the Human Resource Manager, operating further from the interprofessional teams, believes themselves to have a better perception of the function of the interprofessional teams, than the Human Resource Partner. Further, the Human Resource Partner, who is considered to be the one who actually has a better insight, believes themselves to be disconnected from both direct and indirect leadership of interprofessional teams. The discrepancy between the Human Resource Manager and the Human Resource Partner about the perception if they directly or indirectly lead interprofessional teams, could be worrisome as this highlights a potential gap in strategic versus operational leadership.

Responsibilities of the Human Resource Function and Finances.

According to Wilkinson (2022), Human Resource Management aims to regulate the relation between the employer and the employee. The Human Resource Partner states that their job, alongside the Department Manager, is to represent the employer. However, they mention that Department Managers sometimes seem to forget about that, and act rather as their Team Members colleague instead of their manager. Possibly, these matters could take valuable time from the Human Resource Partner when they have to remind the Department Managers of their job prescription, when that could be seen as something given. What could be seen as non desirable support from the Human Resource Partner, is instead maybe something that is based on the Department Managers ambiguity about their role.

Adding context, both interviewees got a question regarding their perceived idea of the function of the collaboration within the interprofessional teams. The Human Resource Manager did not directly answer the question but underscored the challenge of having different managers responsible for different professions working together, which was further stated by the Human Resource Partner. Moreover, the Human Resource Partner said they do not have a perception of the everyday function of the collaboration, arguing that they only get in touch with Team Members when conflicts occur and do not interact with their daily work. Leathard (2003) highlights the many challenges for managers to facilitate a well established structure for collaboration, but adopting a mindset of learning from the people you manage, in this case the Department Managers, is an important factor to achieve interprofessional collaboration. More in depth, this requires the Human Resource Function to be both a leader and a follower. The Human Resource Partner mentions that "*You have to listen, a lot of times you have to listen. I am the bridge between them (Department Managers) and the union*". Additionally, "Region Skåne's HR plan 2023 with focus areas 2023-2025" (Region Skåne, 2023) aims to create an attractive workplace, support employee development and use competence in the right way. Not having a clear perception of the function of interprofessional collaboration may, based on Leathard's findings, hinder effective facilitation and hinder success in the focus areas Region Skåns has developed. However, as mentioned previously, there is often a lack of time and resources for the

Human Resource Partner to support the Department Managers, which points to the possibility that the lack of support is due to organisational factors rather than a willingness from the Human Resource Partner to collaborate.

Furthermore, Region Skåne also has a description of the Human Resource Function, stating that their job is to "*Support Region Skåne's managers in the task of managing and developing the business"* and *"The Human Resource Function needs to be continuously developed and has a shared responsibility to ensure that the function is perceived as a well-developed professional support function that contributes to operational benefits".* The Human Resource Partner believes they are responsible for too many managers in order to provide good support and the Human Resource Manager states that there are differences between areas of operations (such as resources and scope of Department Managers that the Human Resource Partners are responsible for), impacting the support provided to Department Managers. They add that the organisation has to become more equal and that turnover rates of Human Resource Partners has been high the last few years. In addition, they say that they have initiated several projects, and that "*... the vision is that you should get a clearer, more equal support as well as managerial and leadership development over their lifetime as a manager and leader in our organisation*". Interestingly, the Human Resource Functions responsibility is to provide good support to managers subordinate them, however, none of the interviewees from this function believed they are able to do so. This leads to the question whether there is a correlation between lack of time and resources to provide good support, and turnover rates. The workload deriving from the top management might contribute to a decreasing motivation for the Human Resource Partner that in turn have a negative impact on Department Managers, Team Members, and ultimately, patients.

Financial performance and successfully managing human capital are closely correlated (Watson Wyatt's Human Capital Index, 2002). Furthermore, organising personnel in interprofessional teams can reduce the financial burden for an organisation (WHO, 2010). Adding to this, financial challenges will ultimately affect the employees all the way through the streamline, including Department Managers and nurses (Rahm-Sjögren & Sjögren, 2002). The Human Resource Manager mentioned that they need to find a better way to coordinate the Human Resource Function in general with the Financial Function so that everyone in the streamline, including the Human Resource Partners and Department Managers, have knowledge about how different decisions affect the financial performance. Additionally, the same interviewee said that they "*to some extent*" still have a diffuse image about what other functions in the organisation does, and that they need to create a more coherent workforce. This raises the question whether financial limitations play the ultimate role in why the Human Resource Function experiences deficiencies in their ability to provide support and not only, as previously mentioned, die to how the top management has organised the hospital.

