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Primary Care Education & Training Project

Shaping the Future for Primary Care Education & Training Project

Finding the Evidence for Education and Training to Deliver Integrated Health and Social Care:

The Project Experience

VISIONS FOR THE FUTURE

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Volume 9

2006

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Executive Summary

Introduction

Collaboration and partnership working between Higher and Further Education and the NHS and Social Care services is an essential requirement for effective delivery of care. The North West Universities Association (NWUA) and the North West Development Agency (NWDA) are two organisations at the forefront of creating such alliances. The research project Shaping the Future for Primary Care Education and Training Project was a collaborative partnership between these two organisations and seven Higher Education Institutions in the North West of England. In addition, the project brought together for the first time key partners in the health, social care and education sectors who are involved in supporting the delivery of integrated health and social care in the Northwest Region.

The Project

The project had a project management and development team and a participative Steering Group. For ease of implementation the project was divided into a series of Work packages, based on the key objectives, each one led by one of the partner Higher Education Institutions (HEI's).

The main aim of the project was to identify the evidence based for delivery of integrated health and social care, the skills and knowledge required to deliver this care, together with the current and future education and training needs of the North West of England Primary Care Workforce (Work Package 1–Project Management). The key objectives of the project were:

(a) To provide a comprehensive literature review of the evidence base for integrated health and social care services within the regional, national and international contexts (Work Package 2).

(b) To identify areas of current practice in collaborative working and integrated health and social care in the community, including education and training initiatives and develop a Benchmarking tool for achieving best practice in providing education and training for integrated health and social care services for Primary Care Trusts (PCT's) setting up such services (Work Package 3).

(c) To map Higher Education/Further Education provision of education and training which can support the delivery of integrated health and social care services, through:

■ The creation of a database of provision of education and training for health and social care professionals and workers available in the North West HEI's/FEC's linked to the Workforce Development Confederations and update this database annually during the lifetime of the project. This would include the development of a Course Finder Tool (Work Package 4).

(d) To identify visions for the future for both health and social care workforce and service users through the preparation of a report which identifies for both groups:

■ Perceptions of strength and weaknesses associated with integrated health and social care education and training;

■ Perspectives on future training requirements needed to deliver the health and social care agenda (Work Package 5 and 6).

(e) To develop and pilot an Education and Training Needs Analysis Model and Tool (ETNA) for identifying the education and training needs of the Primary Care Workforce to meet the NHS and Social Care agendas (this included both clinical and health management staff) (Work Package 7 and 8).

(f) To disseminate, throughout the lifetime of the project, its activities and outcomes to a range of stakeholders in the North West, from service users to service managers. This would include a variety of dissemination methods such as seminars, workshops, conferences and the setting-up of a dedicated website (Work Package 9).

Major findings and recommendations

The evidence provided in the Systematic Review (Work Package 2) was central to the development of all the other project outcomes and outputs. The six key themes, namely team working, role awareness, communication, personal and professional development, practice development and leadership and partnership working, were seen to be helpful in providing guidance for research questions and thematic analysis, together with the development of the final tools of the project, namely the Benchmarking of Practice in Education and Training for Integrated Health and Social Care Tool (Work Package 3) and the Education and Training Needs Analysis (ETNA) Tool (Work Package 7 & 8).

In collating the evidence from all the 'sub-projects' (Work Packages) it became apparent that as well as the six key themes which guided the research outcomes, that there were other major themes emerging. The most predominant was that of the centrality of inter-professional/inter-disciplinary and inter-agency working and to some extent learning in the delivery of effective integrated health and social care services. The other themes were the need for collaboration and the need for service user involvement in education and training. The overarching findings, including these themes, will be presented through determining the recommendations made across all the research and development activity to three key areas:

■ Higher and Further Education Organisations;

■ Primary Care Trusts and integrated health and social care organisations;

■ Service user/care groups.

It is recognised, however, that in many instances there was an overlap across all three areas. The main evidence will be presented as key points collated from the Work Package reports.

Recommendations for Higher and Further Education Organisations

Team Working

- Education and training programmes need to take cognisance of team working in integrated health and social services, not simply working in a team (WP2);

- Education and training for team working needs to be planned to take account of both inter-professional and inter-agency working (WP2);

- Pre-registration/access to health and social care work programmes need to place greater emphasis on team working in integrated health and social care as a core skill (WP2);

- Ensure that all educational and training learning objectives/outcomes reflect national competency framework standards (WP5);

- Ensure that service managers and educationalists work to develop learning opportunities on how to deal with the realities of team working across different professions and agencies (WP5);

- Include clear models of good practice in integrated care in the training of health and social care workers (WP6).

Communication

- Pre-registration and access to health work programmes need to ensure that effective communication skills for integrated working, including use of technology, are core skills (WP2);

- Ensure that all education and training learning objectives/outcomes reflect national competency framework standards (WP5);

- Ensure that service managers and educationalist work to develop learning opportunities focused on how to deal with the realities of team working across different professions and agencies (WP5);

- Place greater emphasis in training on the use of basic communication skills (especially listening skills) in direct client work (WP6).

Role Awareness

- Role awareness should become an essential element of all programmes relating to preparing the workforce to deliver integrated health and social care (WP2);

- Shared learning initiatives between health and social care workforce students in practice should be encouraged to develop awareness and understanding of team roles (WP2);

- Ensure that all pre-qualifying education programmes, Continuing Professional Development programmes and activities, more effectively promote role awareness and inter-professional working (WP5);

- Ensure that where possible all CPD programmes aimed at increasing inter-professional working are planned and delivered as joint enterprises (with health and social care, HEI's and service users) (WP5);

- More effectively involve HEI's in providing empirical approaches to support service developments (WP5);

- More opportunities for health and social care workers to train together to enhance appreciation of different professional perspectives /crossing of professional boundaries (WP6).

Practice Development and Leadership

- Leadership education and training for integrated health and social care services needs to be built into educational programmes for all professions (WP2);

- Practice development in integrated health and social care requires collaboration between education and training organisations and departments to ensure skills and knowledge base meets the requirements for service user outcomes (WP2);

- Develop multi-professional and interdisciplinary CPD activities that are aimed at strengthening leadership capabilities across all levels of the workforce (WP5);

- Continue to work collaboratively in ensuring national quality assurance processes for educational providers inform the development, delivery and evaluation of educational and training programmes (WP5).

Personal and Professional Development

- Flexible learning opportunities need to exist to enable the workforce to be able to access inter-professional/inter-agency working programmes (WP2);

- Increase the awareness within PCT's and future service providers of the scholarship role that universities can have in supporting individual practitioners and PCT's (WP5);

- Ensure the development and delivery of both educational and training programmes more effectively reflect practice needs as well as those arising from academic interests (WP5).

Partnership Working

- Partnership and collaboration between health and social care should be essential in the development of curricula for integrated health and social care (WP2);

- Education and training standards from professional bodies should include core requirements for partnership working, taking account of team working, effective communication and role awareness as essential elements of the programme (WP2);

- Ensure multi–professional and interdisciplinary CPD activities are developed that are aimed at increasing the understanding of roles and responsibilities (WP5);

- Ensure that future education and training competency standards include core requirements for partnership working (WP5).

Recommendations for Primary Care Trusts and Integrated Health and Social Care Organisations

Team Working
- Develop teams with the appropriate skills and knowledge, that are able to liaise and work collaboratively across organisations and agencies (WP2);
- Ensure that any team has the required awareness of all the member role functions and professional background as appropriate (WP2);
- Service planning and service provision need to take account of the education and training required for a whole team when creating new roles (WP2);
- Co-location of teams needs to take into account education and training for new ways of working (WP2);
- Develop change management knowledge and skills at all levels of the workforce and ensure service users and carers are partners in these processes (WP5);
- Undertake organisational culture analysis aimed at promoting a culture which supports greater involvement of the wider workforce in decision making processes (WP5);
- Provide structured and regular 'timeout 'sessions aimed at harnessing organisational learning (WP5);
- Develop systematic organisational evaluative strategies that are capable of evidencing improved team working (WP5).

Communication
- Ensure staff working in integrated teams have well developed communication skills to enable them to work within and across inter-

professional and inter-agency boundaries (WP2);
- Ensure a common language is used between health and social care organisations to aid effective team work (WP2);
- Ensure that the workforce has the knowledge and skills to manage changing communication channels e.g. information technology (WP2);
- Address workload allocation of health and social care workers to allow time for meaningful interaction with clients (WP6);
- Promote and support the development of a 'common language' for integrated health and social care, recognising the organisational and professional socialisation processes that militate against this (WP5);
- Ensure greater transparency in the exchange and access to information through further development of new technologies (WP5);
- Ensure the development of IT systems that are multi-agency capable and fit for purpose (WP5);
- Develop engagement processes that support greater organisation innovation and confidence in how IT systems work (WP5).

Role Awareness
- When developing new roles ensure that there has been organisational preparation for their introduction into the workforce (WP2);
- A variety of innovative learning opportunities need to be considered, including role shadowing, secondments to work with multi-professional teams and inter-professional education (WP2);
- Develop more structured approaches to supporting and recognising the value of informal inter-professional and organisational learning (WP5).

Practice Development & Leadership
- Leaders need to be identified and educated to lead integrated health and social care services (WP2);
- Practice development needs to be led by leaders who take account of a cultural change needed to ensure effective working in integrated health and social care services (WP2);
- Ensure that practice development activities are facilitated by leaders skilled in cultural change processes and that these activities are systematically evaluated (WP5);
- Ensure protected time is identified specifically for multi–agency practice development and CPD activities (WP5);
- Ensure that PCT's, future service providers, educational commissioners and providers work collaboratively in developing new CPD programmes which reflect the changing nature of health and social care practice and the changing environments where such practice is undertaken (WP5).

Personal and Professional Development
- Compatibility needs to exist between all the NHS and Social Care skills and knowledge frameworks in ensuring the workforce is able to work in integrated health and social care organisations and services (WP2);
- Supportive environments needs to exist to enable personal and professional development in integrated working (WP2);
- Being able to work in integrated health and social care situations at all levels of organisations should be built into role descriptions and job specifications (WP2);
- Continue to develop meaningful opportunities that promote life long learning and the systematic identification of training needs (WP5);

- Regularly evaluate the impact and use of new workers in the roles and functions of the existing workforce (WP5);

- Increase the opportunities to work together in developing more effective learning environments capable of supporting flexible learning within PCT's and future service providers (WP5);

- Agree a joint framework agreement for CPD that supports in-house CPD activities being credit rated (WP5);

- Ensure that the knowledge and skill required to work in integrated health and social care services (including in education) from the basis of job descriptions and role specifications (WP5);

- Ensure that integrated personal and professional development strategies are explicitly linked to organisational change strategies and business planning processes (WP5);

- Develop transparent and effective decision making processes that are capable of handling the personal, professional and organisational tensions involved in determining what is seen as *'useful knowledge'* (WP5).

Partnership Working

- Leaders of integrated health and social care services need to offer a supportive culture for integrated working and delivery of care (WP2);

- Develop specific roles to facilitate inter-agency partnership working at the Micro and Meso levels of the workforce (WP5).

Recommendations for service user/carer involvement in education and service development and delivery

- Ensure service users of integrated services are integral to developing communication networks and language (WP2);

- Role awareness education for service users/carers should be considered essential to ensure

effective communication and appropriate use of services (WP2);

- Service users need to be involved in any education and training development which promotes partnership working (WP2);

- Role awareness education for service users and carers should be considered essential to ensure effective communication and appropriate use of services (WP2);

- Establish professional qualification pathways for home care workers (WP6);

- Service users need to be involved in any education and training development which promotes partnership working (WP2);

- With service users and carers develop communication processes aimed at ensuring service users and carers can better understand the different roles and responsibilities of the workforce (WP5);

- Improve opportunities for greater service user and carer involvement in education and training programmes in order to increase awareness and responses to drivers for practice development (WP5);

- With service users and carers, work towards developing a shared definition of the criteria that can be used as a benchmark for systematic service evaluation of integrated health and social care services (WP5);

- Ensure there is an explicit requirement to demonstrate the involvement of service users in educational and training activities in commissioning agreements (WP5);

- Proactive consultation mechanisms are needed to identify the types of services that users would like to see in place. Current arrangements are too passive–the service user has to take the initiative (WP6);

- Find ways of capitalising on obvious service user enthusiasm for training (WP6);

- Involve service users in interdisciplinary training sessions to

enhance workers appreciation of user perspectives (WP6);

- Significant increase in investment in training for home care agency workers (WP6);

- Emphasise that partnership working means partnership between workers and service users–not only between workers (WP6);

- Raise both workers' and service users awareness of the meaning of integrated health and social care; that is not only integration between work of different health and social care professionals but also integration between the work of home care staff and 'professionals' (WP6).

Although these recommendations are generally self-explanatory and are thematically aligned, it was identified that in many instances there was integration between many of them. Thus, we argue, that the recommendations should be read as a related constellation of changes, rather than as single and specific items that might somehow require simultaneous implementation by those concerned with the provision of primary health and social care services, and the commissioning and provision of educational and training programmes aimed at developing the workforce. Indeed we assert a priori that such simultaneous implementation would be both impossible and undesirable.

The project outcomes, including the recommendations noted above, must be seen against the backdrop of unrelenting change. It was clear from data collected in developing the evidence bases that there were multiple versions of a vision of integrated health and social care raises the consequential possibility that not only might *individual* PCT's be involved in a process of conceptual transitions, but individuals *within* these PCT's might be involved in parallel but different processes of conceptual transitions (Warne *et al* 2005).

Such conceptual transitions are in themselves, manifestations of the various layers of change being experienced by individuals and their organisations.

This project has resulted in significant outputs and recommendations. They can be used collectively when establishing new services or individually when for example assessing the education and training needs of the workforce. Their combined outcomes, however, will be of value to all integrated health and social care organisations in their quest to deliver integrated services, which in turn will benefit the local communities. It is also anticipated that the recommendations and outputs will be of value to Higher and Further Education Institutions in order to establish their own strategic plans for working with health and social care providers to ensure an effective and educated workforce to deliver integrated health and social care.

Conclusion

The success of this *Shaping the Future for Primary Care Education and Training* project has been the result of the effective collaboration between Higher Education providers and the organisations delivering and developing health and social care. It is our belief that this should be the precursor of other such initiatives which examine the links between education and service needs in order to ensure that the pursuit of effective integrated health and social care services becomes a reality.

Chapter 1:
Education and Training in Health and Social Care

1.1 Introduction

In November 2001 a meeting was held at the University of Salford to discuss the potential for undertaking a multi–university collaborative research project to investigate the future education and training needs of the workforce in Primary Care Trusts (PCTs). This meeting led to a proposal that the University of Salford would prepare a bid for funds, on behalf of interested Higher Education Institutions, to the North West Development Agency (www.nwda. co.uk). This is one of nine Regional Development Agencies, which *'were set up by the Government to promote sustainable economic development in England'* (www.england srdas.com). The NWDA has 5 key priorities, namely 'Business Development, Regeneration, Skills and Employment, Infrastructure and Image' (http://www.nwda.co.uk). All the Higher Education Institutions (HEIs) involved in the collaborative initiative were members of the North West Universities Association and Higher Education North West. It was through this Association, as part of its strategic direction for the health field, that the potential for such a collaborative partnership originated.

The **Shaping the Future for Primary Care Education and Training project** (to be known as Shaping the Future project) was an opportunity for a number of key stakeholders in health and social care and education to collaborate in a new and unique way, both directly through the project outcomes and indirectly through creating communities of learning across the North West Region. This final report, in the collection of the nine volumes that make up the record of the Shaping the Future project, aims to provide an insight into how these stakeholders experienced the project and what can be learnt from how the project was taken forward. The starting point is to briefly reacquaint the reader with the drivers that have led to a re-focusing of the educational and training processes for health and social care professionals.

1.2 Drivers for Change

Ensuring that the health and social care workforce is educated and trained to meet changing community needs is considered essential for current and future health and social care service provision. There is also a need to ensure that members of that community have opportunities to access and gain employment, that an existing workforce can be re-skilled whenever possible rather than being made unemployed and that key roles are retained. Education and training is one key to successful achievement of such initiatives.

The publication of the *New NHS: Modern, Dependable* White Paper set in train the most comprehensive attempt to modernise the United Kingdom (UK) National Health Service (NHS) (Department of Health, 1997). Greater collaborative, interagency and inter-professional working were key conceptual themes underpinning the structural and functional proposals of this modernisation agenda. It was the *NHS Plan* (Department of Health, 2000) that, in setting out a ten year blue print for the implementation of these changes, brought into sharp focus the overarching policy objective of developing a primary care orientated NHS. Such an orientation was predicated on healthy rhetoric that sought to achieve the conceptual shift from partnership working (represented by inter professional and interagency working) to integrated working (Warne *et al,* 2002). Howarth et al (2004) highlighted a number of ontologically driven issues that continue to impact on the effective development of integrated health and social care services. These included:

■ Increasing collaborative working between health and social care, at policy, and practice levels;

■ Creating a 'seamless' service for patients based on a commitment to reduce health and social inequalities and protection and support of vulnerable people in society (Howarth *et al* 2004: 14).

