Final Report to Trent Workforce Development Confederation

Making the HESP Work:
Choices and Challenges in Trent

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EXECUTIVE SUMMARY

In July 2003 the Centre for Sustainable Urban and Regional Futures (SURF) was commissioned by the Trent Workforce Development Confederation (WDC) to assist the Trent Health and Education Strategic Partnership (HESP) in defining the scope and nature of its role and in meeting the challenges of inter-sectoral co-ordination that it has been established to address. SURF produced a brief setting out a one-month workplan based on a combination of desk research, analysis of secondary documentation and 15 interviews with strategic stakeholders in the HESP. A web and desk-based search was also designed to identify initial sources of strategic intelligence which would assist the HESP (Annex I).

The decision to establish a HESP in Trent can be seen as a response to national directives and set of significant changes in the health and education sectors within the UK. In the health service, the core driver is the move towards a patient-centred approach which has required restructuring the organisation of the NHS and placed new demands on workforce development. The education landscape is equally challenging, as HEIs and FE colleges are required to adopt new roles in relation to their traditional functions of teaching and research, reaching out to local communities and having relevance to society's needs, requiring partnerships with a wide range of agencies.

The interviews revealed a high degree of receptiveness within the Trent area to the need for the HESP and apparent willingness to commit to its success. Yet a number of issues have emerged relating to what the HESP is, what it should do, with what resources and with whom involved. The report highlights key comments in relation to the strengths and opportunities of the HESP and the challenges that it faces in practically moving forward.

The report makes four recommendations for the potential of the HESP to be translated into reality:

- The HESP must move through three-stages: from purpose to process to product.
- The HESP must collectively answer core questions as a precondition for a successful partnership.
- The ground rules must be set and agreed upon.
- The HESP should be assisted through comparing best practice, regional health and education foresight processes and through a strategic intelligence gathering exercise.

There is a clear need and role for the HESP in Trent. The opportunities abound. Armed with appropriate resources and knowledge, united by a common purpose around an initial flagship project, with the preconditions established and ground rules set, the partnership has the potential to forge new relationships and partnerships for the wider benefit of the regional economy, its communities and the health and education sectors.

1. Introduction

In July 2003 the Centre for Sustainable Urban and Regional Futures (SURF) was commissioned by the Trent Workforce Development Confederation (WDC) to assist the Trent Health and Education Strategic Partnership (HESP) in defining the scope and nature of its role and in meeting the challenges of inter-sectoral co-ordination that it has been established to address.

Following a meeting with Professor Tony Butterworth (WDC), SURF agreed to produce a 'thinking piece' to assist the Trent HESP in thinking strategically about its aims, objectives and priorities. The work was to be completed prior to the next HESP meeting (12th September 2003) and was seen to be a starting point, rather than the end point, of a potentially wider and more far-reaching process.

The research has taken place between August and September 2003. SURF produced a brief setting out a one-month workplan based on a combination of desk research, analysis of secondary documentation and 15 interviews with strategic stakeholders in the HESP. The interviewees were identified by the Trent WDC, who took responsibility for the arrangement of times and dates. Efforts have been made to ensure the interviewees were representative in this scoping study and this document is designed to encourage wider debate within the HESP, particularly with those not interviewed.

In writing up the research we have drawn widely on the interviews, conducted both face-to-face and via the telephone. In doing so, we have respected interviewees' right to anonymity and confidentiality and have thus not attributed the extensive quotes used within the report.

The research also draws on SURF's work and experience of research in the fields of city-regional thinking (Office for the Deputy Prime Minister), universities in the knowledge economy (The Contact Partnership) and the contribution of both health and education sectors in regional and economic development.

The report is divided into three main sections. First we consider the context within which the Trent HESP is to operate, looking at the main challenges and constraints within both the health and education sectors. Second, we present the interview analysis, the purpose of which is to reflect the varied opinions presented to us throughout the research. Finally, we make a series of specific recommendations in taking forward the process of partnership working for the Trent HESP.

In addition, there are two annexes following the main report. The first presents an initial overview of capacity and resources for strategic intelligence in the Trent area. This is the result of a web and desk-based search designed to identify initial sources of information which would assist the HESP. The table is organised into three sections in which information sources and intermediaries on characteristics of the Trent area, careers and R&D are listed. The tables must be seen as indicative, rather than comprehensive. The second annex is a bibliography of documentation referenced in the report.

2. Thinking Context

2.1 The Changing Landscape of the Health Sector

2.1.1 The New Structure of the NHS

The NHS is often described as undergoing constant organisational change. Most recently, the change agenda has been driven by the NHS National Plan (D.o.H. 2000), a 10 year plan for investment launched in 2000, that emphasises 'a patient centred service'. The Plan aims to address a number of core and longstanding issues, in particular, variations in health care between different areas (the 'postcode lottery'), long waiting lists and pressured working conditions. To achieve the aims of the NHS plan, a programme of NHS restructuring and workforce development has been underway.

Table 1: The New Structure of the NHS

Organisations	Responsibilities
Local Level Delivery	
Primary Care Trusts (PCTs)	• *Planning and securing services* including of GP services, hospitals, dentists, mental health services, Walk-In Centres, NHS Direct, patient transport (including accident and emergency, population screening, pharmacies and opticians), • *Improving the health of the community* and *integrating health and social care locally*.
NHS Trusts	• Managing hospitals to provide services commissioned by PCTs while being accountable to Strategic Health Authorities.
Care Trusts	• To provide health and social care (can be set up by local NHS organisations and Local Authorities (very few have so far been set up).
Sub-regional Strategic/Performance Management Level	
Strategic Health Authorities	• Ensure coherency and develop strategies for local health services • Ensure high-quality performance of the local health service and its organisations, and working towards improved performance • Building capacity in the local health service.
Regional Level	
Public Health Groups (based in Regional Government Offices)	• Facilitate integrated working between health and regeneration programmes of work.
Sub-national Level	
Directors of Health and Social Care (North, South, Midlands and the East, and London)	• Small teams responsible for overseeing the development of the NHS and social care, assessing the performance of health and social care services, guiding senior NHS staff, improving public health and providing support to Ministers.
National Level	
Department of Health	• Securing management and accountability of the overall and social care system • Developing policy and project managing major change • Overall regulation and inspection of the NHS • Intervention where problems occur.

The programme of NHS restructuring, *Shifting the Balance of Power* (D.o.H. 2001a), launched in 2001, involves structural change that aims to give greater authority and decision making power to patients and frontline staff through changes in cultures, roles and relationships. The new structure removed health authorities and regional offices of the Department of Health and aimed to devolve responsibility to the

frontline of the NHS. The broad aim has been to develop a system in which targets are set at a national level and then translated into local forms of delivery by Primary Care Trusts in consultation with partnership organisations and local communities. The core of the new structure and responsibilities is set out as Table 1.