Leadership, Management and Proactive Work.

Regarding the difference between management and leadership as well as being a manager and a leader, both interviewees agreed with Richards (2023) saying that management is more focused on policies and procedures while leadership provides direction and support. As previously mentioned, a manager is something you become by promotion and a leader is something you become by gaining legitimacy (Lundin & Sandström, 2016). The Human Resource Partner said, "*Being a manager or a leader is not the same thing… I do not witness the managers in their leadership daily. I do not know how they perform it but I can perhaps draw conclusions based on where there is more staff turnover*". The Human Resource Manager said that management is more about formalities. In relation to what has been discussed earlier in this chapter, both respondents perceive themselves to be a supporting function, but do not think they execute leadership. If the Human Resource Function saw themselves as a part of the leadership function, thus playing a greater part in the vertical collaboration, this could potentially mitigate the in-group and out-group comparisons between different levels of the organisations, i.e. Team Members and Department Managers, which is in alignment with Leach et al. (2021).

Tying leadership and management back to the theoretical framework, the role description for the Human Resource Partners at SUS describes how subordinate managers shall be supported in managerial practices as well as leadership development (Skånes Universitetssjukhus n.d.). In addition to this, it is important for the Human Resource Function to have time for proactive work (Khatri et al. 2017). The Human Resource Partner said, "*I wish I had more room for proactive work. 99 percent, well maybe not, 95 percent of my mission is very much reactive... I do not really have time, everything is done afterwards*", and that "*... it gets boring in the long run. When you are constantly putting out fires*". Moreover, one Department Manager said that "*... they (the Human Resource Function) do not work proactively, they work only reactively"* and "*Information comes late... the Human Resources Function should be a sounding board, not a one-line communication that appears when it suits*". Additionally, Leathard (2003) mentions that collaboration is only as effective as the willingness of different actors to facilitate and provide the needed support. Alongside this, Leathard (2003) stresses that a top-down heavy organisation is more likely to limit mid- or senior level managers to gain important knowledge about what is happening on the operating level. Based on the Human Resource Partner's opinion on not having time for proactive work, this might not only be a matter of willingness to collaborate, but instead a matter of other factors such as human resource management's availability to support (San-Martin-Rodriguez et al. 2005), which stems from how the organisation is structured as well as financial resources.

The Human Resource Partner mentions that sharing responsibility with another Human Resource Partner would be desirable. However, they add, "*At the same time, there must always be a recipient*

for an Human Resource delivery. But if there is no time and resources in the organisation to work on it, it does not help to have two Human Resource Partners. The solution lies rather in the organisation. There is no lack of interest, they (Department Managers) are just so focused on the operational work that there is no time left". The respondent shows awareness of the lack of time affecting not only themselves but also personnel further down in the organisation. This raises the question, should there be an increase of Human Resource Partners to help share responsibility and more efficiently support Department Managers? Or should there instead be an increase of Department Managers, to release more time, thus creating better conditions for receiving the support given to them? In other words, is a bottom-up solution required rather than a top-down solution? Or is it a combination where top managers must follow and give more attention to the needs of Department Managers? As of today's landscape, the absolute majority of Human Resource Personnel work strategically further up in the organisation, and only Human Resource Partners and some Human Resource Administrators, work in direct contact with healthcare personnel.

Building Relationships and Sharing Information.