The atypical nature of these issues, in relation to the wider modernisation agenda, belied the paucity of definitional clarity to be found in either the empirical literature and/or governmental guidance.

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1.3 Integrated health and social care

The initial review of the literature carried out for this project (Howarth *et al* 2004) highlighted a lack of clear definitions of what and how integrated health and social care represented, and concluded that integration was dependent on 'successful partnerships between service providers, agencies and professional groups'. The Department of Health note that integrated care is:

❝ *When both health and social care services are combined to ensure individuals get the right treatment and care that they need. It helps frontline organisations to work together to deliver flexible services that help people to remain in control and live independent lives.*❞ *(http://www.dh.gov.uk/AboutUs/Deli veringHealthAndSocialCare/fs/en)*

Mur-Veerman *et al* (2003) envisioned integrated care as:

❝ *an organisational process of coordination which seeks to achieve seamless and continuous care, tailored to the patients' needs and based on a holistic view of the patient*❞. *(Page 1)*

In a similar definition van Raak *et al* (2005) proposed that integrated care as:

❝ *a coherent and co-ordinated set of services which are planned , managed and delivered to individual service users across a range of organisations and by a range of co-operating professionals and informal carers. It covers the full spectrum of health and health care related social care*❞ *(van Raak et al 2003).*

These views of integration as 'working together' in a co-ordinated way can be seen in a number of policy decisions and developments across Europe. One of the most significant areas for the development of integrated services has been in the care of older people (Glendinning, 2003). An example can be seen in an international research project 'Providing Integrated Health and Social Care for Older Persons' (PROCARE) the results of which suggest:

> *that the last 20 years have brought partial success in integrated working and some clear examples of innovative practice, yet overall there appears to be evidence of failure to sustain cooperation between the organisations that are involve".* (Leinchsenring 2004: 10)

Christiansen and Roberts (2005:270) note that *'it is well recognised that poor co-ordination between health and social care providers can have a devastating effect on vulnerable old people'* who often have *'complex multidimensional needs that span the spectrum of social care,* primary cane and secondary care'. The introduction of the single assessment process as part of the National Service Framework for Older People (Department of Health, 2001) should in their view contribute significantly to the success of integrated care. They conclude, however, that this success is dependent on overcoming barriers and that most importantly:

> *This will depend on adequate support for the professions involved, and continuing education and training to bring health and social care providers into closer alignment so that policy objectives are delivered to clients and their carers."* (Christiansen & Roberts 2005:277)

To illustrate the present UK Government's commitment to integrated services, a joint White Paper was announced in July 2005 (Department of Health, 2005). Its purpose *'to bring together proposals for both adult social care and all care received outside hospitals'*. The health minister Liam Byrne, stated in support of this that *'dignity for life is our ambition. A joint White Paper will help put individuals and their families at the centre of care'*. Alongside this commitment to patient led services the Department of Health has also committed itself to ensuring that the organisations delivering and commissioning services should be able to do so. The publication in March 2005 of *'Creating a Patient led NHS- Delivering the NHS Improvement Plan'* (Department of Health, 2005) sets out the changes envisioned for the future structure and management of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs).

It is clear that as these changes come to be implemented those involved in taking these changes forward require greater clarity of purpose. The various teams working on the Shaping the Future project were faced with similar clarification needs. Against this confusing and complex plethora of definitions that made up the context for the Shaping the Future project, a decision was required in relation to what the team could use that would provide a shared understanding for all parties. The team involved in researching the systematic review brought a number of definitions, which highlighted integration as a theme. However it was agreed that we would use our own developed term in order to ensure consistency and simplicity. Thus, the Shaping the Future working definition of integrated health and social care used was:

> *Care that is determined by partnerships between health and social care agencies and users/carers for the health and well being of the (local) community."*

This definition is in keeping with some of the definitions of integrated health and social care that have continued to emerge over the life of the project. As these definitions and terms have begun to emerge and used in planning processes for the integration of services, other factors have come to the fore. For example, the need to ensure that the workforce required to deliver the changes will in turn have different education and training needs.

Effective workforce development and planning becomes essential, as does the need for collaboration between Higher and Further Education and the National Health Service (NHS). The Department of Health consultation report (Department of Health 2002:2) on the funding and development for the healthcare workforce highlighted that future funding should be 'reorganised on an interdisciplinary basis' and should be 'underpinned by key values of transparency, equity, comprehensiveness, responsiveness, integration, partnership and flexibility'. Of particular relevance to the Shaping the Future project was the value of partnership whereby it was noted that:

> *the health and education sectors, social care and private and voluntary sectors should work together to deliver training .There should be continuing support for learning and development from the wider NHS and more recognition of the increasing role of further education in the development of the NHS workforce"* (Department of Health 2002:2)

1.4 Workforce Development and Planning

In their March 2001 report on *Education and Training the Future Health Professional Workforce in England,* the National Audit Office outlined the significant developments, which had taken place in relation to developing the workforce since the early 1990s. They also made recommendations for future workforce development in education and training arrangements. These included the recommendation that future Workforce Development Confederations would need to ensure that they:

> involve higher education institutions at all levels in planning education and training, both strategic and operational and adopt a joint approach including shared responsibility for recruitment, selection and retention".

Workforce Development Confederations were established in April 2001 following the publication and consultation of *A Health Service for All the Talents: Developing the NHS Workforce* (Department of Health, 2000). This document was the direct result of the House of Commons Health Select Committee recommendations (Department of Health, 2000) for a major review of workforce planning in the NHS. The terms of reference for this review were to review workforce planning arrangements for all professional groups in the NHS:

■ Considering the roles and responsibilities for workforce planning at all levels within the NHS and the NHS Executive;

■ Exploring the opportunities and barriers which currently exist for effective and efficient workforce planning within the context of current related policy initiatives and known future changes likely to impact on the workforce (Department of Health, 2000:3)

The underpinning philosophy to these proposals was one predicated on the appeal that *'caring for people is what the NHS is all about'* and to achieve this required development and investment in the NHS workforce. Social Services and Social care reforms in workforce development was not at this stage included in the proposals, although a note was made in relation to the need for high quality care which was *'seamless between primary, secondary and tertiary services and care which is integrated with other services, for example, social services'*. The proposals were considered 'wide ranging and radical' and focused on the following themes (Department of Health, 2000):

■ Team working across professional and organisational boundaries;

■ Flexible working to make the best use of the range of skills and knowledge which staff have;

■ Streamlined workforce planning and development which stems from the needs of patients and not of professionals;

■ Maximising the contribution of all staff to patient care doing away with barriers which say only doctors or nurses can provide particular types of care;

■ Modernising education and training to ensure that staff are equipped with the skills they need to work in a complex changing NHS;

■ Developing new , more flexible careers for staff of all professions;

■ Expanding the workforce to meet future demands (Department of Health, 2000:5).

Implicit within the recommendations for improving training, education and regulation was the *'need to build on, and develop, partnership working with those providing training and education for the NHS workforce and with the relevant regulatory bodies'* (p7). Working in a multi-professional/multi-disciplinary way was also advocated as was the need to view the workforce as *'teams of people rather than different professional tribes'*. The review recommendations focused on *'making the needs of patients central to workforce development'*. The results of the consultation focused on five key areas (Department of Health, 2001):

■ Modernising education and training;

■ Changing working patterns;

■ New systems of workforce planning;

■ Modernising funding arrangements and

■ Further reviews.

The consultation responses specifically identified that there was a disappointment that *'the review had not dealt with primary care workforce planning in depth and looked forward to the proposed primary care workforce planning review'*.

1.4.1 The Primary Care Workforce Planning Review

Thus it was that a Primary Care Workforce Planning Framework was developed as a result of the review (Department of Health, 2002b). This had significance for the *Shaping the Future Project,* focusing as it did on Primary Care education and training. The framework consisted of three parts:

Part 1: An introduction to why planning workforce development was important for primary care and the purpose of the framework;

Part 2: Outlined the context for planning primary care workforce development including: integrated plans; national context of Primary care workforce planning and drivers for change; multi-professional education and training budgets and the lifelong learning framework for the NHS;

Part 3: Focused on the elements of a workforce development plan, outlining

the vision, how to identify future demands, mapping the existing workforce and developing the future workforce, educational issues relevant to primary care workforce planning, inter-professional education and training and a workforce action plan.

The main aim of the Framework was to *'help PCTs to shape their plans to develop and modernise the primary care workforce'* in order to contribute to meeting the delivery of the NHS Plan (Department of Health, 2000a) in relation to *'expansion of the NHS workforce'* and *'for better realisation of the potential of the individuals who work for it'* (Amos, 2002). It had been the *Investment and Reform for NHS Staff: Taking Forward the NHS Plan* (Department of Health, 2001c) which in relation to workforce planning had set out the progress made in relation to increasing the number of staff in the NHS and how any changes in the way staff would work for the benefit of patient care (Department of Health, 2001c:3), for example:

> *2500 more doctors, 6300 more nurses and 3500 more qualified scientific, therapeutic and technical staff had been employed with plans to continue this increase in order to influence patient care.*

It concluded that for 2002 there would be:

■ An unprecedented £250 million increase in training budgets;

■ 300 more specialist registrars;

■ At least 150 more GP trainees;

■ 1000 more nurses entering training;

■ 700 more therapists and other key professionals entering training.

It also stated that the report demonstrated how this was improving and modernising arrangements for:

■ Investing in staff by modernising professional education and training and driving forward training for the wider NHS workforce to support our overall goals;

■ Workforce planning to ensure we have the right number of staff with the right skills in the right place at the right time (Department of Health, 2001c:4)

The role of the Workforce Development Confederations was seen to be central to the implementation of all workforce planning and development, in particular managing the multi-professional education and training budget and others. They were to undertake a number of core functions (Department of Health, 2002c):

■ Take a leading role in visioning the future healthcare workforce ;

■ Develop and lead an integrated approach to workforce planning for health and social care communities. In particular, they were charged with working 'with local employers and other agencies to ensure that local workforce planning takes a joint approach to health and social care';

■ Have overall responsibility for developing the existing and future health care workforce;

■ Take a lead in developing a shared approach to HR policy and practice;

■ Establish robust working relationships with the NHS University and with NHS, Social care and allied learning organisations on behalf of its constituent members;

■ Will negotiate, manage and monitor performance of contracts with education and training providers, including Further and Higher education, and support the modernisation of professional preparation, education and training;

■ Have responsibility for practice placements for all students on NHS and HEFCE funded health care training programmes;

■ Will actively promote patient, carer and student input to the development and delivery of healthcare education and training;

■ Will co-ordinate the strategic management of local learning and education facilities in the NHS and support capital development plans for those facilities and their revenue consequences;

■ Will ensure effective systems and procedures are in place for the financial managements and accountability of all funds for which it is responsible (Department of Health, 2002c:3-6).

Interestingly, two years later, the Audit Commission Health Briefing (2004) in providing an overview of the strengths and weaknesses of the Workforce Development Confederation, failed to note specifically how the WDC's had managed the core function of:

■ Develop and lead an integrated approach to workforce planning for health and social care communities.

It did report, however, that good progress had been made 'in establishing themselves and delivering their key priorities', in particular, partnership and stakeholder consultation. One example of good practice was in the North West Region, namely Greater Manchester, whereby in ensuring modernisation of professional preparation, education and training:

" *The WDC's Strategic Development team is undertaking a project entitled a 'Radical Review of Education, Learning and Development'. The project's elements include Developing Learning Organisations; Ensuring Fitness for Purpose (focused on clinical placements and contracts);Improving Partnerships ;Interdisciplinary Working ; Implementation of the MPET Review; and Providing a Vision of Health and Social Care Education for Greater Manchester". (Audit Commission 2004)*

The Workforce Development Confederations were to be fully integrated into Strategic Health Authorities from April 2004. (Audit Commission, 2004)

As these changes would require substantial development in relation to the future workforce, we considered that the *Shaping the Future* project was timely in relation to determining what these were. Coincidently, as with all the changes taking place within the NHS with regards to education and training there were similar ones taking place within Higher and Further Education organisations who had a major stake in the future health and social care workforce.

1.5 Education and Training of the Health and Social Care Workforce

The Audit Commission (2001:71) posited the idea that in order for the new Primary Care Trust (PCT's) organisations to effectively develop joint working processes they should:

" i*ncreasingly deliver services through integrated teams whose members have a range of professional backgrounds. In these organisations clinical teams will work together across professions and expect to train together and to draw on resources from each other".*

The Audit Commission also concluded that a *'profession-bound model'* of education and training and development did not *'sit easily with current health policy which (rightly) starts with the experience of the patient or client seeking help, often from primary care'*. It proposed that there would be a need for more *'co-ordinated training and development'* –for multi-professional teams.

In the same year, the Department of Health set out its vision and strategy for developing this future workforce in their *Lifelong Learning Framework* (Department of Health, 2001b) and proposed to support this with the setting up of the National Health Service University (NHSU). However, this utopian dream was never achieved and the NHS University was dissolved on July 31st 2005. Although never established as a learning and teaching entity, it was *'replaced'* by the NHS Institute for

Innovation and Improvement in 2005 (NHS, 2005). Learning remains one of its key aims. Despite the failure of these politically driven aspirations it is clear that the existing Higher Education and Further Education institutions have a significant role to play in the education and training of the health and social care workforce.

For example, Further Education provides a number of different *'access to health'* programmes such as the BTEC National Diploma in Care, as well as in some institutions (in partnership with Higher Education colleagues) the new Foundation Degrees. These are awards, which bring together institutions and employers *'to create a blend of academic and work based learning'* (www.foundationdegrees.org.uk). In the Greater Manchester area these have been linked to the development of a new workforce role, that of the Assistant Practitioner (see www.gmsha.nhs.uk for further information). New roles such as this is part of the drive towards changing the skill mix of the healthcare workforce (Sibbald *et al* 2004) and role redesign (Hyde *et al* 2005). These offer new challenges to education providers and practice managers (Warne and McAndrew, 2004a).

Higher Education Institutions have the responsibility, in partnership with the NHS and Social Care organisations, to educate and train the future health and social care professions, as well as for new roles such as those described above. One of the major developments affecting all these is that of inter-professional education. Loxley (1997) considered that this had *'been long and widely held as an essential component of collaboration',* an issue which was to be established as a central concept within the Shaping the Future project. D'Amour et al (2005:116) noted that *'inter-professional collaboration is a key factor in initiatives designed to increase the effectives of health services currently offered to the public'.* However, they offer a new concept for consideration in relation to inter-professional education, namely that of 'interprofessionality'

(D'Amour and Oandasan, 2005) which they conclude:

> **"** *concerns the processes and determinants that influence inter-professional education initiatives as well as determinants and processes inherent within inter-professional collaboration. Inter-professionality also involves the analysis of the linkages between these spheres of activity***"**

They also consider that *'an attempt to bridge the gap between inter-professional education and inter-professional practice is long overdue'* and that *'the two fields of inquiry need a common basis for analysis'.* They proposed a new frame of reference, an inter-professional education for collaborative patient–centred practice framework[1].

The centrality of the service user or patient to inter-professional education is also influencing their increasing involvement in education and training of the health and social care workforce generally (Humphris and Hean 2004; Warne and McAndrew, 2004b; Porter *et al* 2005 ; Humphreys 2005). Indeed, Porter *et al* (2005:327) suggest that as *'service user /carer involvement in all aspects of health care delivery is one of the key target areas in the government's modernisation agenda'* it should also be *'reflected in educational programmes'.* Further information on the role of inter-professional education can be found in Howarth *et al* (2004) and that of service user involvement in education and training in Reid *et al* (2005), both reports from the overall Shaping the Future project .

Continuing Professional Development (CPD) for the current health and social care workforce is also a cornerstone to the changes taking place in the NHS. In July 2002 it was announced (Department of Health, 2002e) that a project would be commissioned to develop a *'Shared Framework for Health Professional beyond registration'.* It was anticipated that the three key outputs would better enable both education

providers and Workforce Development Confederations to gain a better understanding of different issues around CPD and enable better planning of any current and future provision. As yet however no outcome of the project has been formally published.

There is a commitment by Strategic Health Authorities to develop the workforce in order to ensure that these 'drivers for change' are accommodated. We can see in Box 1 the strategic direction adopted by Greater Manchester Strategic Health Authority in its 'Integrated Health and Social Care Workforce Strategy' (Greater Manchester Strategic Health Authority, 2005).