There are also new forms of targets and performance management. At the core of these are national priorities for services (namely reducing waiting lists, increased booking for appointments and admission and more choice for patients and improving emergency care), key disease areas (cancer, coronary heart disease, mental health, older people, improving life chances for children), improving the overall experience of patients, reducing health inequalities and contributing to the cross-government drive to reduce drug misuse. While these targets are set nationally, it is up to local level organisations to find appropriate frameworks for delivery involving a three year planning cycle.

An important part of the restructuring of the NHS is that it also implies new forms of working relationships. For example, there is increased emphasis placed on partnership working and PCTs in their new roles will require developing relationships with local authorities and voluntary organisations as they work to integrate health and social care services. Indeed, there is now a duty of partnership between health organisations and local authorities (Health Act 1999, DETR 1999).

2.1.2 Workforce Development

Meeting the aims of the NHS Plan to delivery a 'patient centred service' has important implications for developing the NHS workforce both in terms of capacity (increasing numbers) and capability (developing different ways of working). *HR in the NHS Plan* (D.o.H. 2002) developed a new approach to workforce planning based on four pillars of making the NHS a model employer, ensuring the NHS provides a model career (offering a 'skills escalator'), improving staff morale, and building people management skills. At the core of this has been the need to modernise learning and development and workforce development. Key to the latter is the Workforce Development Confederations (WDC) established in April 2001 with coterminous boundaries to Strategic Health Authorities (see http://www.doh.gov.uk/workdevcon/guidance.htm). While employers – both NHS and non-NHS – retain responsibilities for their own workforce planning, the WDCs provide an above employer level of coordination between employers of health care staff to: ensure coherence within an area and ensure staffing requirement are identified; provide information to support central planning; plan and contract NHS-funded education and provide a focus for developing HR strategies where appropriate.

The development of the NHS University (NHSU) (see www.nhsu.nhs.uk), due to be launched in the autumn of 2003, is also an important development. The aim of NHSU is to "contribute to the transformation of the NHS" by providing "help to secure radical improvements to healthcare in this country by delivering learning for everyone." The NHSU is seen as playing a vital role in implementing policies for lifelong learning, the operation of a skills escalator and the development of improvement science in healthcare delivery. Currently, the NHSU has a consultation document out over its development. Issues under consideration include its potential roles in researching and designing the learning offered; the need to avoid all unnecessary duplication of provision; and partnership work with a range of agencies, including the Workforce Development Confederations, Strategic Health Authorities, managers throughout the service, the Open University, Ufi/learndirect and UK e-

Universities, with the Learning and Skills Council, and with the new Health Sector Skills Council.

2.1.3 Local and Regional Roles

Consideration of the development of the NHS workforce needs to be understood in relation to the wider aspects of local and regional development. The DoH's (2001b) consultation paper *Tacking Health Inequalities* highlights the important role the NHS can play through its "investment in staff and capital, the purchase of services and the development and regeneration of local economies". The potential role of the NHS has been developed by a Kings Fund report *Claiming the Health Dividend* (Coote, 2002) which links issues of NHS development with the government's White Paper *A better Quality of Life: A Strategy for Sustainable Development for the UK* (Cm 4345 2002), highlighting the potential impact of the NHS on health, the environment and the social and economic fabric. In relation to workforce development specifically, the report notes the role of the NHS as the largest single employer in the country and the well documented relationship between ill-health and unemployment/poor working conditions. The report argues that increasing local recruitment by developing pre-employment training and helping employees move on through the NHS 'skills escalator' could prove beneficial to the health of local populations while also developing a local workforce that is more sustainable for the NHS. Coupled with the NHS's role as a purchaser, the development of the NHS, along with the health sector more generally, can lead to positive effects for local and regional economies. For these reasons, the Public Health Strategy in the East Midlands, *Investment for Health* (East Midlands Assembly 2003), links to the Economic Strategy *Prosperity for People*. While *Investment for Health* requires a thriving economy to delivery its agenda, the development of the regional economy also requires a good level of health. *Investment for Health* notes that 'a major area for future development is capitalising on the significant contribution the NHS makes to the East Midlands economy at every level'. The report *The Business of Health* (Chant et al 2002) details the economic contribution the NHS can make to the East Midlands in terms of employment, demand for goods and services, and capital investment.

2.2 The Changing Landscape of Education

2.2.1 Building the Knowledge-Based Economy

The higher and further education sectors are also undergoing significant transformations, in relation to roles, responsibilities and expectations. This is largely connected to the development of the knowledge economy, in which research, teaching, knowledge transfer and outreach to local and regional communities assume prime importance. The development of the knowledge economy places universities, as major knowledge producers, at the heart of economic development processes: "as generators of new knowledge, basic and applied, research-oriented universities are to the information economy what coal mines were to the industrial economy" (Castells and Hall, 1994: 231). The production of knowledge and the application of that knowledge is a function that the university has always been well placed to fulfil, but a premium is now placed on extracting economic and social benefit from university-based knowledge. The recent White Paper (2003) *The Future of Higher Education* – the most recent statement on higher education - makes it clear that the UK's record of scientific excellence must not be compromised in research. Thus we see the creation of 6* departments to which an increasing proportion of monies from the Research

Assessment Exercise (RAE) will be channelled leading to greater research concentration and selectivity.

The knowledge economy also implies a shift in the nature of skills necessary for competitive success. Rather than founding competitive success on traditional sectors such as manufacturing or agriculture, developed countries are increasingly looking to enhance productivity and growth through exploiting knowledge, skills, innovation and creativity. This is also referred to as building a 'high value added' economy, characterised by high wages, high employment and high skills. Indeed, the importance of knowledge as a factor in wealth creation and productivity is often seen to characterise an economic shift from 'action-centred' to 'intellectual' skills, from 'brawn' to 'brains', or from tangible to intangible created assets (Bryson et al, 2000. Accordingly, the teaching role of higher and further education establishments in producing a skilled and educated workforce is paramount and as a means for social inclusion and equality. Thus we see the Government's widening participation target to have 50% of 18-30 year olds in higher education by 2010.

In addition to bringing the research and/or teaching functions of the higher and further education sectors to prominence, the shift to an increasingly knowledge-based economy has increased the importance of knowledge transfer. It is not enough to simply produce knowledge, but to transfer that knowledge to industry, user and community groups. Hence we see renewed efforts invested in commercialising university research, in creating spin-offs, science parks and in tailoring courses to the needs of industry. There is a focus on Higher Education Institutions (HEIs) as generators of new knowledge and sources of innovation, reflected in the cross-departmental Science Strategy (2002), *Investing in Innovation*, and in initiatives such as the recently strengthened Higher Education Innovation Fund, worth £90m a year in 2005-06 (DfES, 2003), to represent a permanent third stream of funding, alongside funding for research and teaching.