Collaboration, building relationships and sharing information is not only of great importance horizontally, but also vertically in an organisation (Leathard, 2003; Rahm-Sjögren & Sjögren, 2002; Gibson et al. 2012). The Human Resource Partner mentioned that they expect Department Managers to lead interprofessional teams in some areas since organisational hierarchical structures hinder Human Resource Partners from getting access to some of the information that the Department Managers have. Furthermore, they expect Department Managers to ask for help when they need it, at the same time as they believe Department Managers do not do so due to lack of time. As mentioned earlier, not having access to the same information can negatively impact the collaboration (Kvarnström, 2009) and it is up to each individual to share relevant information (Youngwerth & Twaddle, 2011). It is also important for personnel to share information in order to build trust and relationships (Lindh Falk, 2017; Leathard, 2003). However, it seems to be contradicting to have expectations of Department Managers to reach out for help when they need it, but also realising that there is no time. It also further poses the question, are the Human Resource Partner responsible to support only when help is needed? And what responsibility do they have in clarifying in which cases the Department Managers should ask for their help? The answers to these questions could potentially be found in previously discussed factors such as lack of time, also for the Human Resource Partner. It might not be about willingness, but lack of time to build professional relationships and act proactively.

The Human Resource Manager believes that the Human Resource Partners have the best possibility to deliver messages and information to a greater extent of people within the organisation. They also believe that collaboration is built on relationships, which in turn rely on communication, trust and knowledge. This is supported by Sifaki-Pistolla et al. (2019) highlighting that spending time on

addressing factors that can create trust is effective to improve interprofessional collaboration. Even though the Human Resource Manager argues that the Human Resource Partner is best suited for building relationships and, in thus, benefits the collaboration, the Human Resource Partner again refers to the lack of time to do so.

5.4 Collaboration between Team Members, Department Managers and Human Resource Function in Inpatient Care

This chapter aims to answer the main question of how Team Member, Department Managers and Human Resource Function collaborate in inpatient care. This question, in turn, aims to fulfil the purpose of this study, which is to "...contribute to an increased understanding and knowledge about the horizontal collaboration between Team Members of interprofessional teams and the vertical collaboration between three actors; Team Members of interprofessional teams, Department Managers and The Human Resource Function..." (chapter 1.2). In order to answer both the research question and ultimately fulfil the purpose of the study, this chapter will analyse and discuss how the three actors collaborate according to findings discussed in 5.1, 5.2 and 5.3.

Collaborative practices for healthcare workers include personnel who are not in direct contact with patients (Leathard, 2003; WHO, 2010). As seen in chapter. 5.1, 5.2 and 5.3 the interpretation of team, interprofessional teams and consequently, interprofessional collaboration, views some interesting differences in the empirical data, both between the different actors, but also within those isolated groups. On the notion of Team Members, Department Managers and the Human Resource Partner, not seeing the doctors as part of the team, but as an evidently important part of the interprofessional collaboration poses some questions, as the key to achieve interprofessional collaboration stems from working in an interprofessional team at the inpatient care department, which they all seem to agree upon as well. This can further create barriers to collaboration, as effective interprofessional collaboration is also predicated on understanding that all members of the team uniquely contribute towards the same goal. However, if there is uncertainty about who is part of the team, and if some are perceived as "outsiders", it makes it hard to align people towards that same vision and goal. Additionally, it is interesting that both Team Members and Department Managers of every department contrastingly also expressed a lack of motivation for common goals. This in turn could potentially pose barriers for both Department Managers and the Human Resource Function, as it is evidently hard to align and support people when there is no clear image of where they are going with that vision and goal. This consequently impacts the collaboration, both horizontally and vertically as it can create tensions between the actors.

Adding further dimension to the above, the Human Resource Manager believes they indirectly lead interprofessional teams and interprofessional collaboration, while the Human Resource Partner does not. However, for context the Human Resource Manager referred to teams on strategic levels, not those in the operational interprofessional teams. If both the person in better position of making strategic decisions for the departments (Human Resource Manager), as well as the person in better position of transforming operational information about the departments to the strategic level (Human Resource Partner), are disconnected from the actual interprofessional teams and collaboration, they might fail to understand the team dynamics. Thus, a risk of failing to address practical challenges faced by those in the front line, i.e. Department Managers and Team Members. The empirical data also suggests that this can become problematic as both Department Managers and Team Members believe the goals derive from top management rather than something they have a possibility to impact. Another dimension gets added to this, when both Department Managers and Team Members express that goals are more unclear and unstructured the further up in the organisation they derived from. Conclusively, the Human Resource Manager, in contrast to the Human Resource Partner, express that they have a good perception of how the interprofessional collaboration is functioning while the Department Managers and Team Members on the other hand, express that the top management is not capable of setting goals in alignment with their lived reality. When combining these two views, it is clear that there is a discrepancy that needs to be worked on in order to enhance collaboration, again, both vertically and horizontally.