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[1]Further detail on this model can be seen at the Health Canada website (www.hc-sc.gc.ca)

Box 1

Greater Manchester Strategic Health Authority is committed to ensuring that all health , social care, independent and voluntary sector organisations are equipped with the skills, knowledge, competence and the tools and techniques to produce an organisation or network integrated workforce strategy and workforce action plans to deliver workforce capacity and enable key organisational objectives and targets to be met. The SHA also recognises the importance that an integrated strategy can play in modernising services through visioning new services, whole system planning of scenario's, assessing demand and supply, bridging and prioritizing gaps within the system and then implementing action plans to deliver the vision. This strategy sets out the drivers and principles that underpin the need to produce a workforce strategy and workforce plan to enable the SHA to fully comprehend the current reality of workforce demand and development requirements within Greater Manchester and the desired future for workforce. The overarching macro strategy produced from the sum of all the organisation micro strategies will assist the SHA in a number of key areas namely:

- Appropriate education commissioning and delivery of the education and learning strategy;
- Delivery of the e-learning strategy;
- Evidence based primary data for human resource and workforce intervention strategies;
- Underpinning new developments in the 'delivering the workforce' programme;
- Provide intelligence for the modernisation strategy;
- Outline priority areas for organisational development and leadership strategic and operational intervention;
- Substantiate our actions in delivering workforce reform as part of the productive time efficiency measures;
- Detail clear objectives for new projects to enhance capacity, capability and sustainability;
- Assist in the devolution of services to Greater Manchester organisations (shifting the balance of power).

Box 1: Extract from Greater Manchester Integrated Health and Social Care Workforce Strategy 2005-2010 Resource Pack "Modelling Your Desired Future" (GMSHA, 2005)

1.6 Conclusion

As can be seen in this brief overview there has been and continues to be significant change taking place within the NHS (including social care) which in turn has had a major impact on the work undertaken by both Higher and Further Education in the education and training of both the future and current workforce. Recommendations from the Shaping the Future project as to possible future developments can be seen in Chapter 3.

Chapter 2: Project Design

2.1 National and local context in which the Project was situated

For the purpose of this project Primary Care was viewed as encompassing social, community and primary care. It was recognised that at the commencement of the project that these areas were distinct and discrete rather than being encompassed in a generic term.

As was seen in Chapter 1 the national and regional Primary Care agenda requires a workforce that is capable of driving through NHS policies and delivery of integrated health and social care services, as well being able to interface with the Acute Care sector. To be successful in achieving this will require an investment (professional and financial) in staff, which is based on sound evidence of current and future education and training needs.

Both the NHS and Higher Education Institutions are major employers nationally and regionally, as are, to a lesser extent, the independent health care organisations and Further Education Institutions. Ensuring a future workforce that is employable as well as being employed, with the right skills and knowledge to deliver services, is in many ways linked to how these organisations work collaboratively for the benefit of local communities.

The agreements between the Department of Health and the Higher Education Funding Council (Department of Health/HEFCE, 2002) to work closely on developing collaborative partnerships should enhance this process, as long as the evidence used in support of this is based on both local and regional need. For example, given the rapid change taking place with the social, community and primary care sectors it will be essential that all stakeholders involved in delivery of health and social care and education and training work collaboratively to avoid duplication of provision (especially when collaboration as providers would be more productive in terms of both skills and financial resources). In addition, such approaches provide further opportunities to examine new ways of working and share good practice, whilst ensuring that competition in provision does not dilute the potential for working together and will ensure a better quality of education and training provision.

In a parallel and illustrative process, the Shaping the Future project provides a good example of this partnership approach. It brought together for the first time key partners in the Health and Education sectors who are involved in supporting the delivery of integrated health and social care in the North West Region. These organisations include:

- The North West Development Agency who funded the project as part of their Key Targets for Health;
- The North West Universities Association, who initially stimulated the development of the collaborative initiative;
- The 3 Strategic Health Authorities in the North West (and prior to 2004 the Workforce Development Confederations), key organisations in ensuring education and training development and funding to all NHS Trusts and Primary Care Trusts for the majority of the health care workforce;
- The Primary Care Trusts in the North West who are the local employers of health and social care staff;
- All Higher Education Institutions and Further Education Colleges both directly and indirectly involved with the Project Management;
- Social Services.

It was anticipated that the Steering Group, with membership from the above organisations and associations, and the Project Team would be the precursor to a close regional partnership, which could create real synergies at a regional level, developing practices, which can later be applied at national level.

2.2 Aims and Objectives of the Project

The main aim of the project was to identify the evidence base for delivery of integrated health and social care, the skills and knowledge required to deliver this care, together with the current and future education and training needs of the North West of England Primary Care Trust workforce. This would take account of the NHS modernisation agenda and the needs of the independent sector as it interfaced with social, community and primary care.

The specific objectives of the project were:

(a) To provide a comprehensive literature review of the evidence base for integrated health and social care services within the regional, national and international contexts. (Work Package 2)

(b) To identify areas of current practice in collaborative working and integrated health and social care in the community, including education and training initiatives and develop a Benchmarking tool for achieving best practice in providing education and training for integrated health and social care services for Primary Care Trusts setting up such services. (Work Package 3)

(c) To map Higher Education/Further Education provision of education and training which can support the delivery of integrated health and social care services, through:

- The creation of a database of provision of education and training for health and social care professionals and workers available in the North West HEIs/FECs linked to the Workforce Development Confederations and update this database annually during the lifetime of the project. This would include the development of a Course Finder Tool. (Work Package 4)

(d) To identify visions for the future for both health and social care workforce and service users through the preparation of a report which identifies for both groups:

- Perceptions of strength and weaknesses associated with integrated health and social care education and training;
- Perspectives on future training requirements needed to deliver the health and social care agenda. (Work Package 5 & 6).

(e) To develop and pilot an Education and Training Needs Analysis Model and Tool (ETNA) for identifying the education and training needs of the Primary Care Workforce to meet the NHS and Social Care agendas (this included both clinical and health management staff). (Work Package 7 & 8)

(f) To disseminate, throughout the lifetime of the project, its activities and outcomes to a range of stakeholders in the North West, from service users to service managers. This would include a variety of dissemination methods such as seminars, workshops, conferences and the setting-up of a dedicated website. (Work Package 9)

(g) To undertake both internal and external evaluation as an ongoing process.

(g) To produce a report, which summarises the outcomes of the project and makes recommendations as to how all the key Stakeholders can collaborate to meet the NHS agenda for Primary Care in the future.

2.3 Project Management

This was a large, complex project, which needed to be carefully and closely managed to ensure successful and timely delivery. In order to ensure successful management of the aims and objectives, the work of the project was divided into a number of different Work Packages (sub-projects), each being led by one of the partner HEI's. A small-dedicated team was set up, with the aim of managing the project through a Project Management Group charged with delivering inputs at an operational level by partners. This group was able to regularly monitor the progress of the individual 'sub-projects' (Work Packages) whether they were the responsibility of a single partner or a number of partners working through a lead partner. This approach enabled the various Work Package leads to develop their own small teams and arrive at methodologies that were relevant to gathering the required data and achieve their project objectives.

Work Package 1: Overall Project Management: Lead - **University of Salford**

Work Package 2: Systematic Review of the Literature: Lead – **University of Salford**

Work Package 3: Developing a Benchmarking Tool for best practice in education and training for integrated health and social care: Lead - **Liverpool John Moores University** and from April 2005 the **University of Salford**

Work Package 4: Mapping of Education and Training Provision in Higher Education and Further Education Institutions in the North West of England and development of a Course Finder Tool: Lead – **University of Salford**

Work Package 5: Vision of the Future for Integrated Health and Social Care education and training – the Primary Care Workforce Perspective: Lead – **Manchester Metropolitan University**

Work Package 6: Vision of the Future for Integrated Health and Social Care Education and Training –The Service User perspective: Lead **University of Central Lancashire**

Work Package 7: Development of an Education and Training Needs Analysis (ETNA) Model and Tool for the Primary Care Trust Workforce: Lead - **Bolton University**

Work Package 8: Testing and Evaluating the Education and Training Needs Analysis (ETNA) Tool for the Primary Care Trust Workforce: Lead – **Lancaster University**

Work Package 9: Dissemination of Project Development, Delivery and Outcomes: Lead – **University of Salford**

Although the project was divided into these individual Work Packages it was the intention that in order to fulfil the aims and objectives that an iterative and integrating process could take place, whereby the whole Project team was involved in the decision making process and the development of each of the Work Package outcomes (see Figure 1- Project Management Communication).

Initially, this approach allowed for much sharing of ideas and a great deal of commitment to all of the various work-packages, and latterly this solid foundation of team working supported the overall team in working through the many practical issues of doing 'real life' research.

Figure 1: Project Management Communication
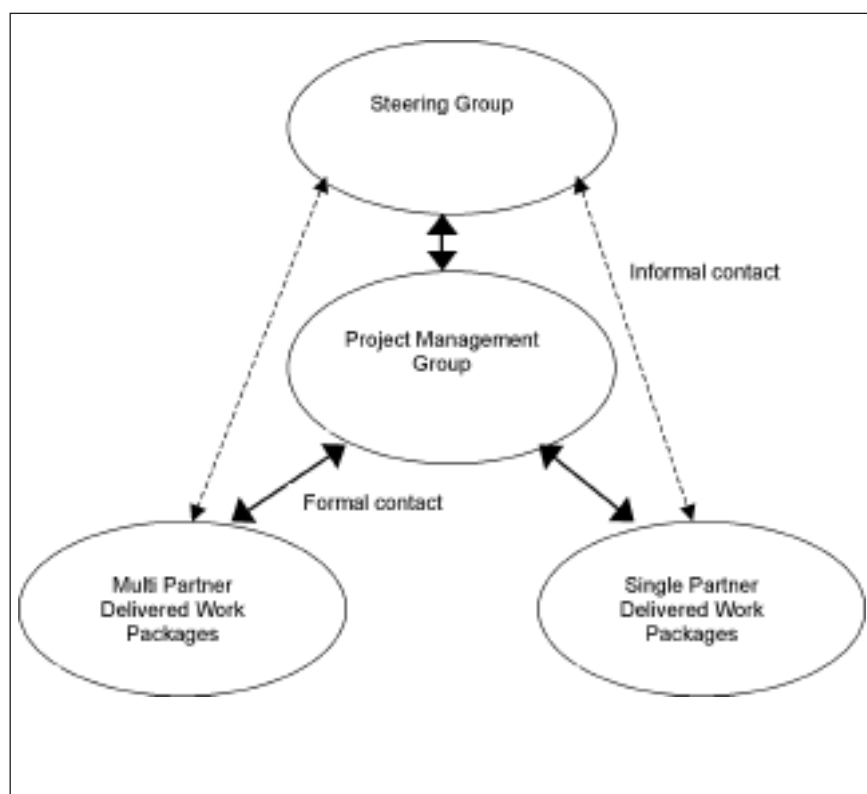
2.4 Monitoring and Evaluation

Each Work Package had its own internal monitoring and evaluation criteria. However, there was a need to ensure that progress was monitored across the project and that the project work plan was both realistic and achievable. With this in mind monitoring and evaluation also took place in a collaborative way by the evaluation team.

2.4.1 Internal Evaluation

An internal evaluator from the University of Salford was appointed to the Project to monitor the project's overall progress and identify issues that required attention by the Project Management Team. The intention was that the evaluator would act as a *'critical friend'* to the Project Manager over the life of the project and ensure that ongoing reports on the project's progress were produced to inform project management strategy and development.

2.4.2 External Evaluation

An External Evaluation team was also appointed to the project from the University of Chester. This team were to ensure that there was an independent analysis of the project direction and outcome, in particular, in relation to the role and function of the Steering Group and dissemination activity. Their findings are provided independently of this report to the funding body.

2.5 Audit Compliance

The University of Salford had systems in place which ensured the monitoring and recording of project spend and output delivery and also ensured the project met the requirements of the project auditors. Membership of the Project Management Team included a Finance Manager. This appointment was instrumental in assuring good financial management of the project which was essential given the number of project partners and the individual finance arrangements pertinent to each HEI involved.

2.6 Steering Group

The Steering Group was to provide a strategic steer for the project and act on reports from the Project Director over the length of the project as well as offering guidance and advice, in particular in relation to the way external influences such as new national policies in health and social care or education and training could affect the direction of the project and the Work Packages themselves (see Appendix for Terms of Reference and membership) Membership included two lay members of the public.

2.7 The Project Development and Outcomes

This section will outline the progress of the project as proposed in the Project Plan. The organisation of the Project into individual Work Packages precludes the discussion of an overarching project methodology. However a brief overview is identified in the different Work Package summaries.

2.7.1 Project Management (WP1)

Effective project management is dependent on a number of issues including communication, team working and effective planning (NCTeam, 2002). To facilitate this the Project team and external evaluators attended a two-day residential to get to know one another and also to discuss and understand the requirements of each Work Package aims and objectives. It was agreed at that event that the Project Management Team meetings would take place on a monthly basis.

At the end of the first 6 months of meeting it was apparent that there was a need for development meetings as well as the more formal team meetings. It was agreed that the latter would only occur every 3rd month and that the other two meetings would then be available for development work. This proved to be one of the most positive steps in the management of the project, in particular, given the number of partner organisations and also the inter-relationship of the individual Work Packages.

Effective communication was considered vital to the success of the project. As well as the monthly meetings the project team made use of the project intranet, which proved invaluable in the development of the project outputs. Newsletters had been considered but this idea was discarded in favour of the intranet and the main web site, which was linked to a number of search engines. Regular data as to the use of the web-site to communicate and disseminate project activities was provided by the web-design team.

One of the key determinants of a successful project is also effective administration and given the complexity of the project it had been agreed to include within the funding bid sufficient funding for an Executive Officer Grade 2 post. The collaborative working between the Project Administrator, the Director and Chair of the Steering Group has without doubt added to the success of the project's management strategy.

During the proposal development it had been recognised that one of the key determinants for successful project commencement and continuation was the obtaining of Ethical approval from a Multi-site Research Ethics Committee (MREC). Given previous experience we had built in additional time for the approval process but even this was insufficient. As noted in Warne *et al* (2005) this was a major hindrance to the commencement of data collecting activity. Eventually approval was obtained in June 2003, some six months after commencement of the project. However, even though we had approval from MREC our progress overall was still hampered by the requirements of many of the NHS Trusts Research Governance Committees, which required an additional process of approval (Warne *et al,* 2005). There is a clear need to ensure that such arrangements are robust enough to ensure effective research governance, but flexible in implementation so as not to become an additional burden for researchers working in the field. This aspect, in itself provides further opportunities to consider the educational and training needs of managers and researchers in terms of how to work more effectively in integrated research and evaluation projects. This might be work best left to Steering Groups and their like, but there might also be a case for a more proactive response being adopted.

2.7.2 The Steering Group contribution

The first task of the Steering Group had been to establish agreed Terms of Reference and pattern of meetings to meet the funding body (NWDA) requirements (Four times a year). It had been agreed at the project management meetings that the proposal for the Steering Group to have a *'hands on'* approach to the project development

would be discussed at the first meeting. The agreement to be involved in the development of project by the Steering group proved to be of immense value, in particular, given the breadth of expertise and knowledge that the members contributed on an individual and organisational level. The project team was kept updated on ongoing and new developments, which over the period of the project turned out to be continual and often extensive. In terms of the health and social care workforce these happened to be very significant e.g. implementation of the Agenda for Change policies (Department of Health, 1999), the introduction of new roles such as Assistant and Advanced Practitioners and the drive for inter-professional education. Although it had been the intention at the onset of the project that another regional group would evolve from the Steering Group (see 2.2) to date this has not occurred. The regional picture with regards to health and social care has changed considerably, in particular, with the Department of Health's commitment to make integrated health and social care a reality. The publication of the recent White Paper – *'Our health, our care, our say'* (Department of Health, 2006) demonstrates the commitment to ensuring this integration.

2.7.3 Internal Evaluation

Two levels of evaluation were considered to be helpful to the project: namely strategic (External) and operational (Internal). The internal evaluation was primarily formative, i.e. it was aimed at supporting project improvement throughout the delivery period, whereas the external evaluation was aimed at assessing the impact of the project, and thus had much more of a summative emphasis. The nature of formative evaluation means that the distribution of effort during a project tends not to be uniform, with the majority of the lessons being learnt during the early developmental stages. The use of the internal evaluator is a relatively new approach in the UK, so it is worth summarising the sorts of role that will and will not work (Patton, 1997) (See Table 1).

During this project the main roles undertaken by the internal evaluator were Management Consultant, Planner, Decision Support and Systems

Generalist. Internal evaluation reports were made directly to the Project Director. These were sometimes formal (written), but more often informal (verbal).