Finally, the last decades have seen an increasing emphasis on the need for outreach to local communities and the role of educational establishments in contributing to local and regional development. Further education colleges and former polytechnics have traditionally had an outward-looking perspective, with a greater emphasis on civic responsibilities and more local catchment areas and tailored provision. Universities on the other hand have been traditionally seen as 'in but not of' their localities, but this is no longer the case:

> *"Universities need to adapt rapidly to the top-down influences of globalisation and new technologies, as well as the bottom-up imperatives of serving the local labour market, innovating with local companies, and providing professional development courses that stimulate economic intellectual growth"* (David Blunkett, 15th February 2000, Press Release).

The development of the 'third mission' can be seen for instance in the White Paper on Enterprise, Innovation and Skills (2001) which explicitly aims at building strong regions and communities through establishing university innovation centres and technology institutes in the regions to boost R&D and a £75m regional incubator fund to promote regional clusters (DTI and DfEE, 2001). Such initiatives build on previous policies, such as the Higher Education Regional Development fund (HERD), the Higher Education Reach Out Business and the Community Fund (HEROBC) and Science Enterprise Challenge.

2.2.2 Thinking Scale

The diverse roles and functions of the university in the knowledge economy are multi-scalar. Research needs to be conducted at an international level in order to meet criteria of world class excellence; it also needs to be embedded in local and regional contexts if the kinds of benefits expected from the knowledge economy are to be realised. International consortia and networks need to be formed and economies of scale built, through 'super-universities', as well as collaboration between universities in particular localities. Student markets are now international, with overseas applicants representing attractive sources of much needed finance; but a *'knowledge economy for the many not the few'* (Tony Blair) requires increasing applications from local and particularly deprived communities to both higher and further education establishments. Similarly, universities or FE colleges may seek closer relationships with large multi-national companies or may prefer to 'stay nearer to home' working with SMEs or social enterprises on community-related issues. In the 21st century, it is not a simple question of 'either/or' but of selecting the appropriate combination of actions at a number of different scales.

2.2.3 Specialisation, Diversification and Partnership

The UK policy landscape for higher and further education is multi-faceted, with new expectations in the knowledge economy, new considerations of scale and responsibility to local and regional contexts. There are multiple roles and functions. Yet it is not expected that any one institution fulfils all roles at all times. For instance, at the launch of HEFCE's draft strategic plan (2003-08), Sir Howard Newby was quoted as saying that individual universities:

> *'must build upon their own chosen areas of strength, and work in collaboration with other providers, so that the sector as a whole continues to deliver all that is required of it in the increasingly competitive global marketplace'.*

This requires institutions to play to their strengths and work in collaboration with other institutions to collectively meet the socio-economic demands placed upon them (DfES, 2003). Choosing the right strength or specialism is particularly important given the increasing relationship between specialism excellence (research, teaching, 'third mission') and funding. Yet it is also clear that incentives for engaging in teaching and outreach or knowledge transfer activities are still dwarfed by those available for traditional research.

Consequently, the HE and FE landscape is not only marked by increasing specialisation of roles and diversification but the potential for competition. The evolving roles of institutions offer opportunities for greater engagement, but also raise sets of complex issues in respect of traditional functions. For instance, the widening participation target may bring universities into competition with FE colleges in terms of new types of course provision which broaden traditional catchments. New online, distance learning and private universities, as well as initiatives such as the University for Industry and the NHSU render complex the educational landscape, with a plethora of different providers, educators and producers of knowledge. In this landscape, the distinctive strength of particular forms of provision become difficult to identify. More recently, the Secretary of State for Education has made it clear that state funding for a 'medieval' style community of scholars is not likely to be sustained. This echoes the provision in the recent White Paper on Higher Education for further education colleges to become universities without research degree awarding powers.

2.3 Contextualising the HESP

The context outlined above highlights a number of similarities between the health and the education sectors. We see changing organisational landscapes with new providers and multiple expectations; national imperatives to forge clarity about roles and responsibilities and to design future-oriented strategies which consider regional as well as local needs. Institutions within both sectors are required to be strategic and are increasingly asked to consider their roles as major employers, trainers, educators, researchers, and civic agencies. Most importantly, the implications of changes in both sectors is that common goals will only be reached through working in partnership with other providers and agencies within and between different sectors.

The recent establishment of the Strategic Learning and Research Advisory Group for Health and Social Care (StLaR) by the Departments of Health and for Education and Skills in the UK reflects this increasing awareness of the numerous links and interconnections between the health and social care and education sectors. StLaR aims to improve and oversee joint working at the interface between the two sectors and to provide a forum for major partners, represented at the most senior level, to consider the interplay between areas of mutual interest, develop supportive and complementary approaches in planning and development and tackle specific issues that require a national and integrated response.[1]

Clear benefit is seen in mirroring StLaR's functions at the local level. In a recent letter to Chief Executives of Strategic Health Authorities, Workforce Development Confederations, Primary Care Trusts, NHS Trusts and Local Authorities, the Permanent Secretaries for the Departments of Health and Education and Skills have strongly endorsed the establishment of local Health and Education Strategic Partnerships (HESP) to ensure effective coordination between health and social care, research and learning at the local level.[2] Potential areas of activity suggested included the impact across sectors of partners' strategic plans; securing the future NHS workforce; the role of both sectors as major local employers and in promoting the well-being of local communities and addressing capacity and capability issues for the health and social care, research and teaching workforces. At the same time, the new HESPs are advised to set their own local agenda, balancing considerations between short term and strategic priority setting: 'we strongly hold the view that what issues are addressed, and how are for local determination'.[3] It also states that it looks to the Chief Executives of SHA to be the lead drivers for the establishment of HESPs.

It is against this background that the Trent HESP had its first meeting in May 2003, organised by the Trent WDC on behalf of the Strategic Health Authority. As the initial proposal to establish a HESP in Trent noted, 'the case for a strategic forum that can anticipate and plan for change in Trent is compelling' (Trent WDC, 2003).

In the next section we draw upon the interviews conducted with key representatives at that first meeting to consider the needs, expectations and aspirations for the HESP in Trent.

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[1] http://www.doh.gov.uk/hrinthenhs/learning/section4a/stlarhomepage.htm
[2] Letter dated 22nd May 2003, http://www.doh.gov.uk/hrinthenhs/learning/section4a/hespsletter.htm
[3] ibid.