As the Human Resource Function's primary task is to give support to the Department Managers, it is important that they have a well established relationship with one another. As the empirical data reveals, there seems to be, although with varying amounts, trust among the Team Members and Department Managers. One of the Department Managers expressed that the collaboration between them and the Human Resource Partner is functioning well because when they have asked for help, they have received it. However, the majority of Department Managers expressed a dissatisfaction of support from the Human Resource Function, which is an implication of lack of trust. Further, Department Managers also express that there is no initial extra support when entering the role, and that they are the ones responsible for reaching out for that support, which is confirmed by the Human Resource Partner. When researching the underlying reasons, it seems to be due to lack of time which evidently leads to lack of proactive work. When the Human Resource Partner instead has to evermore act reactively, this also affects the Department Manager's ability to work proactively, as they do not attain the support that they need. Conclusively, it seems that the collaboration between Department Managers and the Human Resource Function, in particular the Human Resource Partner, is based upon the request of support from the Department Managers. This one-way path of communication disables the actors to act proactively, which the Human Resource Function plays an important strategic role in facilitating, and instead only focuses on acting upon things that have already

occurred. This in turn negatively impacts the collaboration and patient-centric care that, unmistakably, is expressed as the most important common vision and goal with the organisation. Additionally, the collaboration between the Human Resource Function and the Team Members does not seem to exist. However, with the established managerial structures and relationships, it does not seem to be the intended outcome either. With this in mind, a well functioning collaboration between the Human Resource Function and Department Managers becomes evidently important, as their relationship plays an important role in how Team Members perceive their work environment.

Both Team Members and Department Manager agree that it would be beneficial if the Human Resource Function was more visible at the department at times. The Human Resource Partner expresses that the visibility is driven by the need for support. Meanwhile, the Human Resource Manager says that visibility is not a necessity as long as the Human Resource Partner has a well established relationship with the Department Managers, and can in turn speak in favour of them to the Team Members. Ultimately, the Human Resource Partner perceives the relationship between them and the Department Manager in a more desirable way than the Department Manager. This shows a rather large discrepancy in the perceived insight that the Human Resource Function claims to have in the organisation. However, with the previous discussion about lack of time in mind, it does not come as a surprise that the Human Resource Function does not have the time to learn more about each department, especially when they are responsible for 36 Department Managers.

Building upon the previous paragraph, the lack of time affects both the Human Resource Function and the Department Managers ability to not only give time to management, but also leadership. When there is only time for management, the leadership aspect seems to end up in the shadow of management, which in turn affects the ability to create a sense of community and unity between the Team Members. As the empirical data reveals, the departments have established a distributed leadership, often in constellations which stems from the hierarchical levels between professions, i.e. doctors lead nurses and nurses lead assistant nurses. This, again explained in the empirical data, seems to function well at times, but when it does not, it is not because of the specific profession but rather the person. This is due to the lack of time to get to know and trust each other, which can create tension and negatively impact the collaboration. Conclusively, the fact that the Human Resource Function and the Department Managers does not seem to have time to create a desirable relationship between each other, ultimately impacts the ability for Team Members to create those relationships between each other as well. However, one could argue that the Team Members also carry a responsibility in expressing the need for support, although, it does not come as a surprise that this is not done if they do not have knowledge or trust in their assigned Department Manager or Human Resource Function.

As mentioned, Team Members' perceived view of their collaboration is often coloured by person, and not someone's specific profession. This empirical conclusion sheds light on the importance for Department Manages to give attention to what is happening between the Team Members on the operative level to mitigate possible conflict which could disrupt the collaboration. The fact that there is a larger expression for person-based issues, rather than profession-based, could be seen as both a barrier and facilitating factor to achieve interprofessional collaboration. On the positive note, the Department Managers could more easily mitigate the negative impacts that the hierarchical differences and lack of knowledge of each other's professions sometimes pose, due to the fact that Team Members do not see the professional boundaries as a barrier. Instead, they could focus on building trust amongst the Team Members, mitigating the tensions raised by someone's person. The hierarchical differences could then act as a facilitating factor instead, as this, in alignment with the empirical data, can create clearer roles and structures, increasing the understanding of each other. However, on the more challenging note, profession-based issues are not to be diminished, as these can be devastating for interprofessional collaboration if it is not managed and dealt with, as the different professions is what makes an interprofessional team. According to the empirical data, the Department Managers perceived experiences today, shows that there is no time for those types of activities which Team Members would agree with. This in turn makes it even more important the distributed leadership, enabling the Team Members to actively manage conflicts or tensions by themselves.