Table 1: Roles of Evaluator (Patton, 1997)

Successful roles	*Unsuccessful roles*
1. Management consultant	1. Spy
2. Planner	2. Hatchet carrier
3. Decision support	3. Number cruncher
4. Management information resource	4. Organisational conscience
5. Systems generalist	5. Public relations officer
6. Expert trouble-shooter	

The Project Director and Internal evaluator agreed a number of questions to be considered in the ongoing evaluation:

1. What lessons for future multi-partner projects can be learnt from the project development process?

It was clear from the earliest discussions with the funding agency (NWDA) that the project to be developed should be collaboration between a range of North West Higher Education Institutions (HEIs), with the University of Salford as the lead organisation. The project development process, therefore, had to keep a delicate balance between:

■ Offering the Region's HEIs the opportunity to participate; and

■ Creating a project plan that was both realistic and achievable within budget and time constraints.

The process was initiated by holding a meeting to which all the North West's HEIs were invited in order to present the project idea and identify which organisations wished to participate. All those attending indicated that they wanted to participate. A follow-up with those not attending confirmed that they either were not able or did not wish to be involved. However, a key problem with developing projects involving a significant number of partners is in creating a project plan, which balances a number of factors:

■ Each partner should feel satisfied that they have a sufficiently large part to play in the project;

■ Partners should have the available expertise to perform their tasks;

■ Partners should be clear about, and sign up to, their tasks;

■ Partners should understand the dependencies between their tasks

and those of other partners;

■ Sufficient resource is allocated to project management and coordination.

As was noted above, the chosen approach of using a series of work packages helped ensure these issues were addressed at the planning stage, and developed further as the activities required to reach the desired outcomes were separated into discrete groups for each Work Package (See Section 2.4). A second meeting was then held where the work package approach was discussed and agreed with partners. Partners were then asked to identify which Work Packages they felt best able to deliver given their research interests and areas of expertise. The Work Packages were then allocated to partners on this basis, with one-to-one conversations taking place to ensure that each partner was satisfied with the result of this process.

The Work Packages were then developed in detail, identifying objectives, specific activities, milestones and outputs. Overall, there was a nominal budget allocated to the project and this was then split between the Work Packages in as fair a way as possible, with each partner being asked to confirm their acceptance not only of the Work Package detail but also the budget allocated to it.

Running in parallel with the above process was the continuous involvement of the NWDA's Project Champion. This person was an NWDA employee whose role it was not only to ensure that the project developed as originally intended by the Agency, but also to act as the promoter of the project when it underwent assessment. It was, therefore, seen to be critical that the Champion be involved and consulted as much as possible during the development process.

2. What lessons for other multi-partner projects can be learnt from the project initiation process?

Experience shows that even when significant time and effort is spent involving partners in the development phase it is often the case that only the lead (or contracting) organisation has a full grasp of the project, the proposed activities and its intended outcomes. The problem is often compounded when, as in this case, some of the partners changed the personnel involved when moving from the planning to the delivery phase. This meant that the project started with a team of deliverers, not all of whom, necessarily knew each other and had varying levels of understanding about the project and its goals.

It was, therefore, important to start the project with activities which:

■ Started the process of building the team;

■ Brought all the team to the same level of understanding of not only the role of their organisation, but also of the roles of the other partners and the interdependencies between them; and

■ Clarified the process of project management and administration.

The catalyst for addressing these issues was a two-day meeting at a hotel in the centre of the Region. This opportunity was important not only from the perspective of developing a common understanding of the aims of the project, but also for developing the creation of a mutually supportive team. It is likely that the good relationships developed by those working with the project would not have been as successful as it has been if this event had not taken place.

The issue of project management and administration was an important aspect of this two-day meeting for two reasons:

a) Projects like this need good leaders. Everyone involved in the project delivery was working part time on the project. This meant that meeting the needs of the project was not necessarily at the top of everyone's 'to do' list. Effective development of a good relationship between the Project Director and the rest of the team early on was important in

ensuring that the team responded to the needs of the project as and when asked. The Director realised this and put considerable efforts into early relationship development. This was supported by a leadership style which, while giving the team members a voice in decision-making, nevertheless recognised when to take the lead to ensure the project kept on track in delivering outcomes against the agreed schedule. Partners appreciated this approach and were both flexible and responsive to the changing needs of the project, particularly when one WP had delivery problems.

b) The project was to be subject to audit on behalf of the NWDA. This meant that each partner had to put systems into place that provided the evidence required by audit. This was a new concept to a number of the partners' staff delivering the project and an early discussion of the requirements was essential to ensure that major problems would not be encountered later on. It also gave a human face to the person responsible for collating claims and audit evidence, which also aided later compliance with requests for additional/clarifying information from partners.

3. How was the progress of each Work Package measured?

With the delivery of each Work Package being the responsibility of different partners, it was important that the Project Director had regular updates on the progress of each Work Package. In order to give a uniform approach to reporting, the project proposal was analysed in detail and a work plan was produced for each Work Package showing planned activities, milestones and outputs. In advance of each quarterly Steering Group meeting Work Package leads were asked to report to the Project Director indicating the % rate of progress towards delivering each activity and the obstacles to progress. The Director was then able to take any necessary corrective action, either directly or through the regular progress reporting mechanism to the Steering Group.

The value of having an internal evaluator who was in fact a 'critical friend' to the project team proved invaluable throughout the project but in particular

during the first 12 months, as the team sought to establish itself and learn to work together. For example, one of the tasks he undertook was to determine what each of the Project team members hoped to gain from being part of this large multi–partner project. This provided the Project Director with information which was then used to assist in achieving their individual aims. One of the key ones was to be involved in disseminating the ongoing project development and outcomes. All the Work Package Leads achieved this to a lesser or greater degree (see Appendix 3 for Project Dissemination outputs).

2.7.3.1 Effective Collaboration between Higher Education Institutions

One of the aims of the evaluation process was to identify the factors which can lead to a successful collaboration between HEIs. These factors are summarised in the Factors Leading to Successful Collaboration given in Figure 2. An examination of these factors illustrates that the foundations for the creation of a successful collaboration are laid during the planning and project initiation phases, where effective leadership is also relevant. This is covered in Section 2.8.3.

Other factors of relevance are:

Effective team working

Creating an effective team was not just a question of developing good individual relationships, but also ensuring that the team were clear about how their Work Packages contributed towards the overall aim of the project and what outputs their Work Packages were committed to deliver. Linked to this was a need for all members of the team to understand how others depended on their activities in order to deliver their roles, and vice versa.

Figure 2: factors Leading to Successful Collaboration
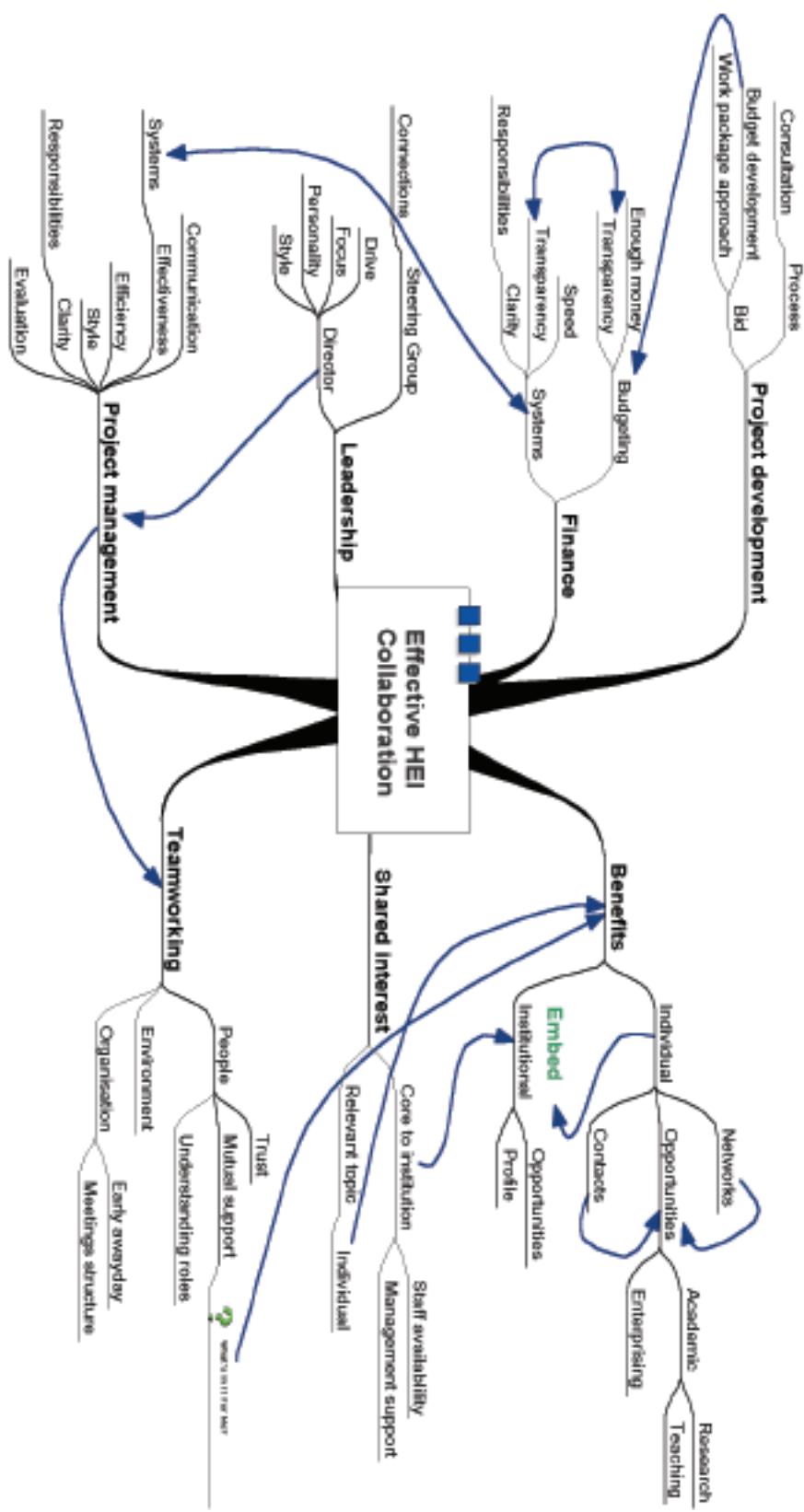
There was a shared view that this was a very complex project in which most of the Work Packages were linked to each other. Initially, these linkages were not fully appreciated and efforts were made to reach a common understanding.

Sound project management and administration

With each Work Package having a different lead individual, it was important that all activities were monitored and a good communications system was put into place.

Only in this way could issues be identified early and remedial action taken. Having a full time member of staff with responsibility for this was critical to the success of the project.

Effective financial procedures

The contract with the NWDA required that the project be subject to external audit upon its completion. This meant that systems had to be put in place which ensured that the contract holder (University of Salford) was able to successfully pass this audit. These systems were based on the assumption that the audit requirements would be similar to those for other NWDA funding programmes, such as the Skills Development Fund (SDF). It was, therefore, important that the finance systems used by the project, particularly those required for grant claims, were clearly explained to all partners, with a significant part of the project initiation meeting being given over to this process. This was only partly successful and it was found necessary to directly involve the Finance Departments of some partners to ensure that the claims process worked smoothly.

Another key issue was that the NWDA does not allow grant to be transferred between financial years (which run from April to March). Consequently, any grant unclaimed at the end of each financial year would be lost to the project. All partners were made aware of this requirement, as were their Finance Departments.

In the end most partners, while not enjoying the process, recognised the need to provide the level of detail and evidence of expenditure required by the audit procedures. Despite certain problems the entire grant allocated for the project was drawn down.

Clarity over the expected benefits to both partner organisations and individual team members

Successful delivery of any project requires there to be clarity over the anticipated benefits for both the partner organisations and the individuals involved in its delivery. Data for both these areas was gathered by either questionnaire or interview in the early stages of the project. This then enabled the Director to support not only the delivery of the project and its outcomes, but also those of the partners and their representatives.

At a personal level there were two key themes with respect to what individuals wanted from the project:

■ Networking and collaborating with other HEIs and the Health and Social Care sector; and

■ Gaining experience, improving reputation and developing an area of academic interest, for both teaching and research.

This was a positive outcome as it demonstrated that the delivery team not only understood the value of the project to themselves, but also the potential for working together in the future. It was apparent that the delivery team had a clear view as to "what's in it for me" and that those personal benefits coincided well with what the project is trying to achieve.

The perceived benefits to the organisation (i.e. the HEI) showed a good correlation to the desired personal benefits:

■ Creating networks for future collaboration;

■ Academic enhancement either through research or improved course provision and delivery; and

■ Raising institutional profile.

Progress towards achieving these aspirations was monitored and it became clear that the project enabled considerable networking to take place and created opportunities for the project team and its HEIs that would not otherwise occurred. These opportunities ranged from writing/presenting papers in journals and conferences, to the development of new project ideas and finally to some consultancy work.

2.8.4 The systematic review (WP2)

This early piece of work was influential to the successful development and completion of the project as a whole. The team's responsibility was to identify key literature and provide themes on which the other Work Packages could base their development and end outcomes. An iterative search strategy was used and the review *'took account of the importance and interconnectedness of policy, practice, population and workforce needs within an integrated health and social care service'* (Howarth *et al* 2004).

Six key themes emerged from the findings: team working, communication, role awareness, practice development and leadership, personal and professional development and partnership working. The team considered that a combination of all themes were 'essential requirements of education and training to deliver effective integrated health and social care' (See Chapter 3).

2.8.5 Benchmarking of Best Practice in Integrated Health and Social Care Education and Training (WP3)

This element of the overall project led to the development of a Benchmarking Tool to identify good practice in integrated health and social care education and training. An expert group established the framework for the tool, which was then refined and evaluated by a number of key focus groups across the North West Region. The definition of integrated care was used to guide the development. Unfortunately, due to a number of factors we were unable to pilot the tool in practice once it had been amended. This was considered a limitation on its value across health and social care services (see Howarth *et al* 2006). However, what has emerged is a tool for benchmarking current practice in education and training in organisations, focusing on integrated health and social care (see Howarth, Holland, Hardiker & Lunt 2006).

2.8.6 Mapping of Education and Training Provision from Higher and Further Education (WP4)

This Work Package focused on the mapping of education and training provision in Higher and Further Education organisations across the North West of England and culminated in the production of a web-based Course Finder Tool. These organisations *'provided the source material used to populate the database of courses' and the tool 'in contrast to other similar tools, focuses specifically on courses that can support the delivery of integrated health and social care'* (Hardiker, 2005). It was discovered that there were gaps in the provision of programmes considered necessary to educate and train the workforce to deliver integrated health and social care. However, prospectuses and course information did not necessarily provide adequate information as to what was actually included in the programmes' content. The recommendations of this are discussed in Chapter 3.

2.8.7 Visions for the Future – Health and Social Care Workforce perspectives (WP5)

A multi-methods approach to the research design was adopted in order to explore the views of current primary health and social care workforce. Data were collected that illustrated the nature of integrated health and social care as they experienced it. This approach, using a survey questionnaire, semi–structured interviews, participant and non-participant observation and a series of workshop case studies and involved participants from three different levels of organisational responsibility and role. This Macro, meso, micro cross sectional approach to data collection was also used in the initial stage of analysis (Warne *et al* 2005). Findings noted the effects that continual change within PCTs had on the workforce and how individuals and groups within these organisations responded. A great deal of rhetorical agreement was evident over the need for integrated working, but little evidence as to how this was translated into organisational, educational, and professional practices (see Chapter 3 for recommendations).

2.8.8 Visions for the Future – Service User perspectives (WP6)

The aim of this study was to explore service users *'perspectives concerning integrated health and social care, and to identify the perceived strengths and weaknesses associated with the current workforce and services provided'* (Reid *et al* 2005). A mixed methods approach included the use of focus groups, questionnaires and in-depth interviews. Findings were mixed, from examples of good practice to what the research team describe as 'disintegrated care' (see Chapter 3 for recommendations).

2.8.9 Education and Training Needs Analysis (ETNA) Model Development (WP7) and Piloting and evaluation of ETNA Toolkit (WP8)

According to Stead and Nettleton (2005) *'three methodological commitments underpinned the development of the ETNA Toolkit',* namely collaboration, learning and interaction. It was developed in three phases: (1) the creation of a prototype tool; (2) testing this and; (3) the final production of the Toolkit. The identification of workforce education and training needs is essential if the delivery of policy objectives such as those described in Chapter 1 are to be implemented with any degree of success. A feature of the tool is the potential to include users and carers in any skills and knowledge gap analysis undertaken.

2.8.10 Dissemination

The dissemination strategy considered a number of options. The main dissemination route was via the project web-site (www.pcet.org.uk) which ensures ongoing information for twelve months past the end of the project date. All project reports and other outputs are made available on this site.

Given that it was essential that all stakeholder groups were to be encouraged to participate in the project development as well as being made familiar with the anticipated outputs which they could use within their organisations a number of briefing events took place within year one. These proved immensely valuable as networking events and for direct contacts to participate in the expert groups.