3. Thinking It Through

The purpose of this section is to summarise key reflections in relation to the HESP through analysis of the interviews undertaken with the identified stakeholders. First we consider different conceptualisations of the HESP, its purpose, function and expected outcomes. Second, we move on to consider the particular priorities identified by the first HESP meeting. Next, we examine the questions of resource and capacity, participation and representation, before finally exploring the challenges and opportunities, strengths and weaknesses of 'making the HESP work' in Trent. In doing so, we give insight into the thoughts and views of particular individuals, their aspirations, hopes and expectations. Throughout, we have sought to provide a linking narrative to the set of interviews, whilst enabling voices, opinions and perspectives to come through. The extensive quotes that have been used are non-attributable, in order to guarantee anonymity of interviewees.

3.1 What is this thing called HESP?

At a general level, the interviews all revealed an enthusiasm at the opportunities created by the HESP for inter-sectoral co-ordination between the health and education sectors:

> *The HESP offers some exciting potential for dynamic inter-relationships that create sparkiness and zest between the education sector and health provision.*

The HESP was widely seen as needed to bring together objectives and strategies that are planned across different agendas that have a health-related outcome to create, as several interviewees stated, greater 'joined-up thinking':

> *The trick is to understand that agendas might not fully overlap, but there are a series of circles that do overlap so it is about finding connections, where do the circles touch?*

For one interviewee, the HESP is both about achieving synergy and coherence between different agendas, but also about finding new ways of working:

> *There are big changes in education and in the NHS. There is room for economies of scale, room for modernisation and targeting, better ways and different ways of doing things...so we know it is a good idea.*

In this sense, the HESP is seen as a vehicle for filling the gaps, providing a unique opportunity for partnership working between health, higher education, further education and social care agencies.

Part of the distinctiveness of the HESP related to the strategic orientation which it was hoped the HESP would be able to adopt, in opposition to both the SHA and the WDC which many interviewees felt were still growing in their roles and had not yet developed either strategic overview or long-term orientation:

> *The SHA has to look at more 'domestic issues', meeting the specific targets laid out for it and enshrined in the NHS plan. But the HESP can be more outward looking and look at the contribution to the whole region.*

Enthusiasm at the idea of the HESP similarly came from those who felt that existing bodies often worked across each other rather than in co-ordination:

> *There is some medium term thinking ...but we do tiny bits of work in isolation and this isn't communicated across boundaries.*

In this respect, the benefit of the HESP was seen to come from its ability to sit 'over and above' current structures and forums, to add value to what currently exists and to be 'more than the sum of its parts'. For several interviewees, this added value comes from the ability of the HESP to translate between national and local agenda, acting as an 'intermediary' between central and local agencies:

> *The HESP is an opportunity to shift the balance of power to set up a local system...there is a need to lobby for best patient care and best provision in the educational arena.*

This linked to a wider desire articulated by several interviewees to develop common themes and priorities across Trent and build into a wider regional identity:

> *In Trent there is a loose allegiance of health providers, almost impotent against central dictates. This leads to infighting and there are no common themes or agreement about how to fight them. The HESP could do this.*

Indeed, throughout the interviews there was little agreement on what those common themes should be. For some, commonality between partners was restricted to a 'realpolitik' of seeking to influence and shape others, building on shared relationships and agendas, whilst for others the HESP should be driven by patient needs and improved service delivery:

> *We need new boundaries and alliances to look to the best interests of the patients, it isn't about the organisations themselves.*

> *Breaking down barriers needs work ... however, everyone seems to be trying and if we stay focused on community needs, then we can stay on track.*

More than one interviewee referred to the need to subjugate individual and organisational interests to the 'greater good', if the potential of the HESP is to be realised. However, identifying that 'greater good' also revealed differences of opinion. At a general level, it was noted that patient needs, local needs and population needs are often seen as synonymous, yet this masks important differences in orientation and focus.

In particular, the question of whether local specific needs even existed emerged from interviews. Several interviewees referred to the recruitment and retention issues in Lincolnshire and in pockets of Northern Nottinghamshire as being a particular priority, while others felt that health and education needs were more generic:

> *Trent is too small an area to think of particular population needs. We need to encourage providers to think big in terms of collaborations and programmes of work.*

More generally, it was felt by some interviewees that the unifying theme of the HESP should be contributing to wider regional economic and social prosperity, particularly given the large size of both the NHS and the HE/FE sector as employers in Trent:

> *The other side is what that workforce can do for the wider community. The NHS are the largest employers, totalling 5% of any workforce in any area...so we have an opportunity to contribute to the wider community and to the economy of the wider community.*

One of the core differences distinguishing between interviewees conceptions' of the HESP relates to its overall function and purpose. On the one hand, there were those who felt strongly that the HESP needs to deliver and have tangible outcomes by the end of its first year of operation:

> *The objectives of the HESP need to be focused around what can be influenced...it isn't just a talking shop or just an exchange of information...it must be more than that.*

> *We need to start with where people are, navel gazing is one thing, but people at senior level don't want a frippery jolly.*

In this respect, many interviewees noted that the HESP needed to be a 'doing forum' rather than a 'talking shop'.

On the other hand, an equal proportion of interviewees felt that thinking and talking is exactly what is needed, that the HESP should be a space for reflection, enabling the different partners to develop, over time, a shared orientation, strategic overview and commonality of opinions that would have long-term benefit in the Trent area:

> *Is it a thinking shop? We must allow ourselves thinking time and resist the immediate output thing. If it is interesting and clever then they might not walk away.*

> *We need to be realistic about what we can expect to deliver within existing timeframes...people are busy and we do need to deliver, but we need to speculate to accumulate.*

In this sense, the added value of the HESP stems very much from its ability to provide an alternative space in which people could think, free from the normal constraints of delivery, 'avoiding the quick win'.

This is a fundamental difference and affects both what is expected of the HESP and the criteria by which its success is judged. Thus, for one interviewee, without demonstrable benefit and outputs, the HESP will be a 'flop':

> *We need to see that the outcomes of the HESP would help everyone strategically and day to day.*

Whilst for others, it is the process in itself that is more important than immediate outputs:

> *It is more about getting people working together more actively that they already do...partnerships that work best build relationships over time...you get to the point where suddenly you find extra value.*

Alternatively, the success of the HESP relates to a more general impact on building a Trent identity and improving regional fortunes:

> *There is no sense of cohesion in Trent because of the geography...there is no Trent family...we need a sense of belonging so that people move within it and not across.*

This interviewee noted the absence of a strong East Midlands identity, 'trapped between the North and the South' and the need to put 'Trent on the map', seeking not only wider regional economic benefit through better inter-sectoral co-ordination, but also a reputation for best practice nationally, for instance, in the creation of a centre of excellence in developing the workforce.

3.2 What should the HESP do?

Moving from general conceptualisations to particular priorities, the interviews revealed unanimous agreement that the three areas identified in the first meeting were a fair representation of the issues that the HESP needed to tackle: excellence in health careers, translational research and partnership funding.