It is evident that facilitating collaboration only within one department of inpatient care is challenging. First of all, it is resource demanding for Department Managers, and second of all demanding for the Human Resource Partner, responsible for 36 different Department Managers. In light of the above stated paragraph, the willingness of Team Members to collaborate is of major importance for the ability for Human Resource Partner and Department Managers to collaborate and execute a well-rounded job. Therefore, the needs for collaboration to be achieved can not only be reliant on the Human Resource Function and Department Managers to raise awareness about. The Team members also most certainly carry a responsibility to express their opinions and needs when the chance is given to them, for example during APT meetings. Again, it is important to build trust in order to enable an environment of open communication, facilitating these conversations.

The Human Resource Function has an idea of how to create a well functioning organisation and thus share information in alignment with that idea. However, according to the empirical data, the information is not communicated in a way that makes it graspable for the receivers, i.e Department Managers, and ultimately makes it hard for them to create a plan for how the information or guidelines should be realised. Eventually, it is the Department Managers who carry the ultimate responsibility for the APT meetings, taking both the role as a leader, transforming information to the Team Members, but also as a follower to pass information back to the Human Resource Partner. This

undesirable and thus challenging way of communicating risks to give rise to conflicts, which, in alignment with the empirical data, there is no time to manage in a desirable way. Further, the Department Managers and Human Resource Function seem to have an understanding of each other, regardless if in a desirable or undesirable way. However, the understanding is in isolation from each other, as their own perceived views have not been communicated. Again, the communication's intention might not get perceived by the receiver.

6. Conclusion

After a rigorous empirical data collection which has been analysed and discussed in accordance with theory, the research questions and purpose have been answered in chapter 5. This chapter (6) aims to pinpoint and ultimately conclude the major findings to all four research questions.

How do Team Members of interprofessional teams experience barriers and facilitating factors influencing the interprofessional collaboration?

After an extensive gathering of empirical data from 12 Team Members of varying professions within an interprofessional team, the following can be said. Team Members recognize a distinction between management and leadership and further express the importance of having a leader, not only a manager. Additionally, all Team Members seem to have a clear and sharp opinion of what determines great leadership in order to achieve interprofessional collaboration. However, when asked about key barriers and facilitating factors the same factors that were expressed as important, does not seem to permeate the collaboration at the department. Barriers such as unclear and incomprehensible goals, undesirable communication both horizontally and vertically, in turn impacts the Team Members motivation and trust for each other which stems from lack of time and resources. This becomes evident as Team Members express an undesirable relationship with doctors, not due to their profession per say, but because of the different managerial streamline which makes them less integrated with the rest of the Team Members everyday work. This in turn is what makes some Team Members not view doctors as part of the team, or that doctors themselves have a hard time to feel a part of it. Finally, Team Members believe that deficiencies from the top management affects the Department Managers which in turn affects the entire department and thus, the collaboration. Conclusively, Team Members view these organisational deficiencies as barriers for interprofessional collaboration.

How do Department Managers of interprofessional teams experience barriers and facilitating factors influencing interprofessional collaboration?

Department Managers, much like Team Members, seem to have clear views and opinions on what determines desirable leadership. However, the expressed needs for facilitating factors influencing interprofessional collaboration are difficult to realise, which becomes evident as only one Department