As the project progressed it became apparent that it was essential that the project teams became aware of the developments taking place within the Primary Care organisations themselves as well as gaining an understanding of the political and care contexts in which the health and social care workforce found themselves. A small number of these volunteered to host events, which would not only benefit the project but also themselves. An example of the event held with Knowsley can be found in Appendix 4.

In terms of integrated health and social care Knowsley was an excellent example of the changing face of integrated health and social care. It was unique in the North West region at the time, in that the Chief Executive of the PCT was also the Director of Social Services. This inter-relationship of roles permeated the duality of the organisations and the ensuing structure of health and social care services. As with other trusts in the North West of England, Knowsley has many examples of developing integrated health and social care services, e.g. Go Integral Project for Older People Services.

One other key event took place at the University of Salford, which involved the future health and social care workforce. This was a joint event between the project and the University of Manchester School of Primary Care, and focused on 'Interprofessional learning in Primary Care: The student experience.' (see Appendix 5 for full details). The focus of the day was deliberately chosen, as we were discovering that alongside the drive for integrated health and social care was that of the drive for inter-professional learning. We determined that an insight into any inter-relationship between the two was essential if we were to provide recommendations as to the future education and training needs of the future health and social care workforce. Issues raised by the students included:

- The need to understand each other's professional roles and responsibilities. One student highlighted the problem with lack of understanding from a patient's perspective, in that 'if we don't understand each others roles how do we expect a patient to do so?' and 'if they come into a Health Centre and are faced with lots of different professions looking after them how do they know who does what in their care?'

- The wish that they could 'follow the patient journey' in practice in order to understand all their care not just the part that their professional group played (The centrality of the patient within their learning experience was evident throughout the discussions).

A second student event took place 12 months later, when similar themes regarding the lack of practice experience of inter-professional working and learning became evident. The students agreed at both events that there were significant benefits to working inter-professionally and inter-agency.

The Project Team had agreed at the onset of the project that it would take every opportunity to disseminate the work of each project team and the overall project and a number of the team have presented their work at conferences and to date through a small number of publications. It was recognised that the majority of publications would be attained post project completion (see Appendix 3 for list of dissemination outputs). Many of these would be collaborative, in keeping with the overall delivery of the project.

2.9 Collaboration

According to Sullivan (1998) the 'literature is replete with myriad and varied descriptors that are snippets of definition's of collaboration and is open to many interpretations'. For the purpose of this project we chose Sullivan's own definition, developed from a concept analysis, whereby:

" *Collaboration is defined as a dynamic process of creating a power sharing partnership for pervasive application in health care practice, education, research and*

organisational settings for the purposeful attention to needs and problems in order to achieve likely successful outcomes" (1998:6)

2.9.1 The Collaborative Experience of the Research Team

The Project was what Hardy *et al* (2003) define as an inter-organisational collaboration. It was a research collaboration, a term which Smith & Katz (2000) in their study of collaborative approaches to research in Higher Education, found difficult to define for a variety of reasons. They did, however, identify ideal types or models of collaboration, namely a) Corporate partnership b) team collaboration and c) inter-personal collaboration. This project involved all three types to a lesser or greater degree.

a. Corporate Partnership

It was a corporate partnership between seven HEI's in the North West, led by the University of Salford who were responsible for the overall Project Management and Dissemination of project activity. As Smith & Katz (2000) identified, there are a number of benefits to such partnerships, which were also realised in this project. Examples are:

- Identification of institutional complementarities and pooling of resources – through both the Steering Group and Research Team which enabled access to a wide range of human and physical resources;

- Promote cultural transformation and new synergies among partners with potential spin offs – through, for example, new insights into development of education and training programmes in different organisations and bringing together a wide range of stakeholder organisations who are active participants in the project learning community. Potential 'spin-offs' included future collaborative bidding by the team and others in their respective organisations and development of new programmes to meet local and regional need through creating new partnerships

between previously 'un-connected' stakeholders.

b. Team collaboration: The Project Team as a Learning Community

It was a team collaboration and in addition there were similarities to a *'learning community'*. Defining what is meant however by a *'community of learning'* proved a challenge. Its use is most predominant in the use of electronic media for remote collaboration (Calvani *et al* 1997, Hall 2003). Three themes, however, emerged from the literature as to this concept: (1) Communities of learning are collaborative (Thomas *et al* 2002); (2) transformative (Macdonald, 2002) and (3) emancipatory (Lleras, 2003). Further, Eraut (2002) offers a challenging editorial on many of the new terms to emerge that *'attempt to capture the social and collaborative dimensions of learning'*. One definition of community is *'the people who live, work or learn within a particular boundary'* (Eraut, 2002). It was anticipated that within the Shaping the Future project there would be many such *'communities of learning'* but working across organisational and professional boundaries and interacting with each other and not just individually. The closest relationship to such a *'community of learning'* was evidenced within the overarching project management team. Examples of team collaboration and therefore communities of learning were:

- Research focused collaboration involving teams of researchers based in various departmental, research centres or other units at two or more institutions. There were seven in this project;

- Teams involving universities, industry or professional practice: these include the Project Team and two 'expert' development groups as well as a number of smaller focus groups and expert reference groups in the wider consultation exercise.

Benefits of such collaborative teams include the development of appropriate skills and expertise and high University – user inter-facing (Smith & Katz 2000: 11). Team collaboration was considered the key to successful completion of the project aims.

C. Inter-professional Collaboration

Smith & Katz (2000:11) note that 'collaboration is intellectually driven and discipline based and sometimes, in larger collaborations, discipline organised. However, it is dependent on essentially personal relationships between two or more university based individuals, sometimes groups.' Examples of key features of inter-professional collaboration found in the Shaping the Future project are:

■ It was based on personal relationships, trust and ability to work together;

■ It was facilitated by regular –face to face contact but can be substituted by the development of other forms of contact e.g. e-mail or intranet.

The benefits of such collaborations according to Smith and Katz (2000) include:

■ A key to disciplinary development/intellectual curiosity;

■ Enhancement of personal and joint capacity;

■ The social basis of collaboration i.e. collaboration is fun;

■ Benefits for teaching and research training.

In terms of collaboration the project proved instrumental in creating networks and stimulating dialogue between local, regional and national groups. It also acted as a catalyst for bringing people and organisations together in a variety of ways – for example, as groups which can be considered communities of learning e.g. Education and Training Needs Analysis Tool Development group and also the Project Development Team itself. It also acted as a vehicle for developing research skills (as per Smith & Katz, 2000) of sub-project team members e.g. a doctoral student who had the opportunity to work with a team of experienced academics and researchers and enjoy team support and supervision of this expert team. It created a wealth of knowledge and practice in collaborative working, team building and those activities that Sullivan (1998) has defined in her definition of collaboration. It also demonstrated what D'Amour *et al* (2005) in their review of the literature, identified as five underlying concepts to collaboration, namely sharing, partnership, power, interdependency and process.

It was the responsibility of the Project Director to pull together the different facets of the project. Key factors emerging that appear to contribute to successful development of the project work included:

■ Internal evaluator role – acting as critical friend to the project team and supporting the Director in learning to manage a project of this size and complexity;

■ Skills and experience needed to lead this project and for the research and development elements of it, in particular, the need for experienced team members to lead sub-projects;

■ Recognition of the contribution of the Steering Group and its expertise in shaping the project;

■ The need for an effective communication strategy and tools e.g. Project intranet site;

■ The expertise and skills of all of the Project Management team towards the development of the whole project and recognition of this contribution;

■ Networking and collaboration with the external world, especially in education and health and social care organisations that are involved with education and training of their respective workforce.

2.10 Conclusion

The Shaping the Future for Primary Care Education and Training Project achieved all its main project outcomes. At times this appeared to be an ambitious plan, given the size of the overall project teams and the number of organisations involved. However, with an ongoing developmental approach to project management and excellent collaboration from those who led and participated in the individual studies we have succeeded in producing end of project material that will be of value to organisations and individuals as they participate in the continual ongoing changes occurring within Primary Care services.

Chapter 3:
Education and Training to Deliver Integrated Health and Social Care: The Future

3.1 Introduction

Warne *et al* (2005) highlight the overarching context in which this study took place, in particular the continued turbulence, which appears as a result of policy change. The results of this they point out *'has resulted in disjunctions and tensions between managerial, educational, political and professional discourses, theories and practice'* (Warne *et al* 2005:6). The implications of this for education, service and service users are far reaching but we concluded that the evidence from the project would illuminate ways of managing these whilst ensuring effective delivery of integrated health and social care services.

3.2 Emerging themes

As seen in Chapter 2 the evidence provided in the Systematic Review (Work Package 2) was central to the development of all the other project outcomes and outputs. The six key themes which emerged were seen to be helpful in providing guidance for research questions and thematic analysis, together with the development of the final tools of the project, namely the Benchmarking of Practice in education and training for integrated health and social care tool (Work Package 3) and the Education and Training Needs Analysis (ETNA) Tool (Work Package 7 & 8). The interconnectedness of the six key themes of team working, role awareness, communication, personal and professional development, practice development and leadership and partnership working with policy, practice, population and workforce needs can be seen in Figure 3, The Framework of Evidence.

In collating the evidence from all the 'sub-projects' (Work Packages) it became apparent that as well as the six key themes which guided the research outcomes, there were other major themes emerging. The most predominant was that of the centrality of inter-professional/inter-disciplinary and inter-agency working and to some extent learning in the delivery of effective integrated health and social care services. The other themes were the need for collaboration and the need for service user involvement in education

and training (see Figure 4: Framework for Education and Training).
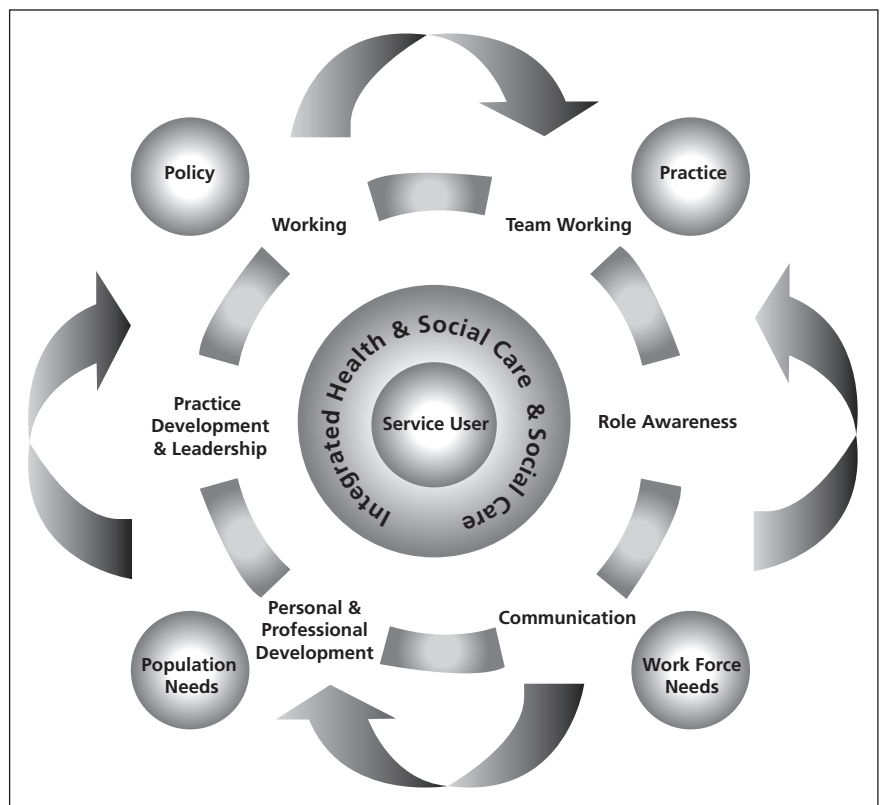
Figure 3: Framework of Evidence

Figure 4: Framework for Education and Training
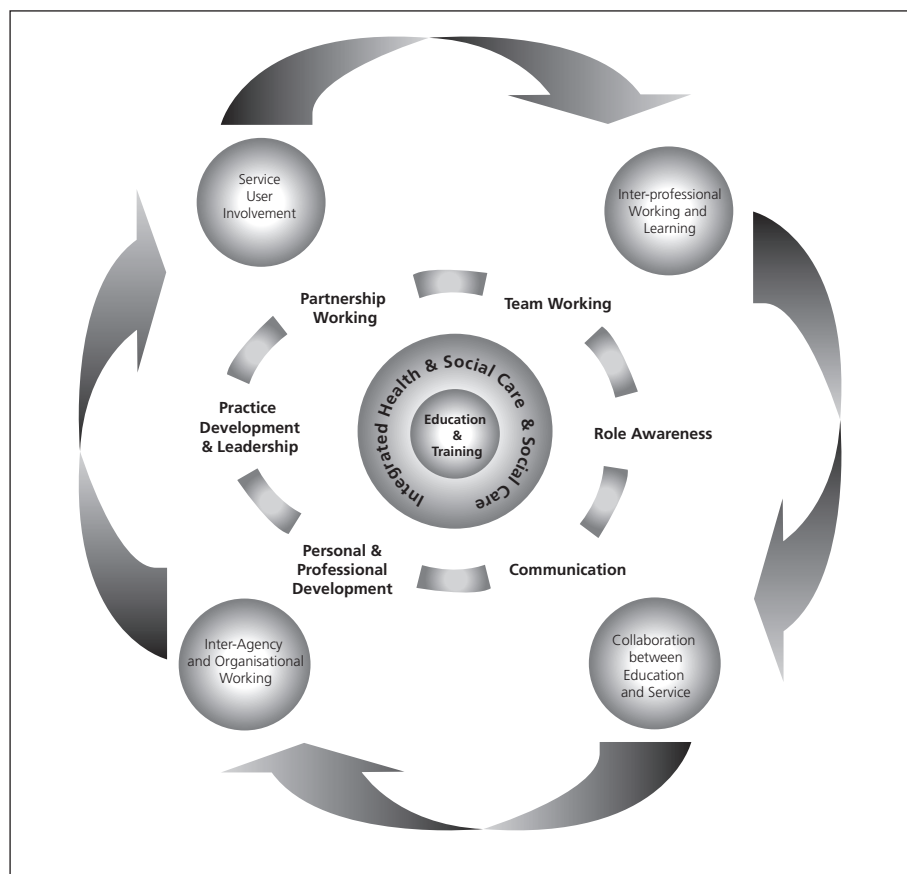
The overarching findings, including these themes, will be presented through determining the recommendations made across all the research and development activity to three key areas:

- Higher and Further Education Organisations;
- Primary Care Trusts and integrated health and social care organisations;
- Service user/carer groups.

It is recognised, however, that in many instances there was an overlap across all three areas. The main evidence will be presented as key points collated from the Work Package reports.

3.3 Recommendations for HE/FE organisations

Team working

- Education and training programmes need to take cognisance of team working in integrated health and social services, not simply working in a team (WP2);
- Education and training for team working needs to be planned to take account of both inter-professional and inter-agency working (WP2);
- Pre-registration/access to health and social care work programmes need to place greater emphasis on team working in integrated health and social care as a core skill (WP2);
- Ensure that all educational and training learning objectives/outcomes reflect national competency framework standards (WP5);
- Ensure that service managers and educationalists work to develop learning opportunities on how to deal with the realities of team working across different professions and agencies (WP5);
- Include clear models of good practice in integrated care in the training of health and social care workers (WP6).

Communication

- Pre-registration and access to health work programmes need to ensure that effective communication skills for integrated working, including use of technology, are core skills (WP2);
- Ensure that all education and training learning objectives/outcomes reflect national competency framework standards (WP5);
- Ensure that service managers and educationalist work to develop learning opportunities focused on how to deal with the realities of team working across different professions and agencies (WP5);
- Place greater emphasis in training on the use of basic communication skills (especially listening skills) in direct client work.

Role Awareness

- Role awareness should become an essential element of all programmes relating to preparing the workforce to deliver integrated health and social care (WP2);
- Shared learning initiatives between health and social care workforce students in practice should be encouraged to develop awareness and understanding of team roles (WP2);
- Ensure that all pre-qualifying education programmes, Continuing Professional Development programmes and activities, more effectively promote role awareness and inter-professional working (WP5);
- Ensure that where possible all CPD programmes aimed at increasing inter-professional working are planned and delivered as joint enterprises (with health and social care, HEIs and service users) (WP5);
- More effectively involve HEIs in providing empirical approaches to support service developments (WP5);
- More opportunities for health and social care workers to train together to enhance appreciation of different professional perspectives/crossing of professional boundaries (WP6).