Most commonly referred to was the need to create the future workforce for the NHS, to tailor current provision to produce the 'new kind of worker' necessary for the 21st century and to improve the connections between academic training and professional needs:

> *If we are going to deliver on national targets, we need people with the right skills in the right places at the right times. HESPs might be able to do that.*

> *The interface between medicine and professions allied to medicine is too distinct – this is beginning to blur and the HESP is about populating the blurred edges.*

A key element in this was seen to be redefining forms of training and innovating in terms of provision and course curricula. One good example is the creation of 'multi-disciplinary and flexible workers' who could be deployed in different settings through the establishment of common syllabuses for the first years of degree courses, with specialisation only in the final year and top-up training available for those wishing to re-train later on in their careers. Demonstrating the value of non-typical NHS careers, particularly to those in more deprived communities or where take-up into FE and HE is lower, such as Lincolnshire, was also seen as important.

While it was felt that there were some instances of good practice, for example in the plans for a shared Foundation Year at Lincoln University that also feeds into courses at Nottingham University or collaboration between institutions in relation to nursing placements and supervision, a number of interviewees felt that provision is not locally embedded nor complementary enough between universities or other education providers:

> *Overall we understand what is going on in terms of University training provision, but we don't know enough details... or what the different specialisms of the Universities are.*

A second priority relates to 'translational research' and the interconnections between research, undertaken predominately in the universities, and the needs of the NHS and service deliverers:

> *One thing we want to look at through the HESP is research through universities – could we be more aligned to meeting the service requirements of the NHS?*

This interviewee was concerned that although there was a great deal of research being conducted into biological sciences or blue skies research, there was not enough concern with relating that to service delivery and patient need:

> *We need to have a continuous circle from blue skies research to patient trials...to directly benefit patients...more uncommitted research might be directed into areas that the health community could be interested in. ...We don't do as much as we should in the Trent area and this is something the HESP should be able to bolster and strengthen.*

A first step in doing this was felt to be raising awareness about health-related research that actually takes place in universities:

> *We need to discuss what research interests in the universities are, how can we hit research aspirations and also hit application and the aspirations of the city?*

Through helping the workforce to be more 'research aware and research receptive', it is hoped that further collaborations will emerge which will attract funding, such as through the European Union's Framework 6, and also lead to the better identification of gaps in research to develop a more 'holistic' approach to health and medical research.

Ensuring greater integration between funding streams and thinking 'outside silos' was the third commonly mentioned priority for the HESP, to make the most of the large amount of existing resources for both education and research in the Trent area:

> *There is huge money already floating around – are we getting value out of what we have put in? The HESP must question this...it is not about taking money out or putting money in, but making it work better.*

The benefit of this was seen to be not only in reducing duplication and waste of resources but in forging greater strategic agendas:

> *If we combined resource, it would be of great benefit and perhaps we need pump priming for that ... in time that would help us to understand what we have, where we wish to be and how we each contribute.*

The importance attached to each of these priorities differed between interviewees, with research and partnership funding appearing of less immediate urgency than the question of health careers. One interviewee felt that greater prioritisation was needed:

The HESP needs to look at the real health problems, prioritise threats and then to take the top one and keep hitting it....the important thing is to do one thing extremely well in a joined up way.

However, another perspective was that the distinctiveness of the HESP lies in bringing stakeholders together to discuss the interconnections between research, education and funding, to explore the implications for practice of research and vice versa, the relationship between future scientific discoveries and the commissioning of particular training programmes and in attempting to vision where long-term changes and trends lie.

3.3 Resources and Capacities: Empowering the HESP?

What the HESP is and what it can do are directly related to the resources and 'clout' that is has:

We can't begin to think about what we want to achieve until we have the tools. What do we have to play with?

It's a chicken and egg situation...when we know what the job is to be done we will be able to see what we need.

For some, resources, whether in the form of direct financial assistance or personnel support, would be essential, particularly given the heavy workloads of those involved:

If we are dependent on the [sole input of] the people round the table then it isn't going to work...we need clichés to translate into meaningful actions.

In contrast, another interviewee referred to the initial voluntary commitment that would be needed, before financial assistance could follow as a result of commonly forged goals. The HESPs 'clout' therefore lies in its ability to influence the agendas of others, by virtue of its position and the seniority of those involved:

The HESP is a collective point to bring things out of us...it isn't a resource giver but could bring resources together. It might charge others with doing things.

It is not only a question of what resources the HESP needs to have a meaningful and tangible impact, but what external capacities it can draw upon. Here, the interviews revealed an honesty about the significant gaps in understanding with respect to different institutional agendas as well as to sources of external strategic intelligence:

We don't know what resources we need as we haven't had the discussions on where we can contribute and we do not know what else is going on.

Intelligence in the region was felt to be fragmented, held in a number of indeterminate locations and agencies, with no single repository of knowledge:

At the strategic level there is lots of information that isn't joined up, from the business sector to the East Midlands Development Agency, about the health of the population – it isn't married together in a meaningful way.

Indeed, while the research team's desk-based research revealed a number of potential sources of intelligence (see Annex I), such as East Midlands Public Health Observatory, the Nottingham Research Observatory and the Trent Research Information Access Gateway (TRIAGE), interviews revealed a poor awareness of their existence, leading several interviewees to comment on the need for a more systematic piece of capacity-identifying work to be carried out.

The need for a clearer picture of future trends and overview of the current evidence base led to the identification of several gaps that could be filled to assist the HESP in carrying out its function. Most importantly, these related to the desire for a foresight process to identify common priorities and goals, 'time out' with external facilitators to better understand mutual and individual agendas and the need for comparative learning:

> *The HESP should not invent the wheel...we need to find out what is happening elsewhere and learn from other areas to share best practice.*

3.4 Who should be involved?

Several interviewees felt that the uniqueness of the HESP as a forum came from its wide representation and inclusivity, bringing together key stakeholders, at senior level, in a way that does not currently exist:

> *The distinctiveness of the HESP is the seniority around the table to identify areas to work together on to improve the health of the SHA population.*

However, other interviewees pointed to a degree of concern over the representative nature of the forum, both in terms of its health / education / social care mix and in terms of the extent to which representatives of different organisations feel able, and willing, to represent their larger sectors:

> *We don't want too many health bods...the WDC is leading [the HESP] in alignment with the SHA, but it isn't supposed to be just about the NHS...the WDC still have a broader set of stakeholders in the interests of delivering the workforce for health and social care in the future.*
>
> *Often the social care sector is called upon to represent the whole profession, but we only employ 40% of care staff, the other 60% in the private sector are not represented.*

However, as another interviewee noted, engaging the private health and social care sectors, and indeed the voluntary sector, in collective fora was seen as difficult:

> *The private health care sector is slow moving, there are hundreds of nursing homes so there is no organic brain. The voluntary sector is also interesting, but they have no collective voice. We know about some but not all.*