Manager clearly and integratively expressed how they incorporate leadership into their role as a manager. Another barrier for taking a leadership role is that there are varying views on which professions belong to the team due to different managerial streamlines, but also due to the nature of inpatient care, working in different constellations 24 hours of the day. Department Managers express that they are responsible for the collaboration at the department, however, also express that they are not everyone's manager. These contradicting views ultimately impact leading interprofessional collaboration as it becomes unclear who is responsible for delegating responsibilities, managing conflicts, building trust and respect, creating motivation as well as sharing information and securing an understanding of each other's professions. Additionally, the Department Managers also expressed a lack of understanding and meaning of having goals as they do not see how they contribute to the collaboration, since they do not have the time or enough information about how to realise them. As the Department Managers carry the main responsibility for managing and leading the departments, and thus setting goals, this could ultimately create barriers to achieve interprofessional collaboration. Finally, the Department Managers operate as a middle ground in the organisation, meaning, they need to take on different roles, as a leader and a follower, both in the eyes of Team Members and the Human Resource Partner. Taking a leadership role is a very time consuming task. This in combination with their heavy managerial workload largely prohibits any type of proactive work.

How do the Human Resource Function view their support to Department Managers in facilitating interprofessional collaboration?

The Human Resource Functions perspective on their support to interprofessional collaboration involves a strategic overview that is often disconnected from the lived reality that Team Members and Department Managers face. The Human Resource Manager is so disconnected from the interprofessional teams that they could not express an opinion about their support to Department Managers in facilitating interprofessional collaboration. On the other hand, the Human Resource Partner, who is expected to have the closest interaction with the departments, have a merely impossible way of working proactively due to the fact that they are such a small part of the Human Resource Function, with a heavy workload carrying the responsibility of 36 managers. The Human Resource Manager commented this, expressing the importance of re-coordinating different functions in the organisation to enable more interactive work, which in turn can better manage the organisation’s financial resources. This would further contribute to the Human Resource Functions ability to live up to both Region Skåne’s outlined mission for the Human Resource Function and their Human Resource Plan, ultimately contributing to interprofessional collaboration. To conclude, the lack of support seems to be based on organisational structures, time constraints and resource allocation, rather than a willingness to provide Department Managers with the support they need.

How do Team Member, Department Managers and Human Resource Function collaborate in inpatient care?

After examining the views of all three actors it is clear that they all carry different roles. However, they all seem to have varying perceptions of those roles; who is responsible for what and for whom. They all seem to have good intentions with the effort they put in and a willingness for enhancing collaboration, but the lack of horizontal and vertical communication between the three actors hinders this achievement. Yet again, it is not the willingness that seems to be the underlying factor, but instead lack of time and resources. This in turn is what creates the foundation on which other barriers to collaboration lays. Motivation, goal alignment, trust and understanding of both each other, the different roles or professions becomes difficult to facilitate since there is no time for proactive work, according to both Department Managers and the Human Resource Partner. This is also evident amongst the Team Members, expressing dissatisfaction towards how parts of the collaboration is managed, but also a lack of understanding regarding both the purpose and benefits of different facilitating factors, such as establishing common goals.

Conclusively, interprofessional collaboration does not function in a desirable way and there is a lack of communication and understanding of each other, both horizontally and vertically. The different shortcoming, originating from top management are financial resources, lack of time, proactive work and undesirable organisational structures. However, even though it stems from higher up in the organisation, for there to be improved collaboration in the future, it also requires Team Members to express their needs which then needs to be taken seriously by the Department Managers, in order for this in turn to be escalated within the organisation and lead to change. This is not a one way communication solution from any side, but instead everyone needs to take their responsibility, both horizontally and vertically, to communicate and thereby facilitate desirable leadership, trust, motivation, goal alignment, conflict resolution and understanding each other's profession. The issue does not seem to be ambition or lack of willingness, which creates good conditions for improving collaboration and thereby enhancing quality of care for patients but also the work environment for healthcare personnel.

6.1 Future Research

First and foremost, in alignment with the delimitations of this study, future research is of essence to expand the number of studies, both within and outside inpatient care at SUS but also at other hospitals, to collect more data and thus enabling greater generalizability. This would generate more empirical data which in turn could be used as a foundation to explore measures to strengthen the role of the Human Resource Function and the overall interprofessional collaboration. This study has acknowledged the issues of lack of resources and organisational structures which impacts the ongoing

healthcare crisis. However, the crisis is here and now, and the question is about what we can do with what we have, as well as how to, with limited means, better utilise the Human Resource Functions role, which ultimately is to provide support and facilitate well-being at the workplace. Additionally, it is important to further investigate how to ensure that Department Managers are able to be attentive towards their subordinates but also have time to facilitate other obligations, such as administrative work, that their role requires, without being overwhelmed. Finally, it would be interesting to further research how to facilitate self-leadership amongst Team Members of interprofessional teams so that they can collaborate without as much needed support from Department Managers and, by extension, the Human Resource Function.