Practice Development and Leadership

- Leadership education and training for integrated health and social care services needs to be built into educational programmes for all professions (WP2);
- Practice development in integrated health and social care requires collaboration between education and training organisations and departments to ensure skills and knowledge base meets the requirements for service user outcomes (WP2);
- Develop multi-professional and interdisciplinary CPD activities that are aimed at strengthening leadership capabilities across all levels of the workforce (WP5);
- Continue to work collaboratively in ensuring national quality assurance processes for educational providers inform the development, delivery and evaluation of educational and training programmes (WP5).

Personal and Professional Development

- Flexible learning opportunities need to exist to enable the workforce to be able to access inter-professional/inter-agency working programmes (WP2);
- Increase the awareness within PCTs and future service providers of the scholarship role that universities can have in supporting individual practitioners and PCTs (WP5);
- Ensure the development and delivery of both educational and training programmes more effectively reflect practice needs as well as those arising from academic interests (WP5).

Partnership Working

- Partnership and collaboration between health and social care should be essential in the development of curricula for integrated health and social care (WP2);
- Education and training standards from professional bodies should include core requirements for partnership working, taking account of team working, effective communication and role awareness as essential elements of the programme (WP2);
- Ensure multi–professional and interdisciplinary CPD activities are developed that are aimed at increasing the understanding of roles and responsibilities (WP5);
- Develop curricula that explicitly provide learning opportunities for partnership working (WP5);
- Ensure that future education and training competency standards include core requirements for partnership working (WP5).

3.4 Recommendations for Primary Care Trusts and Integrated Health and Social Care Organisations

Team working

- Develop teams with the appropriate skills and knowledge, that are able to liaise and work collaboratively across organisations and agencies (WP2);
- Ensure that any team has the required awareness of all the member role functions and professional background as appropriate (WP2);
- Service planning and service provision need to take account of the education and training required for a whole team when creating new roles (WP2);
- Co-location of teams needs to take into account education and training for new ways of working (WP2);
- Develop change management knowledge and skills at all levels of the workforce and ensure service users and carers are partners in these processes (WP5);
- Undertake organisational culture analysis aimed at promoting a culture which supports greater involvement of the wider workforce in decision making processes (WP5);
- Provide structured and regular 'timeout' sessions aimed at harnessing organisational learning (WP5);
- Develop systematic organisational evaluative strategies that are capable of evidencing improved team working (WP5).

Communication

■ Ensure staff working in integrated teams have well developed communication skills to enable them to work within and across inter-professional and inter-agency boundaries (WP2);

■ Ensure a common language is used between health and social care organisations to aid effective team work (WP2);

■ Ensure that the workforce has the knowledge and skills to manage changing communication channels e.g. information technology (WP2);

■ Address workload allocation of health and social care workers to allow time for meaningful interaction with clients (WP6);

■ Promote and support the development of a 'common language' for integrated health and social care, recognising the organisational and professional socialisation processes that militate against this (WP5);

■ Ensure greater transparency in the exchange and access to information through further development of new technologies (WP5);

■ Ensure the development of IT systems that are multi-agency capable and fit for purpose (WP5);

■ Develop engagement processes that support greater organisation innovation and confidence in how IT systems work (WP5).

Role Awareness

■ When developing new roles ensure that there has been organisational preparation for their introduction into the workforce (WP2);

■ A variety of innovative learning opportunities need to be considered, including role shadowing, secondments to work with multi- professional teams and inter-professional education (WP2);

■ Develop more structured approaches to supporting and recognising the value of informal inter-professional and organisational learning (WP5).

Practice Development & Leadership

■ eaders need to be identified and educated to lead integrated health and social care services (WP2);

■ Practice development needs to be led by leaders who take account of a cultural change needed to ensure effective working in integrated health and social care services (WP2);

■ Ensure that practice development activities are facilitated by leaders skilled in cultural change processes and that these activities are systematically evaluated (WP5);

■ Ensure protected time is identified specifically for multi–agency practice development and CPD activities (WP5);

■ Ensure that PCTs, future service providers, educational commissioners and providers work collaboratively in developing new CPD programmes which reflect the changing nature of health and social care practice and the changing environments where such practice is undertaken (WP5).

Personal and Professional Development

■ Compatibility needs to exist between all the NHS and Social Care skills and knowledge frameworks in ensuring the workforce is able to work in integrated health and social care organisations and services (WP2);

■ Supportive environments need to exist to enable personal and professional development in integrated working (WP2);

■ Being able to work in integrated health and social care situations at all levels of organisations should be built into role descriptions and job specifications (WP2);

■ Continue to develop meaningful opportunities that promote life long learning and the systematic identification of training needs (WP5);

■ Regularly evaluate the impact and use of new workers in the roles and functions of the existing workforce (WP5);

■ Increase the opportunities to work

together in developing more effective learning environments capable of supporting flexible learning within PCTs and future service providers (WP5);

■ Agree a joint framework agreement for CPD that supports in-house CPD activities being credit rated (WP5);

■ Ensure that the knowledge and skill required to work in integrated health and social care services (including in education) from the basis of job descriptions and role specifications (WP5);

■ Ensure that integrated personal and professional development strategies are explicitly linked to organisational change strategies and business planning processes (WP5);

■ Develop transparent and effective decision making processes that are capable of handling the personal, professional and organisational tensions involved in determining what is seen as 'useful knowledge' (WP5).

Partnership working

■ Leaders of integrated health and social care services need to offer a supportive culture for integrated working and delivery of care (WP2);

■ Develop specific roles to facilitate inter-agency partnership working at the Micro and Meso levels of the workforce (WP5).

3.5 Recommendations for Service User/Carer Involvement in Education and Service Development and Delivery

■ Ensure service users of integrated services are integral to developing communication networks and language (WP2);

■ Role awareness education for service users/carers should be considered essential to ensure effective communication and appropriate use of services (WP2);

■ Service users need to be involved in any education and training development which promotes partnership working (WP2);

- Role awareness education for service users and carers should be considered essential to ensure effective communication and appropriate use of services (WP2);
- Establish professional qualification pathways for home care workers (WP6);
- Service users need to be involved in any education and training development which promotes partnership working (WP2);
- With service users and carers develop communication processes aimed at ensuring service users and carers can better understand the different roles and responsibilities of the workforce (WP5);
- Improve opportunities for greater service user and carer involvement in education and training programmes in order to increase awareness and responses to drivers for practice development (WP5);
- With service users and carers, work towards developing a shared definition of the criteria that can be used as a benchmark for systematic service evaluation of integrated health and social care services (WP5);
- Ensure there is an explicit requirement to demonstrate the involvement of service users in educational and training activities in commissioning agreements (WP5);
- Proactive consultation mechanisms are needed to identify the types of services that users would like to see in place. Current arrangements are too passive –the service user has to take the initiative (WP6);
- Find ways of capitalising on obvious service user enthusiasm for training (WP6);
- Involve service users in interdisciplinary training sessions to enhance workers appreciation of user perspectives (WP6);
- Significant increase in investment in training for home care agency workers (WP6);
- Emphasise that partnership working means partnership between workers and service users –not only between workers (WP6);
- Raise both workers' and service users awareness of the meaning of

integrated health and social care; that is not only integration between work of different health and social care professionals but also integration between the work of home care staff and 'professionals' (WP6).

Although these recommendations are generally self-explanatory and are thematically aligned, it was identified that in many instances there was integration between many of them. Thus we argue that the recommendations should be read as a related constellation of changes, rather than as single and specific items that might somehow require simultaneous implementation by those concerned with the provision of primary health and social care services, and the commissioning and provision of educational and training programmes aimed at developing the workforce. Indeed, we assert *a priori* that such simultaneous implementation would be both impossible and undesirable.

The project outcomes, including the recommendations noted above, must be seen against the backdrop of unrelenting change. It was clear from data collected in developing the evidence bases that there were multiple versions of a vision of integrated health and social care raises the consequential possibility that not only might *individual* PCTs be involved in a process of conceptual transitions, but individuals within these PCTs might be involved in parallel but different processes of conceptual transitions (Warne *et al,* 2005). Such conceptual transitions are in themselves, manifestations of the various layers of change being experienced by individuals and their organisations.

This project has resulted in significant outputs and recommendations. They can be used collectively when establishing new services or individually when for example assessing the education and training needs of the workforce. Their combined outcomes, however, will be of value to all integrated health and social care organisations in their quest to deliver integrated services, which in turn will benefit the local communities. It is also anticipated that the recommendations and outputs will be of value to Higher and Further Education Institutions in order to establish their own strategic plans for working with health and social care providers to

ensure an effective and educated workforce to deliver integrated health and social care.

3.6 Discussion

The collective outputs of the Shaping the Future project represent how the felt experiences of individuals working in the current PCT system were first captured, interpreted and, in some instances used to build models, tools and guides for future thinking. Overall, these accounts represent a valid evidence base that has been constructed from data collected in various ways. Where this has involved participants describing their experiences, we argue that while such data is authentic, there can be no guarantee that this data are representative of all those working in primary health and social care. However, the various teams have, in their reports, been able to reveal the extent of the generally high level of shared awareness of the need to develop more integrated ways of working in primary health and social care.

It was interesting for us that when we embarked on this project the types of integrated health and social care concepts now being proposed in the White Paper – *Our health, our care, our say* (Department of Health, 2006) were still in its infancy. Given that Primary Care Trusts were also still in the early stages of development it could be considered a risky decision by the project team to examine the implications of such integration for the future health and social care workforce. However, it appears that our *'reading of the runes'* in many respects, has become a new reality.

There has been over the life of this project a move from a position where concepts around multi-professional working, multi agency working, partnership working and collaborative working, were often previously conflated, used inter-changeably by participants to a place that is conceptually more stable. It is if the term 'integration' is being used a verb, not a noun as is more usual. For example, the evidence base points to a vision of the future that is of a primary health and social care service characterised by integrative working practices. We argue that this vision is *not* the same as the vision of developing integrated health and social care services and points to the difficulties that might result from similar

examples of conflation and reductionism as these new futures begin to take shape. Thus, we argue, that the publication of this latest White Paper (Department of Health, 2006) is opportune in the context of the recommendations arising from this project, in particular, in relation to preparation of the workforce to deliver the proposed changes. For example, there are explicit policy indicators setting out the shift in focus and methods of working for those involved in current primary health and social care services and the consequential impact this shift will have upon staff *'it will mean changes for all staff, whether they are focusing more on prevention or working in new settings'* (Department of Health, 2006: 185). One of the fundamental changes being proposed is *'better integration between those working in the NHS and those working in social care'* and states that:

> *" A better integrated workforce –designed around the needs of people who use services and supported by common education frameworks, information systems, career frameworks and rewards –can deliver more personalised care, more effectively"*. (Department of Health, 2006:185)

Such appeals to popular professional rhetoric's are not new however. It has been argued that these rhetoric's allow individuals and groups to unconsciously recognise and respond to the link made between an often remote, yet widely known, context, and the immediate situation they find themselves in (Warne *et al,* 2005). Likewise, how these politically driven objectives aimed at 'reshaping' future services are to be achieved is still to be agreed. Indeed, we argue that there is no reason to assume that the different interests of the many diverse stakeholders involved in health and social care education, training and service provision coincide. There is a need to keep in view the whole systems approach to planning and facilitating responses to the educational and organisational implications of developing integrated health and social care first outlined by Howarth *et al* (2004) and further developed by Warne *et al,* 2005 and Reid *et al,* 2005 in their analysis of

the workforce and service user experiences.

The Systematic Review of the literature (Howarth *et al* 2004) highlighted six themes that facilitated critical exploration of factors involved in the successful integration of health services through effective education and training of the workforce. These themes were then used throughout the project teams' work to determine their value and usefulness in attempting to capture the needs of the workforce and other key stakeholders in the care process. Such a process was inevitably context driven.

The overarching context, represented in the achievement of integrated health and social care services, was in itself, part of a wider and more complex context. So for example, whilst some PCTs involved in the Shaping the Future project, were clearly able to demonstrate organisational activity that supported the realisation of the current governmental vision *'of increasing partnership working and collaborative approaches',* this often appeared to be the consequence of a continuing debate around whether to provide a wide range of general services or move to the provision of more specialist services. There was evidence to suggest that such debates often occurred at the macro level of planning and decision-making. However, there was also evidence in the form of parallel operational processes, for example, the assimilation processes many participants were involved in as part of the implementation of Agenda for Change for example (Department of Health, 1999).

However, even where more specialisation replaces genericism in terms of future working, greater innovative integration, *per se* will be required to ensure that more effective outcomes are achieved for professions, organisations and patients. The PCTs of the future will have greater responsibility for ensuring such integration through the proposed new commissioning arrangements.

Given that integration implies bringing together different health and social care workers in new ways of working it will be essential that purposeful consideration is given to the way that teams are affected by the introduction of new and sometimes different individuals.

The skills of team working in any context can not always been be considered as being simply transferable into any health and social care settings, particularly where there is a systematic attempt being made to ensure such services are integrated. Effective team working relies heavily on the level of understanding of each others' roles each team member has, as indicated in the recommendations arising from the role awareness theme. This approach is clearly linked to the inter-professional and inter-agency working agenda where understanding one another's roles is essential for effective team working (Freeman *et al* 2000). We argue that this is a particularly important factor for those educational and training programmes that involve pre-qualification programmes. In these programmes, the first step in acquiring knowledge and skills for practice, integrated working should be seen as a core skill and be embedded in the processes involved in *'becoming'* a professional.

In this context we also argue that rather than teaching about team working per se, the emphasis needs to shift to an approach that includes learning about *how to deal with the realities* of team working. The importance of effective communication skills for integrated working is seen in the 'Statement of Guiding Principles relating to the commissioning and provision of communication skills in pre-registration and undergraduate education for Health care professionals' (Department of Health, 2003). Ineffective communication between health and social care professions can result in far reaching outcomes as for example was evidenced in the report from the Victoria Climbie enquiry (Laming, 2003).

Our recommendations for service users/carer involvement in education and training also has a resonance with the new White Paper (Department of Health, 2006) in particular as it relates to informal carers. Two of the recommendations of Reid *et al* (2005), for example:

■ 3.5 Significant investment in training for home care agency (WP6)

- Establish professional pathways for home care workers (WP6)

are reflective of the White Paper recommendations:

" *We must ensure that informal carers can move in and out of the paid workforce*" *(Department of Health, 2006:189)*

and

" *We envisage a much greater role for informal carers and people who use services in training staff - with 'expert' carers running courses for nurses, doctors, allied health professionals, social workers and other staff*" *(Department of Health, 2006:188)*

The change to more community based care, including community based hospitals, where health and social care will merge, will also require that the future workforce, in particular, pre-registration health and social care students, gain experience of this. This will require Education and Service providers to work closely together in order to ensure that this future workforce more effectively develops learning and teaching approaches that prepare staff to meet patient and carer needs in the new and emergent service contexts. The pursuit of inter-professional learning will need to continue, but not without a parallel process of inter-professional working in practice. However, it is not easy to move from the rhetoric to a new reality. For example, in the feedback from the Inter-professional Study day (see Appendix 5) it was clear that not all students have experienced this. In our view the drive towards inter-professional learning will be counter productive unless there is also new investment to support the development of this within practice.

Much of what is stated in the various recommendations arising form this project will also require continued and new investment in education and training of staff and as indicated, the service user and their carers. However, there is a real danger that in the headlong pursuit of integrated working, educational experiences will be replaced by competency based and skills based training programmes. For example, the early experience of many Assistant

Practitioners point to the dangers of not ensuring training for new workers in the health and social care workforce that is appropriately underpinned by effective educational experiences. It can be argued that every aspect of health and social care service provision ultimately depends on the knowledge and skills of individual staff. Education and training for the workforce is a major industry in itself. The large scale of educational and training processes is increasingly matched by a corresponding complexity in the commissioning processes.

Health and social care generally, and primary and community health and social care in particular, have experienced a period of rapid and often unpredictable change. These changes are set to continue as the future PCTs role changes to reflect a role more around service commissioning than that of direct provider of services. It is likely that these commissioning processes will continue to grow in complexity as new organisational forms for primary health and social care services continue to develop.

Likewise, if PCTs are not providing services in the future, they will not need to directly employ many of the clinical workforce currently on their payrolls. It is possible to envision a future that, in terms of career pathways for individual primary health care practitioners and professions, would appear more fragmented than integrated.

There are implications also for educationalists and those responsible for ensuring individuals are competent and fit to practice. For example, given the difficulties that there might be in ensuring coherent CPD, re-registration, personal and professional development processes exist, the creation of a new primary health and social care worker would appear to be a desirable development. Additionally, developing a new primary care workforce would not entail having to deal with the transfer of employment of the current workforce to non-NHS organisations. For example, pension rights, and equality of national terms and conditions of employment.