Other significant omissions at the first meeting that interviewees felt was important to be involved ranged from local authorities, representatives from regional agencies such as the Government Office and Regional Development Agency, the NHSU, Learning

and Skills Councils, regional politicians and big occupational employers, such as Toyota. However, as one interviewee pointed out:

> *We need to build on the strongest group first and then include others...all you would be saying is come and join our nebulous discussion*

While others felt that there were already too many representatives around the table:

> *there are too many people at the moment, there is a trade off between inclusivity and being overwhelmed... people were pulled in [to the first meeting] who happened to answer the phone.*

Who is included and/or excluded in the HESP is an important issue in so far as it affects its nature and priorities and operation of the partnership:

> *The solutions found will very much depend on who is there.*

3.5 Making the HESP Work?

Throughout the interviews there was a overwhelming agreement on both the need for and general commitment to the idea of the HESP. This was seen as a key foundation for interviewees' optimism about the potential of the new partnership. The seniority of members around the table, predominately at Chief Executive level, was seen to symbolise a willingness to making the HESP work:

> *It was important that the Chair of the SHA was orchestrating HESP, this showed symbolic commitment from the top.*

The first meeting was felt to be positive, building on good relationships that currently exist between partners:

> *The meeting was relaxed and enabled time for people to put their views forward.*

Another interviewee commented that the challenge was not only to recognise differences and where there are gaps in understanding, but also to celebrate successes and existing best practice. This was noted in particular in relation to the extent of collaboration between the Trent Universities. While some referred to historical rivalries, others felt that significant progress had been made in overcoming traditional barriers to cooperation, not least through the East Midlands Universities Association (EMUA):

> *We need to build a picture of what is and not of what was.*

> *I think that the Universities get on quite well as institutions...there are the beginnings of a partnerships and fertile ground for progress.*

Other areas of good practice to be built upon and integrated into the HESP's overview included discussions that are currently taking place with respect to more joined up thinking between EMDA, the CEOs of SHAs in EM, GOEM and regional director of public health or the EMUA health task group. A number of sub-regional initiatives were also noted as positive developments in creating shared agendas and joined-up

thinking, examples given within Lincolnshire and Southern Derbyshire which aim to link supply and demand in education provision, and gain a local health community perspective on joint working.

However, despite the enthusiasm, willingness, top-level commitment and existing good practice, four practical issues emerged in terms of the effective functioning of the HESP.

First, many feared that over time the level of senior commitment to the HESP would diminish, particularly if tangible impact wasn't seen. This would diminish the potential influence, both nationally and regionally, of the partnership.

Second, for one interviewee at least, genuine differences between partners have not yet been aired:

> *The meeting was very polite and the unpleasant things were under the carpet…people need to say when they are uncomfortable so that we can explore why and can work round them.*

As another interviewee commented, the challenge was to have a healthy and realistic assessment of the gaps, similarities and differences:

> *The challenge at the first meeting was to get people to actually say that they had no idea of what any one else was doing in the big picture. One barrier is the assumption that senior people actually understand others strategic agendas.*

Key to this is an understanding of the environmental peculiarities within which different sectors operate, particularly in terms of their incentives. For instance, the question of whether appropriate incentives for translational research exist in the higher education sphere was noted by several interviewees:

> *Universities are not really interested in benefit to patients and academic leadership in clinical areas […] they are more interested in the RAE assessment. We need to find the middle ground, without it we might go to war.*

> *There is a danger that we might end up with a big medical model versus some of the other models, such as action research, that might not be respected and seen as small fry but that might actually make a difference to healthcare.*

Consequently, one interviewee noted that it is difficult to see under the current funding regime, as laid out in the White Paper on Higher Education (2003), how 'local communities can influence R&D policy and whether they can get money'.

However, it was not a question of negativity, rather that through airing differences and recognising institutional distinctiveness, a greater sense of what is shared could be generated. In this sense, the HESP should be a 'committee of creative difference'.

The relative lack of understanding about partners' agendas leads to a third practical consideration in making the HESP work, relating to the clear definition of roles, responsibilities and relationships. There was a general acknowledgement of the lead roles of the SHA and the WDC in taking forward the workings of the HESP:

> *We need some more clarity about the SHA role - there is no strategic overview of what it is up to. They are about performance management but they also need to be about leadership and support*

The nature of the relationship between the SHA, WDC and HESP in terms of strategic oversight remained unclear in the minds of several interviewees. Is the HESP the operational arm of the WDC? Is it a coordinating network or an advisory group? How does it fit within existing structures?

> *Part of the difficulty in situating the HESP comes from the relative immaturity of both the SHA and the WDC. In both cases, having only been in existence for 18 months or so, they have not et fully defined the parameters of their roles.*

Interviewees also pointed to the absence of understanding about the relative strengths of higher and further education players in the areas, rendering difficult the identification of particular contributions to the HESP. A number of simple characterisations emerged – the new medical school at Derby being better attuned to local needs and more responsive to community agenda; Nottingham University's focus on biomedical research and medical education; new innovative courses at Lincoln Universities; Nottingham Trent's focus on social care; further education colleges as being better equipped to reach out to more disadvantaged communities. However, it was not clear that these characterisations, while seemingly shared, were evidence-based or represented the wealth of activity that takes place within institutions.

Similarly it was not clear what the place of the new NHSU would be within the health and higher education landscape, causing unease and in some cases disappointment:

> *The NHSU was set up with laudable aims about bringing the educational underclass into the NHS. But now we are moving to aims associated with higher professional groupings …that still leaves the underclass and brings the NHSU into conflict with existing providers.*

Lack of clarity, as yet, over roles, responsibilities and specific institutional contributions led to an oft expressed concern that the HESP will duplicate existing activities, not adding value but subtracting it, through an inadequate knowledge of what currently exists, a task made more difficult by rapidly changing health and education sectors. However, in this respect, the need for the HESP becomes greater:

> *The HESP can be a forum for continuation in looking after local needs…we can build stability in policy development and implementation across the wide picture.*

From the interviews, then, a number of issues have emerged relating to what the HESP is, what it should do, with what resources and with whom involved. We have highlighted key comments in relation to the strengths and opportunities of the HESP and the challenges that it faces in practically moving forward. In the final section of this report we pose a set of core questions, outline the process and ground rules for moving forward.

4. Thinking Allowed: Summary and Conclusions

The decision to establish a HESP in Trent can be seen as a response to national directives and set of significant changes in the health and education sectors within the UK. In the health service, the core drivers relate to the need for a patient-centred approach within changing NHS structures and a particular focus on workforce development. The higher education landscape is equally challenging, as universities are required to adopt new roles in relation to their traditional functions of teaching and research, reaching out to local communities and having relevance to society's needs, requiring partnerships with a wide range of agencies.