Conclusively, it is important to further investigate Team Members, Department Managers and the Human Resource Function at hospitals in isolation to gain more knowledge on their perceived reality and thus, find what actions are needed to then realise those needs. However, not to forget, the collaboration amongst them is of uttermost importance to gain knowledge on how they can benefit from each other and thereby increase the interplay.

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Appendices

Appendix 1: Interview Guide Team Members

Introductory Questions

1. What is your professional title?
2. Which department do you work at?
3. How long have you been working at the department?
4. What does your work as x include?
5. What does an average working day look like?

Interprofessional Team

→ *Introduce the thesis definition of interprofessional team and interprofessional collaboration.*

1. Do you experience working/being part of one or several interprofessional teams?
2. Do you feel that you cooperate across professional boundaries in this team? Is the cooperation good/bad in your opinion? In what way?
3. Do you feel that you cooperate across professional boundaries in this team? Is the cooperation good/bad in your opinion? In what way?
4. How do you feel the size of the team(s) in your department is in relation to achieving effective team collaboration?
5. Have you worked in a team other than an interprofessional team before?
6. Do you feel that there has been any change in your department regarding the conversation/attitude towards interprofessional collaboration? Has there been an improvement/deterioration or is it similar? Your attitude?

Leadership

→ *Introduce the thesis definition of leadership.*

1. Do you think there is a difference between management and leadership? If yes, what?
2. Do you feel that your Department Manager delegates responsibilities to members of the interprofessional team?
3. Do you feel that you and your colleagues share responsibilities within the interprofessional team? Is there room for individuals in the interprofessional team to take on more responsibility if they want/need to?

Leading Interprofessional Collaboration

1. What do you consider to be the key factor(s) for achieving interprofessional collaboration?
2. What do you think are the key factors for successfully leading interprofessional collaboration?

Theme: Relationships

1. Do you feel that you have a professional relationship with your colleagues?
2. Is there trust between you and your colleagues? In what way? How important do you think it is? How is trust achieved according to you?
3. Do you think there is motivation and commitment in the team? How is that achieved according to you? What role does the Department Manager play in facilitating that?

Theme: Goals och Vision

1. Do you have common goals/ vision in the teams? Explicit/implicit?
2. Do you help each other in the teams to set goals/visions?
3. Do you feel that your Department Manager facilitates goal setting in a desirable way? If yes, how? If not, what would need to be done differently?
4. Do you feel that you have support at a structural level to develop, maintain and achieve your goals and visions?

Theme: Knowing Each Other's Professions

1. Do you feel that there is respect for each other's professions within the team? Do you experience that there is a hierarchy?
2. Do you feel that time/resources are spent on understanding each other's professions? Or is it something that is learned in the team over time? Does/ should the Department Manager do anything? How do you experience it Team Member to Team Member?

Theme: Conflict and communication

1. Do you feel that there is support from your Department Manager or HR in case of a conflict?

Theme: Sharing information

1. Do you feel that everyone in the team has access to the same type of information? From the Department Manager? From Team Members?
2. Do you feel that access to information affects interprofessional collaboration?

Theme: Support from Human Resources

1. What support do you feel HR provides in working interprofessionally? What do you miss from HR?

Appendix 2: Interview Guide Department Manager

Introductory Questions

1. What is your professional title?
2. Which department do you work at?
3. How long have you been working at the department?
4. What does your work as x include?
5. What does an average working day look like?

Interprofessional Team

→ *Introduce the thesis definition of interprofessional team and interprofessional collaboration.*

1. Do you find yourself leading one or more interprofessional teams?
2. Do you feel that you cooperate across professional boundaries in this team? Is the cooperation good/bad in your opinion? In what way?
3. How do you feel the size of the team(s) in your department is in relation to achieving effective team collaboration?
4. Have you previously led or been part of another type of team?
5. Do you feel that there has been any change in your department regarding the conversation/attitude towards interprofessional collaboration? Has there been an improvement/deterioration/similar? Your attitude?