Likewise, the process of creating a patient-led NHS, which uses new commissioning approaches, payment by results and money following patients is likely to add to the already turbulent

environment of the NHS. If individual practitioners increasingly feel at risk and vulnerable to such processes, they may chose to opt out of the health and social care workforce completely. It is clear from the evidence that the organisational demands made of staff (for example, in meeting government targets) often result in a practice being characterised by a sustained sense of busy-ness which works against collaborative practice being developed (Warne *et al*, 2005). Against these organisational demands, education alone is unlikely to lead to better collaborative practice. Indeed, *'intra-institutional'* (such as imbalances in student numbers; finding suitable accommodation for both large and small group teaching, timetabling problems across groups with discrete discipline-specific curricula) and *'extra-institutional'* inhibitors (such as disparate professional bodies; unsynchronised validation cycles; separate funding streams) often work against the successful implementation of inter-professional education programmes. Similar issues are transposable to health and social care organisations.

The UK health and social care field is populated by large organisations rather than single entrepreneurs or small free-standing units. Although these various organisations have long been exhorted to work together in a more interrelated way, achieving this or even inter-organisation co-ordination remains difficult and problematic. Partly, the reason for this is a consequence of two different relationship concepts (1) vertical relationships (usually involving a top down approach to service development and management); and (2) lateral relationships (usually involving partnerships between agencies or across networks) resulting in countervailing processes of collaboration and/or conflict. The way in which individuals and groups within and between organisations behave in response to these countervailing processes is also important to consider. The collective accounts represented in the nine volumes of reports stress the need to locate the health and social care workforce and educational preparation within a broad understanding both of the changing nature of who make up this workforce, and of the turbulent nature of the context

3.7 Conclusion

Primary health and social care workers aim to provide services against a policy backdrop, which calls for an increasing focus on integrative, multi-professional and multi agency working, in order to provide seamless and effective services to patients. This requires a more effective involvement of a much wider workforce than that traditionally involved (medical, nursing, allied health professionals and other health and social care support workers). There are new roles being developed that will need to be accommodated and assimilated into the traditional workforce. Alongside these shifts, requiring greater diversity amongst primary care workers is the need for greater flexibility, in employment practices. Individuals with the workforce will increasingly face service and practice developments that challenge traditional many aspects of professional practice. The emergent policy guidance on the development of a patient-led NHS, provides both challenges and concerns for the future health and social care workforce. These changes, in policy and practice, have significant implications for the education and training of future health and social care workers, necessitating equal measures of flexibility and innovation from educational institutions as will be expected from primary care staff.

Given the unrelenting level of change taking place in health and social care there needs to be some stability in relation to education and training and development of the workforce. With the publication of the White Paper (Department of Health, 2006) this is not yet likely to occur. If its proposals for integration of health and social care are to occur there will of necessity need to closer working relationships and collaboration between Education and Service providers in particular through the work of the new Regional Strategic Health Authorities. Such work is crucial if those that can provide education are not disenfranchised by the increasing pursuit of skills based training programmes.

Holland (2004:229) concluded that:

" *To achieve fully integrated services supported by inter-professional and inter-agency working will require a significant cultural change for a number of organisations at all levels*

*of service management and delivery. Central to this will be the need for effective leadership and most importantly effective partnerships and collaboration between health and social care services and their respective education partners to ensure that any future workforce will have the skills and knowledge to deliver the care that users of this service require***"**.

The success of this *Shaping the Future for Primary Care Education and Training* project has been the result of the effective collaboration between Higher Education providers and the organisations delivering and developing health and social care. It is our belief that this should be the precursor of other such initiatives which examine the links between education and service needs in order to ensure that the pursuit of effective integrated health and social care services becomes a reality.

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Steering Group membership

Sue Lightup	Director, Social Services	St Helen's MBC
Richard Jones	Director, Social Services	Lancashire County Council
Bernard Walker	Director, Social Services	Wigan MBC
Eileen Martin	Dean of Health & Chair, NWUA Health Sub-Group	UCLAN
Dr Janine Talley	Staff Tutor	Open University
Jean Llewellyn (from 06/03 – 10/04)	Project Champion	NWDA
Jane Flanagan (from 10/04 – Present)	Project Champion	NWDA
Prof. Norma Raynes	Chair, Project Steering Group	University of Salford
Dr Keith Lawrence	Project, Internal Evaluator	University of Salford
Karen Holland	Project Director	University of Salford
Andy Duffin	Project Administrator	University of Salford
Chris Jeffries	Assoc Dir, Education & Learning Resources	GMSHA (Gtr Manchester Strat Health Authority)
Tony Watmaugh	Director, North West Region	Association of Colleges
Jo Reeve	Honorary Lecturer - Primary Care	Cheshire & Merseyside tPCT
Maria Thornton	Deputy Director, Teaching & Learning	Salford PCT
Tina Egan	Principal Officer (Ops)	NWUA
Prof David Pilgrim	Clinical Dean	Blackburn with Darwen PCT
Prof Valerie Wass	Professor of Community Based Medical Ed.	University of Manchester
Pat Sandiford	Manager of Community Based Medical Ed.	University of Manchester
Prof Godfrey Mazhindhu	Dean of Health	Liverpool John Moores University
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Celia Granell	Development Manager	CLSHA (Cumbria & Lancs Strat Health Authority)
Dave Jones	Project Manager, (CMSHA Post Reg. Framework)	CMSHA (Cheshire & Merseyside Strat Health Auth)
Jacky Knapman	Education Director	Cheshire & Merseyside tPCT

Steering Group Meetings- Terms of Reference

1. To actively shape and influence the Project and its progress, including communicating and liasing with the Project Team and relevant organisations

2. To advise the NWDA (as the funding body) on the progress of the project and its monitoring

3. To monitor financial management of the project in collaboration with the Project Director

4. To develop a sustainable collaborative partnership between key organisations and individuals involved in the delivery and development of integrated health and social care, education and training and workforce development in the NW Region. This includes actively pursuing other opportunities for collaborative initiatives as a result of the project objectives and outcomes.

5. To assist in the dissemination process through networking activities and attendance at local, regional and national events and forums.

6. To receive regular reports on project progress from Project Director in accordance with the Project Plan.

7. To attend quarterly meetings as per agreed annual calendar

Dissemination Activity of Project Team

Conference presentations

Hardiker N 2004: The PCET Course Finder Tool presentation, Project Regional Conference, Reebok Stadium Conference Centre, Bolton

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A Collaborative Event

Shaping the Future for Primary Care
Education and Training Project
&
Knowsley

Tuesday May 11th 2004

Venue: European Suite
Liverpool Football Club, Anfield, Liverpool

'Education and training to deliver integrated
health and social care'

A Conference to share good practice in integrated
health and social care

Report from the Event

Website: www.pcet.org.uk

Introduction

The event itself was the outcome of discussions between Karen Holland, Project Director, Shaping the Future for Primary Care Education and Training Project, University of Salford and Anita Marsland, Chief Executive of Knowsley Primary Care Trust/Director of Social Services and Wendy Pickard, Deputy Director of Service Provision, Knowsley PCT.

The key aims of the day were to:

1. Establish the perspective of health and social services workforce as to what they considered to be essential knowledge and skills necessary to deliver integrated health and social care services;

2. Establish how Knowsley could be involved in the Shaping the Future Project;

3. Enable the Shaping the Future Project team to gain a better understanding of issues related to working and learning in an organisation that was identified as an integrated health and social care service;

4. To enable Knowsley to establish a baseline evaluation of the workforce perspective of its current position with regards to an integrated health and social care organisation;

5. To enable a way forward to be planned for the future education and training needs of the workforce in Knowsley.

Delegates

47 delegates attended the day, with 40 from Knowsley and 7 from the Shaping the Future Project Team (A Full list of delegates in Appendix 1).

Programme of the Day

Following registration and coffee the day began with a welcome from Councillor Ken Keith, Knowsley Borough Council. He spoke highly of the collaborative partnership between the Primary Care Trust and social services, in particular the work of the Older People Services. He thanked all the staff present and their colleagues for their hard work and dedication in caring for the people of Knowsley. He was thanked for his welcome by Wendy Pickard, Knowsley PCT.

Following this Wendy Pickard gave an overview of integrated health and social care nationally and locally – entitled 'Better Together' (Copy of full presentation in the Publications Menu on the www.pcet.org.uk website entitled *'Better Together'*). This provided an excellent background for the delegates and highlighted in particular the health and social care issues of Knowsley. It also highlighted the excellent achievements that had already been implemented in integrating services for the benefit of the local communities.

Karen Holland, Project Director of Shaping the Future for Primary Care Education and Training Project then presented an overview of the project aims and progress (Copy of full presentation in the Publications Menu on the www.pcet.org.uk website entitled *'Overview and Project Aims'*). This generated discussion and offers of support to become involved in elements of the project. It was anticipated that many of the issues would be revisited during the remainder of the day.

Following a coffee break the delegates returned to the main area where Karen outlined the Group Activity for the first session.

The delegates were all allocated to a group with a facilitator from either Knowsley or the Shaping the Future project.

Morning session

Group Activity 1

Identify knowledge and skills to deliver integrated health and social care.

The aim of this session is:

To identify (in broad terms) what are considered to be the essential skills and knowledge for the workforce to be able to deliver an integrated approach to health and social care. (This is not specific to Knowsley).

Consider for the feedback session:

1. What determines the knowledge and skills required to deliver integrated health and social care services?

2. How would organisations determine their specific workforce needs with regards to this knowledge and skills?

3. What essential knowledge and skills are considered essential to deliver effective integrated health and social care services?

4. How would you ensure that the workforce would gain essential knowledge and skills?

Please identify a member of the group to give a brief feedback on these points. Flip chart paper/pens are available to make notes for this exercise.

Feedback from the morning discussion

Prior to the group feedback Anita Marsland the Chief Executive of Knowsley PCT/Director of Social Services addressed the delegates. She gave a brief update on developments and progress in relation to collaboration and partnership activities, the uniqueness of her role and also the issues she faced in her day to day work because of this. This was a very enlightening insight. She thanked Karen, the project team and Wendy for making the day possible and all the staff for making a commitment to take things forward. Delegates had an opportunity to talk with Anita during the lunch break that followed.

The facilitated sessions had provided an opportunity for the groups to get to know each other on both a social and professional basis. There was a lively discussion in all the groups.

The morning activity focused on knowledge and skills in general to deliver integrated health and social care. The issues raised highlighted both national and local drivers influencing workforce needs.

Summary of key issues

Q1) What determines the knowledge and skills required to deliver integrated health and social care services?

Key issues identified were:

■ The needs of the community – in particular, users and cares needs/experiences/ feedback and changing population needs in shift from secondary to primary care;

■ Professional role needs;

■ National drivers and legal frameworks;

- Health promotion , education and disease management;
- Organisation vision.

Although there was variation in how views were expressed it was clear that delegates understood the external and internal drivers determining organisational strategy.

Q2) How would organisations determine their specific workforce needs with regards to knowledge and skills?

Key issues were:
- Consultation process within the organisation and users/carers;
- Training needs analysis linked to business planning;
- Strategic planning and sharing across organisations;
- Respecting diversity;
- Identifying skills mix and gap analysis;
- Appraisal systems.

There was a significant similarity in responses to this question between all five groups.

Q3) What essential knowledge and skills are considered essential to deliver effective integrated health and social care?

Key issues were:
- Good strategic planning and clarity of vision (all levels of staff);
- Good leadership skills- innovation, creativity and vision;
- Organisational development, workforce development and team development;
- Robust communications;
- Organisational vision;
- Knowledge of local needs;
- A range of skills – customer care, effective team working, finance, evidence based practice and IT and communication skills.

There was again significant similarity and agreement between the groups as to essential knowledge and skills. In particular in was also apparent that the delegates were raising similar themes to those already being identified in the Shaping the Future project –Systematic Review.

Q4) How would you ensure that the workforce would gain essential knowledge and skills?

Key issues were:
- Team working and networking;
- Better understanding of each others roles across health and social care;
- Commitment to developing staff and reducing barriers;
- Career mapping;
- Partnership working with academia;
- Role redesign;
- Defined goals–keep focus on integrated working not just inter-agency working;
- Make protected learning time and resources (including training facilities) available – learning becomes a part of the culture.

The overall themes from all the feedback appear to focus on having an initial Strategic vision and planning, clear visionary leadership, taking account of user/carer needs and views, together with having robust training need analysis strategies linked to appraisal and supported by resources and protected time. All this in an environment which supports and promotes collaborative working and partnerships across and with communities.

Afternoon Session

Delegates returned from an excellent lunch and the afternoon session was outlined. There was some negotiation at this point from some supporters of Liverpool Football Club to be given the opportunity to undertake group activity in the Executive boxes overlooking the ground itself. This provided some light hearted discussion on the issue of favourite football teams! It also demonstrated excellent negotiation skills and collaboration between delegates!

The groups again worked hard to achieve the session outcomes.

Group Activity 2

Knowledge and skills for Knowsley

The aim of this session is:

To explore education and training needs of the workforce to be able to deliver an integrated approach to health and social care in Knowsley.

Consider for the feedback session

1. What are the local determinants which will influence what skills and knowledge are required by the health and social care workforce in Knowsley?

2. Do you consider that Knowsley has an integrated approach to health and social care and what leads you to believe that (or not)?

3. What education and training needs do you consider essential if you are to work in an integrated health and social care organisation of the future?

4. How do you envisage that your education and training needs will be met by the organisation?

5. What would the group expect to happen in relation to this event, with regards to their future education and training needs?

Following the feedback Michelle Taylor, Life Long Learning Co-ordinator briefly outlined some of the plans for the future lifelong learning strategy and asked for any volunteers to be involved in the development groups. There was an excellent support for this and names were offered at the end of the afternoon.

We were very pleased to welcome Rosemary Hawley, Chair of Knowsley PCT who gave a short closing address to the day. She then thanked the delegates for their hard work in providing Knowsley community with such excellent service and also Karen and the Project team for making the day possible.

It had been a very successful day – indicating the trust commitment to its philosophy and strategy for integrated health and social care. There are many challenges to be faced within the next

12 months, in particular those related to changing services for Children, and closer working links with the Education service. Given its current position Knowsley will be at the forefront of these challenges and its workforce prepared to get involved in ensuring its success.

Links would continue with the trust through the project and Karen proposed that a similar event took place in 12 months time to evaluate progress and developments.

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Faculty of Health and Social Care
University of Salford

Project Director –Shaping the Future for Primary Care Education and Training Project

and

Wendy Pickard
Deputy Director of Service Provision
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Report preparation:-

Andy Duffin
Project Administrator

Shaping the Future for Primary Care Education and Training Project
University of Salford

11th May 2004

A Collaborative Event

Shaping the Future for Primary Care Education
and Training Project
&
University of Manchester,
School of Primary Care

Hosted by the University of Salford

February 18th 2004

Sponsored by:

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"Inter-professional learning in Primary Care: Exploring
the student experience"

A Conference for North West Region
Health and Social Care Students

Report from the Event

Website: www.pcet.org.uk

Primary Care
Education &
Training Project

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of MANCHESTER

Introduction

The Conference itself was the outcome of discussions between Karen Holland, Project Director, Shaping the Future for Primary Care Education and Training Project, University of Salford and Professor Val Wass, Professor of Community Based Medical Education, School of Primary Care, University of Manchester. The key aims of the day were to:

1. Identify what makes a good learning environment in the community for health and social care students;

2. Identify ways in which inter-professional learning and working could be promoted in the community setting;

3. Identify the skills, knowledge and attitudes needed to work effectively within an inter-professional team in Primary Care/community setting;

4. Identify ways in which their programmes of learning could be structured to enable them to achieve this.

Delegates

Undergraduate students and their tutors had been invited from all the North West Higher Education Institutions, with anticipated attendees from all health and social care groups. Twenty undergraduate students took part in the day's events, from the University of Manchester, Salford, Liverpool & Central Lancashire and Edge Hill College of Higher Education, together with a trainee assistant practitioner from Salford Primary Care Trust. These represented nursing – adult, child and mental health branches, medicine and podiatry.

In addition, there were an additional twelve attendees, which included clinical tutors, Primary Care Trust representatives from Salford and East Lancashire Teaching PCT's and Cumbria and Lancashire Workforce Development Confederation. All students had experienced a community clinical placement and were nearly all in the final year of their programmes of study. Length of time in a community placement varied from a day/two days per week to longer blocks of time of 8 weeks and more.

Programme of the Day

Following registration and coffee the day began with a welcome and introduction to the day by Karen Holland and Val Wass, both giving an overview of their work in relation to education and training issues facing the Primary Care sector. The aims of the day were outlined and participation through discussion was encouraged. All delegates would receive a summary of the day's discussions.