In both sectors, the policy landscape is changing with remarkable speed – from the new Foundation Hospitals and the NHSU to the differing interpretations of the Government's most recent White Paper on Higher Education (2003). Not surprisingly then, there is a degree of confusion about respective agendas, as the job of keeping an eye on the most recent and urgent national policy directives becomes all time consuming in one sectoral context let alone across inter-sectoral boundaries.

Against this background, the establishment of the HESP represents an immense opportunity for a better, more responsive health service and education system, in which traditional functions are fulfilled while new potentials and possibilities for synergy and co-operation explored. Yet it is also a challenge, as the HESP needs to overcome considerable sectoral differences and find its place within a plethora of initiatives, forums, strategies and bodies.

SURF's work represents a first step towards 'making the HESP work' in Trent. Our interviews and desk-based research have made explicit the general overall context within which the HESP must operate, the voices, perspectives and opinions on its role, function and purpose and highlighted issues of capacity and resource. Importantly, the interviews have revealed a high degree of receptiveness within the Trent area to the need for the HESP and apparent willingness to commit to its success.

Yet this 'thinking piece' has been designed to be the beginning, not the end, of the process. In this final section of the report, we outline four inter-related recommendations for the HESP in moving forward in defining strategic priorities, actions and goals.

4.1 <u>Recommendation 1</u>: Three Steps to Success

- The HESP needs to decide what its fundamental <u>purpose</u> and function is. People coming together in a new forum may be distinctive, but real 'added value' will not be achieved without defining the HESP further. What is the collectively identity of the HESP? What is the glue that binds the partners together? The purpose of the HESP needs to be collectively defined and discussed. It must be sufficiently tight to make it work, yet sufficiently loose for different interests and parties to be able to sign up. Action in the absence of understanding or clarity about purpose will be wasteful.
- Having defined the HESP's purpose, the partners need to consider issues of <u>process</u>. How can the collectively defined purpose of the HESP be fulfilled? This requires consideration about what people can bring to the table, what they expect to

get out of it and who should be involved. Chief Executives may be authorised to make decisions, but what are the mechanisms for communicating the messages to the outside world, to those charged with the implementation of HESP recommendations?

- Purpose and process must be accompanied by <u>product</u>. A tangible and feasible difference over the medium term is needed to demonstrate the value of the HESP to those involved and to wider constituencies. The HESP needs to design a flagship project that embodies all that it wants to achieve within a 2-year time-frame that can cut across the three priority areas (careers, research, funding) rather than treating those in silos. This project needs to be owned by the HESP, something to which all can sign up and contribute – including politicians. A project which symbolically stands for what the HESP is and which is deliverable in the medium term would enable both the productive relationships desired between actors to develop, as well as potentially attract funding for longer and more strategic joint work.

4.2 <u>Recommendation 2</u>: Pre-conditions for Partnership

In moving through the above steps, there are three key questions that the HESP needs to answer as a precondition for a successful partnership:

- Why should people come to the meetings?
- What will exist in 2-3 years that doesn't exist now?
- And how is this going to be achieved?

These simple questions must be answered collectively and honestly, as one interviewee noted:

> *The only way [the HESP] will work is if people believe it and have come to their own conclusions.*

4.3 <u>Recommendation 3</u>: Setting the Ground Rules

A series of ground rules for the HESP need to be agreed upon, particularly if the fears of duplication and devolution of responsibility expressed in the interviews are to be avoided. We recommend the following:

- *Clearing the Air:* partners must be honest with each other and air differences where they exist
- *Consistency of Representation:* efforts should be made to ensure that the same people attend the meeting, in order to build effective partnerships.
- *Clarity of Roles and Responsibilities:* greater clarity is needed over what different partners can and cannot contribute
- *Communication*: is essential to those outside the HESP in order to ensure effective action and impact
- *Consensus*: the aims and objectives of the HESP must be commonly understood, collectively agreed and widely shared.

4.4 <u>Recommendation 4:</u> Gathering the Evidence Base

Our final set of recommendations relates to more practical issues of gathering the appropriate evidence base for the HESP.

- A <u>comparative</u> piece of research is needed to explore how the relationship between the health and education sectors is managed elsewhere in the UK, particularly in those places which are seemingly 'ahead of the game'. The examples of Manchester and Cambridge were widely referred to. This relates to the clear desire of interviewees not to 'reinvent the wheel' and explore best practice elsewhere in order to make the Trent HESP work most effectively.
- Interviewees referred to the need both for <u>external facilitation</u> in thinking through the purpose and operation of the HESP and a regional health and education <u>foresight process</u> to identify future priorities
- This need was also based on the lack of a common understanding of what capacity currently exists for strategic thinking in Trent which would have the potential to inform the work of the HESP. Our initial overview of sources of strategic intelligence in relation to general area characteristics, careers and research, presented as Annex I, offers a potential model for a more detailed piece of <u>strategic intelligence gathering work</u>.

There is a clear need and role for the HESP in Trent. The opportunities abound. Armed with the right resources and knowledge, united by a common purpose around an initial flagship project, with the preconditions established and ground rules set, the partnership has the potential to forge new relationships and partnerships for the wider benefit of the regional economy, its communities and the health and education sectors.

Annexes I: Trent HESP Sources of Information and Intermediaries: Area Characteristics, Careers, R&D

1. Characteristics of Trent Area

Information Source/Intermediary	Summary	Location/Contact
Trent StHA Population Figures	Population by Health Authority for England and Wales. Includes total figures for Trent, also sub-divided by age, gender, and for PCTs.	www.statistics.gov.uk/census2001/downloads/pop _health_areas2001.xls
Statistics for Trent StHA Area	Including statistics for: Access to Services; Community Well-being/Social Environment; Education, Skills and Training (including numbers of students and levels of qualifications); Health and Care; Housing (including amenities; People and Society; Work Deprivation (including economic activity breakdown; hours worked).	http://www.neighbourhood.statistics.gov.uk/Area_ Select_fs.asp?nsid=false&CE=True&SE=True&P =S Click 'Statistics by Area', then 'Change', select '2003 Health Areas', then 'East Midlands', followed by 'Trent'.
East Midlands Observatory	Contains statistics, surveys and reports focusing on the economy, labour market, employment for the East Midlands. Also offers profiles of Derby, Nottingham, Lincolnshire, etc, in terms of economic life, deprivation, culture, etc.	www.eastmidlandsobservatory.org.uk
National Patients Survey Programme 2003	Provides survey, benchmarks and tables nationally, by StHA and PCTs with regard to a series of issues, including: seeing a health care professional; visiting your GP surgery or health centre; referrals; medicines; out of hours care; health promotion; and other issues.	www.chi.nhs.uk/eng/surveys/nps2003/pct.shtml Scroll to bottom of page under 'Tables' heading. Subsequently select required tables for statistics by StHA and PCT
Nottinghamshire Research Observatory	A partnership between the Learning and Skills	www.theobservatory.org.uk