Leadership

1. Do you think there is a difference between management and leadership? If yes, what?
2. Do you believe that you allocate responsibilities to the members of the teams? If yes, what kind of tasks?
3. What do you expect the team itself to take responsibility for in terms of leadership? Do they do it?
4. Is there room for individuals in the interprofessional teams to take more responsibility if they want/need to?

Leading Interprofessional Collaboration

1. What do you consider to be the key factor(s) for achieving interprofessional collaboration?
2. What do you think are the key factors for successfully leading interprofessional collaboration?

Theme: Relationships

1. Do you feel that you have a professional relationship with your colleagues?
2. Do you feel that there is room for building professional relationships in the team? (e.g. in

relation to the size mentioned earlier)? Do you actively work on building trust between your Team Members? Between you and the Team Members?

3. Do you believe that there is motivation and commitment in the team? Do you actively work to create this?

Theme: Goal and Vision

1. Are there common goals/ vision in the teams? Explicit/ implicit?
2. Do you contribute to these as a Department Manager? How?
3. Do you feel that you have support at a structural level to develop, maintain and achieve your goals and vision?

Theme: Knowing Each Other's Professions

1. Do you feel that there is respect for each other's professions within the team? Do you experience any hierarchy?
2. As a Department Manager, do you spend time/resources on clarifying this? Or is it something that is learned in the team over time?
3. Do you feel that you get the support you need from HR to move forward on this issue?

Theme: Communication and Conflict

1. Do you feel that there is support from HR in case of a conflict? Have you been given the tools you need?

Theme: Sharing Information

1. Do you feel that everyone in the team has access to the same type of information?
2. Do you feel that, within the team, they work together to share important information with each other?

Theme: Support from Human Resources

1. How would you describe the collaboration between you and the Human Resource Partner? Is it desirable?
2. What do you think you need most support in to lead interprofessional collaboration?
3. Do you feel that HR has enough insight into the operational work of the interprofessional collaboration to provide you with the support you need?

Appendix 3: Interview Guide Human Resources

Introductory Questions

1. What is your professional title?
2. Where on a hierarchical level do you work and what do the different levels look like?
3. How long have you been working there?
4. What does your work as x include?
5. What does an average working day look like?

Interprofessional Team

→ *Introduce the thesis definition of interprofessional team and interprofessional collaboration.*

1. Do you feel that you lead one or more interprofessional teams? Directly or indirectly?
2. Do you have an idea of how the collaboration within the interprofessional teams are in different inpatient departments? What do you base this perception on? (data, experience, things people said etc.)
3. How do you feel the size of the team(s) is related to the ability of managers to lead interprofessional collaboration?
4. How do you feel about the number of people in your area of responsibility in relation to providing good support to managers?
5. Do you feel that there has been any change in your department regarding the conversation/attitude towards interprofessional collaboration? Has there been an improvement/deterioration/similar? Your attitude?

Leadership

1. Do you think there is a difference between management and leadership? If yes, what?
2. What do you expect the Department Managers to do themselves in terms of leading interprofessional collaboration? Without support from you.

Leading Interprofessional Collaboration

1. What are the key factors to achieve good cooperation between you and Department Managers?
2. What do you think are the key factors for successfully leading interprofessional collaboration?
3. What do you think are key factors in supporting the Department Manager to lead the interprofessional collaboration?

Theme: Relationships

1. Do you feel that you have a professional relationship with: (1) Department Manager? (2) Interprofessional Team Members?
    a. Do you consider this relationship to be desirable/problematic?
2. Do you think there is trust between you and the members of interprofessional teams? Why / why not?
3. Do you actively work on building trust between you and the Department Managers?
4. Do you think there is commitment from HR to motivate Department Managers to lead interprofessional teams in a desirable way?
    a. Do you actively work on creating/supporting this?
    b. What do you think is important to achieve it?

Theme: Goal and Vision

1. Are there common goals/ visions at the different departments? Are you aware of the departments' objectives?
2. Is there a collaboration between Department Managers and HR in achieving it? If so, how?
3. Do you feel that you have the input you need from Team Members and/or Department Managers to provide the support needed to achieve the objectives?

Appendix 4: Organisational Scheme of SUS