	Council Nottinghamshire, Nottingham City Council, Nottingham Trent university and others. Offers access to a range of locally-focused research projects (e.g. related to skills, employment, economy, ICT-use, etc), employment statistics, area profile, and publications	
East Midlands Public Health Observatory	One of nine regional Public Health Observatories funded by the DoH to strengthen the availability and use of health information at local level. Covers Derbyshire, Nottinghamshire, Lincolnshire, Leicestershire, Northamptonshire and Rutland. Role of PHOs is to support local bodies by: monitoring health and disease trends and highlighting areas for action; identifying gaps in health information; advising on methods for health and health inequality impact assessments; drawing together information from different sources in new ways to improve health; carrying out projects to highlight particular health issues; looking ahead to give early warning of future public health issues; evaluating progress by local agencies in improving health and cutting inequalities	www.empho.org.uk

2. Information Sources and Intermediaries: Health Careers

Information Source/Intermediary	Summary	Location/Contact
Learning and Skills Council Nottinghamshire (see also LSC for Lincolnshire and Rutland, and Derbyshire)	Offers services including Work Based Learning for young people, including, for example, NVQ training and assisting companies to improve the skills of staff through the provision of NVQs.	www.lscnotts.com
Business Link Nottinghamshire (see also other Business Links for Derbyshire, and Lincolnshire and Rutland)	Details over 100 courses/programmes in training and management development. These are included under headings such as: IT Skills; Personal Effectiveness/Communication; Leadership and Management Skills; Health and Safety.	www.blnotts.com Follow links for Training and Development Programme.
Nottinghamshire Chamber of Commerce (see also Chambers for North Derbyshire, South Derbyshire and Lincolnshire)	Nottinghamshire Chamber offers training courses and programmes in areas which include: Management; ITC; and Vocational Training. Some courses and programmes are available online.	http://www.nottschamber.co.uk/training/
Lincolnshire Institute for Health, University of Lincoln	Provides BSc and MSc qualifications and professional training in subject areas where, it suggests historically, there has been a regional shortfall in expertise such as occupational health nursing, paramedics, geriatric nursing and complementary medicine. Also offers the Joseph Rowntree Foundation Certificate in Care.	www.lincoln.ac.uk/LIFH/index.htm Professor Hassan Hassan Hhassan@lincoln.ac.uk Tel: 01522 – 886851
University of Derby, School of Education, Health and Sciences	Offers a range of programmes from short courses to postgraduate. These include degrees in areas of: occupational therapy; pharmacy and primary care; radiography, counselling and psychotherapy; education and early childhood studies; art and complementary therapies; community, youth and social work.	www.derby.ac.uk/sehs/ Prof. Dawn Forman, Director of School, d.forman@derby.ac.uk

West Nottinghamshire College, Mansfield	Provides a range of courses including: Care EDEXCEL First Diploma; AVCE Health and Social Care; GNVQ Health and Social Care.	www.westnotts.ac.uk
North Nottinghamshire College, Worksop	Offers a variety of courses and programmes for those with an interest in or already employed in a caring occupation. These include HNC/HND courses in Care, City & Guilds Care Management courses at both Foundation and Advanced Levels, also an NVQ in Terminal Care and an Access to Nursing course for mature entrants to the Nursing profession.	www.nnotts-col.ac.uk Tel: 01909 504504

3. Information Sources and Intermediaries: R&D

Information Source/Intermediary	Summary	Location/Contact
Lincolnshire Institute for Health, University of Lincoln	Conducts cross-disciplinary research with regional NHS trusts and colleges	www.lincoln.ac.uk/LIFH/index.htm Professor Hassan Hassan Hhassan@lincoln.ac.uk Tel: 01522 – 886851
Nottingham Trent University, School of Property and Construction, Environmental Health and Safety Group	Research focuses on areas of: occupational health (e.g. mental health at work and stress; skin cancer and construction workers); health promotion; public health policy and awareness; and risk management	http://construction.ntu.ac.uk/graduate_school/Research/HealthAndSafety/default.asp
University of Derby, Pharmacy Academic Practice Unit	Undertakes pharmaceutical research into the stability of parenterals; research into the roles and benefits of pharmacists engaged in pharmaceutical services; research into the application of e-learning in pharmacy practice	www.derby.ac.uk/research-office/research-centres.html#prof Dr David Gerrett, d.gerrett@derby.ac.uk Tel: 01332 593156
University of Derby, Institute of Behavioural Sciences	Undertakes postgraduate research in applied vision, ergonomics, cognitive psychology and health psychology. The institute has one of the largest eye movement laboratories in the UK, and expertise in eye-tracking and ergonomics research. Also has research strengths in psycholinguistics, human reasoning, risk perception, food choice and health behaviours.	http://ibs.derby.ac.uk Prof. Alastair Gale, a.g.gale@derby.ac.uk Tel: 01332 593130
Toyota UK (Burnaston, Derby)	Toyota's Burnaston plant was the 2001 Sir George Earle Trophy winner ('the most prestigious occupational health and safety award in the UK') and as such may offer a model of good practice in occupational health	Public Relations, Toyota Motor Manufacturing (UK) Ltd, Burnaston, Derbyshire, East Midlands DE1 9TA Tel: 01332 282121

The Trent Research Information Access Gateway (TRIAGE)	A gateway to hundreds of web sites containing teaching tools, tutorials, articles, and other educational materials relating to health research	www.shef.ac.uk/~scharr/triage/
University of Nottingham, Centre for Professions and Professional Work	Brings together academic researchers in sociology, social policy and various other disciplines who are researching professions and professional work. The Centre has two divisions. The Centre's work focuses on issues to do with the regulation and political environment of professions at state and international levels, and also on analysis of aspects of professional work including practitioner/client interaction. The Centre has collaborative links with several departments in the Medical School, such as Community Psychiatry, Anaesthesia, Nursing and international links include the Universities of Antwerp, Gothenburg, Bari, Lodz, Versailles, UCLA, Boston, Montreal.	www.nottingham.ac.uk/sociology/research/profwork.html Prof Julia Evetts, Julia.Evetts@nottingham.ac.uk Tel: (0) 115 951 5396
University of Nottingham, Institute of Work, Health and Organisations	Postgraduate research institute in the Faculty of Law & Social Sciences, which focuses on the contribution that applied psychology can make to occupational, environmental and public health and safety, and the management of related health services. Occupational psychology, occupational health psychology and health psychology are among its defining interests. Also provides postgraduate courses closely associated with that research.	www.nottingham.ac.uk/iwho/ I-WHO@Nottingham.ac.uk Tel: (0)115 84 666 26

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