The delegates were all allocated to a group, three student groups and one mixed tutor/service group. There was a set focus to both morning and afternoon sessions:

Morning session

Group Activity 1: Future working in a community setting

Given that you have all experienced clinical placements within a community environment we are interested to know, from your perspective, what it is that would attract you to working there once qualified. In your groups, consider some of the following issues:

- How were you prepared for the learning experience within the community?
- What do you consider to be a good learning environment?
- What contact did you have with other students from different courses/professions?
- What learning and teaching took place in an inter-professional way?
- What benefits do you think inter-professional teaching and learning has for patient care?
- What would you like to see in your curriculum that would help you to learn and to work inter-professionally/inter-agency?

With your facilitator identify:

- 3 key factors that would facilitate learning in a community environment;
- 3 key issues arising from your discussion that would help you to decide to work in a community setting, once qualified.

Karen Holland, Professor Val Wass and Dr Tony Warne (Manchester Metropolitan University, member of Shaping the Future Project Team) facilitated the three student groups.

Group Activity 1: Tutor/service delegate Group

You are asked to develop a programme for a group of students from different health and social care backgrounds to enable them to experience 'working in the community'.

Key issues

- What do you consider would make a good learning environment for community based learning?
- How would you prepare them to work inter-professionally/inter-agency?
- What are the benefits of preparing them for working in such an environment?
- Do you feel that you are prepared for delivery of an inter-professional learning and working curriculum?

Please identify:

- 3 key factors that you would include in a curriculum to support community based inter-professional learning and working;
- 3 key factors that you consider as a group would be essential in the preparation of lecturers and mentors in practice to deliver this curriculum.

Feedback from the morning discussion

The facilitated sessions provided an opportunity for the groups (mixed professional backgrounds) to get to know each other on both a social and professional basis. There was a lively discussion in all the groups, and it was especially pleasing to see the confident and articulate way in which the students conducted themselves. They were a credit to their respective Institutions. The notes from the discussions only illustrate a fragment of what went on in each group but give an overall flavour of key issues.

In terms of what they considered would make a good learning environment it

was clear from both notes and discussion that being valued as a student and person was high on their list of

priorities. During the feedback session and open discussion it was apparent that all the students had experienced clinical placements where this was not the case but they reported that where they were valued, their learning experience had been excellent. Other positives in these particular placements were holistic patient centred care, wide variety of skills for good patient care and working together collaboratively. Student Group A illustrated their ideas of a good learning environment with a map – many of which had also been raised in discussion in the other two groups. One interesting issue was their perceptions of hierarchy, in that it existed more in the Acute Care placements than in the community – where there was more of a focus on team work and peer support.

The key factors identified that would facilitate learning in a community environment illustrated a major issue that arose in the discussions, in that there was a need to understand each others professional roles and responsibilities. For example, there was a lack of awareness of role of podiatrists and that student nurses actually pursued different branches which led to different work roles on qualifying. One student in the feedback session highlighted the problem with this as well from a patient's perspective, in that "if we don't understand each others roles, how do we expect a patient do so?" "If they come into a Health Centre and are faced with lots of different professions looking after them how do they know who does what in their care?"

Many of the students would have liked to follow the 'patient journey' in order to understand all their care not just the part that their professional group played. The centrality of the patient within their learning experience was evident throughout their discussions and feedback. For example, taking account of the patient's life story and the way in which they managed their illnesses i.e. 'Learning from the patient' and seeing 'the patent as a person'.

As can be seen from the discussions the same themes appeared across the three groups, giving some indication that, even if we had had larger numbers of

students present, there were clear indicators of sameness in relation to their clinical experience and what they considered important to them. An innovative idea from a student in Group B was that of 'peer mentoring', i.e. mentoring by other students in clinical placements, and they also felt that being supervised by someone from a different profession was a good learning experience. In terms of what would help them decide if they wanted to work in a community setting once qualified it was apparent that their student experience would determine this if it was a positive one, together with issues such as working flexible hours.

The tutor/service group interestingly picked up on similar issues re learning environment in the community in relation to multi-professional opportunities, but also the need for mentors not just for the students but also the practitioners. In terms of a good learning environment the issue of being a supportive one was noted plus ensuring availability of resources for learning.

They concluded that the benefits of working inter-professionally/inter-agency were numerous none more so than the benefits to the patients and increased understanding of roles which was a major theme with the students.

Lunch provided an opportunity for further lively discussion and their commitment to the day was evident in that everyone returned for the afternoon session!

Afternoon Session

Group Activity 2: Integrated health and social care

You are a group of students undertaking a clinical placement within a large Health centre in an inner city area. As part of major re-organisation there is a plan to set up within this Centre a new integrated health and social care service for rehabilitation of older people who have experienced a stroke. There is also a plan to integrate the service with the Acute Hospitals Trust through the development of an integrated care pathway for this illness.

You are invited as a group to identify the following:

■ Who would you envisage would be the team in this new service?

■ What skills, knowledge and attitudes would the team need to deliver this new service?

■ How would you ensure that the team worked together?

■ How would you determine whether this new service was a success of not?

With your facilitator identify:

■ 3 key points in each of the above sections;

■ 3 key issues that you would expect to see in your curriculum that would enable you to both learn and work in such an integrated health and social care service.

For the tutor/service group:

Consider the student activity and determine your own responses to the same scenario (from the perspective of preparing practitioners to work in this environment).

The students facilitated their own groups for this session. They were all very confident with this approach and given that most of them had not met before this event it was pleasing to see their collaborative working. There were very lively discussions in all the groups and their conclusions reflected the very focused approach they had all taken to the scenario they had been given. In relation to the team required it was evident that on the whole the students considered roles already known to them in relation to delivery of care. However, as they begun to look at the 'patient journey' approach they began to realise that not all the roles were possibly in place to meet patient needs. For example, one group identified the need for a 'Needs Assessor', and linked this to an assessment tool used in nursing, based on a Daily living model of care. It was evident that they saw the need also for input from agencies other than the caring ones, for example, transport, benefits and housing. The importance of being able to educate patients, taking account of their environment and social circumstances were considered important skills and knowledge in

delivering an integrated health and social care service. The term 'patient centred care' encapsulates the underlying theme throughout the day.

As in the morning discussion the issue of appreciation of everyone's role in the care of the patient was noted.

Once group identified six key skills that were essential to the team – including communication and basic care. Regard for other health care colleagues was again noted as an attitude to be held in relation to working in the team. Innovative answers were provided for ensuring that the team worked together, including the need for effective leadership of the team and a removal of any hierarchy.

They acknowledged the importance of evaluation using different means in their determination of whether this new service was a success or not. The tutor/service group noted a number of issues for inclusion in a curriculum that would enable students to learn and work in an integrated health and social care service, many of which linked to the student groups conclusions. Cross training and better knowledge of professions and practice were noted.

Following the feedback from the afternoon discussions the delegates were asked to highlight what they had gained from the day and what they considered could be improved upon.

The key positive issues:

- They have learnt something about other professions;
- The variety of different students that attended was very good;
- The small group work was stimulating;
- The event was not led by lecturers;
- The quality of discussion was very good.

Noted for future (from the students):

- Perhaps mixing up the student attendees with qualified staff in similar professions as both parties could benefit more in this situation by sharing experiences;

- Mixing students with practitioners in a similar student–led event may be useful.

Conclusions

The event far exceeded our expectations in relation to the participation by students in all the activities. It was clear, even with a small representative of professional groups that they had similar experiences in clinical practice within a community setting and that they were agreed on a number of issues that needed to be addressed within both practice and within their curriculum to enhance their learning experience. Being valued as students and individuals was a major theme throughout the day, as was the need for a better working understanding of other professions/agencies roles and responsibilities in the care of patients. This was not only from a theoretical viewpoint but a practical one, as many of the students identified the value of working alongside other professions/health and social care workers within the practice setting. Although the focus of the day was Primary Care experience, the students raised the same issues in relation to working within the Acute Care sector. When asked if they would choose to work in Primary Care/Community when qualified, a number of them said they would consider it and two or three had already made a commitment to this aim. Some of them, however, indicated that the service did not make it easy for employment on qualifying, with some of the nursing students indicating they had been told to gain experience in a hospital before looking for work in a health care centre. The medical students were also aware of the changes taking place in their post–qualifying rotation, whereby a community placement was to become compulsory.

They were unsure of how this would impact on doctors choosing to then work as General Practitioners.

From a Higher Education point of view the day held lessons for how we prepare health and social care students to learn in practice as students and also for their future work. Currently there is a drive for inter-professional learning within the HE classroom. However, based on this event it would appear that it requires more than 'learning in the same classroom' to

ensure that they learn to work inter-professionally. They also need to be experiencing inter-professional/ inter-agency working within their clinical placements and also be able to have the skills to work collaboratively within teams and the attitude of valuing others in those teams for the contribution they make to patient care. This has implications, not only for how the students are prepared for this but also the lecturers/clinical tutors and others who have to facilitate inter-professional working and learning experiences.

Recommendations from the day

- To host another joint event with qualified practitioners from health and social care professions – along similar lines but the perspective of education and training of students in clinical practice to deliver integrated health and social care;

- To host small workshops with health and social care students to explore in more detail some of the issues arising from this event;

- To continue to work collaboratively on issues related to education and training issues in a community setting – University of Manchester, School of Primary Care and the Shaping the Future Project, including a collaborative paper on inter-professional working and learning.

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15th March 2004

Biographies of Project Team

Work Package 1: Karen Holland
Biography: Karen Holland

Karen Holland is a Professorial Fellow in the School of Nursing and Institute of Health and Social Care at the University of Salford.

Karen has extensive experience in both nursing practice and nursing education and her main area of expertise has been in curriculum development and research. She has a specific interest in practice development and inter-professional working and has undertaken activities in a number of NHS Trusts which focuses on these areas.

She is a subject advisor (nursing) with the Learning and Teaching Support Network (LTSN) Health Sciences and Practice Centre, King's College, London and actively promotes the linking of teaching and research both internally within the University of Salford and through her activities with the LTSN.

She is editor of an international nurse education journal Nurse Education in Practice and is a member of the editorial board of Work Based Learning in Primary Care. She has also co-authored and edited two books: Cultural Issues in Nursing and Health Care & Application of the Roper Logan & Tierney Model of Nursing in Practice.

Work Package 2: Michelle Howarth & Maria J Grant
Biography: Michelle Howarth RGN, MSc, PGCE (Dist) & Lecturer

Karen Holland is a Professorial Fellow in the School of Nursing and Institute of Health and Social Care at the University of Salford.

Karen has extensive experience in both nursing practice and nursing education and her main area of expertise has been in curriculum development and research. She has a specific interest in practice development and inter-professional working and has undertaken activities in a number of NHS Trusts which focuses on these areas.

She is a subject advisor (nursing) with the Learning and Teaching Support Network (LTSN) Health Sciences and Practice Centre, King's College, London and actively promotes the linking of teaching and research both internally within the University of Salford and through her activities with the LTSN.

She is editor of an international nurse education journal Nurse Education in Practice and is a member of the editorial board of Work Based Learning in Primary Care. She has also co-authored and edited two books: Cultural Issues in Nursing and Health Care & Application of the Roper Logan & Tierney Model of Nursing in Practice.

Biography: Maria J Grant

Maria is a Research Fellow (Information) at the Salford Centre for Nursing, Midwifery and Collaborative Research (SCMNCR), University of Salford. She has a background in information science and has contributed to a range of health and social care systematic reviews. These activities have included both finding and appraising the research evidence.

Maria has an extensive background in information service provision, having previously worked at the Centre for Health Information Quality (providing a national information service to self help groups and the NHS on producing high quality evidence based consumer information) and the UK Clearing House on Health Outcomes.

Her research interests include enhancing practice through the investigation of optimal database searching – particularly in relation to qualitative research evidence – and investigating the effectiveness of literature searching training provision.

Maria is Chair of IFM Healthcare, a charitable organisation committed to improving the provision of information in enhancing healthcare management and delivery. She is also Chair of the 2003/4 Research in the Workplace Award, an initiative seeking to contribute to the development of the library and information community evidence base.

Work Package 3: Helena Lunt
Biography: Helena M Lunt

Helena Lunt is a Senior Lecturer in Public Health and Primary Care at the Centre for Public Health, Liverpool John Moore's University. Her Public Health career has been underpinned by many years extensive experience in Primary Care. Before deciding to return to full-time study on the Masters in Public Health at Liverpool University, Helena was employed in clinical and managerial positions within General Practice, the Health Authorities and the Primary Care Trusts.

In 2004 she was appointed Senior Lecturer at JMU, and more recently, was given the opportunity to develop her research portfolio by working for Prof John Ashton, Regional Director of Public Health.

Work Package 4: Nick Hardiker
Biography: Nicholas Hardiker

Nicholas Hardiker is a Senior Research Fellow within the University of Salford's Centre for Nursing, Midwifery and Collaborative Research. He has been a registered nurse since 1987 and completed in 2002 a 'Return to nursing practice' course at the University of Manchester. He has been employed in Higher Education since 1993 with a research focus on health informatics.

Shortly after graduating with a BSc (Hons) in Computing (he also holds a Masters degree and a Doctorate in Computer Science) he received the 1993 British Computer Society Nursing Specialist Group Dame Phyllis Friend Award. In 2001, he received the American Medical Informatics Association Nursing Informatics Working Group Award.

His current research interests include: health and nursing informatics, representing health care knowledge, facilitating the integration of research evidence into clinical practice, supporting clinical research through informatics, supporting the user-terminology system/knowledge source dialogue and mediating between heterogeneous health care terminology systems. He has published and presented widely on these and other topics.

In addition to undertaking diverse research projects, he runs postgraduate modules for several institutions including the University of Colorado (on-line), Trinity College, Dublin and the University of Wales, Swansea. He is a former member of the ICNP® Strategic Advisory Group at the International Council of Nurses, a member of the Steering Committee of the US Nursing Terminology Summit and a member of standards bodies at national, European and international levels.

Work Package 5: Tony Warne
Biography: Dr Tony Warne

Dr Warne has worked as both a clinical practitioner and latterly as a manager responsible for a wide range of specialist mental health services, before moving to Manchester Metropolitan University, Department of Health Care Studies, in 1995. He is currently the Principal Lecturer for the Division of Continuing Professional Development and Postgraduate Studies.

His professional background is in mental health nursing. The focus for his research interests is inter-personal relationships. This has involved a long term working partnership that seeks to explore the impact of such relationships on nursing practice, policy, organisation and education using psychodynamic and managerialist analytical discourses. He gained his PhD in 1999, which looked at intra and inter-professional, organisational and economic relationships within the GP Fundholding system.

He has undertaken several large research projects, including a national study looking at mental health nurses preparation for multi-professional, multi-agency team working; workforce planning for nursing staff working in primary care; and a number of local evaluations for organisations within the North West. He has published widely in this area. He has also recently published a book on using patient experience in nurse education.

He is a visiting lecturer to universities in Finland and Kenya. He is a Magistrate with a special interest in the mentally disordered offender and was formerly a nurse reviewer for the Commission for Health Improvement.

Work Package 6: Paul Reid
Biography: Paul Reid

Paul has worked have worked at the University of Central Lancashire for seven years. He is a Senior Lecturer in the Lancashire School of Health and Postgraduate Medicine and Course Leader for our BA/BSc (Hons) Public Health. His areas of teaching are: substance misuse, health psychology, health communication and mental health.

Much of his research activity has focused on aspects of substance misuse. For example: the health and service implications of polydrug misuse; peer intervention concerning harm reduction and amphetamine misuse; and the evaluation of drug prevention strategies which target Black and minority ethnic groups.

He also has a strong research interest in homelessness, having carried out research into self medication and substance misuse amongst homeless young people, and having completed a PhD focusing on homeless young people's ways of coping with harassment. His research career has mainly focused upon the ways in which the perspectives of current and potential service users can be used to enhance service provision.

Prior to coming to the University of Central Lancashire he worked for several years as a Research Fellow at Manchester Metropolitan University, and prior to that as a Residential Social Worker with Mencap and other non-statutory organizations providing services to people with learning disabilities.

Work Package 6: Geraldine Nicholson
Biography: Geraldine Nicholson

Geraldine has been a researcher in the Lancashire School of Health & Postgraduate Medicine at the University of Central Lancashire in Preston for approximately eight years working on various projects.

She has recently had the opportunity of working within the NHS as Research Governance Coordinator for East Lancashire Teaching PCT.

She has a Masters degree in Medical Ethics and Law, and has a wide range of interests and experience of working in an unpaid capacity with vulnerable members of society including youth groups, people with learning difficulties and people from differing ethnic backgrounds. This work has incorporated fundraising activities, organising and encouraging outdoor pursuits activities and teaching and advocate.

Work Package 7: Rob Nettleton
Biography: Robert Nettleton

Robert Nettleton led this work package from The University of Bolton where he is Director of Health and Social Care Programmes. His professional background is in health visiting and community nursing practice and education. He has experience of integrated working in child protection services, integrated nursing teams in primary care and the development of the skills escalator across boundaries between health and social care through Greater Manchester Workforce Development Confederation's 'Delivering the Workforce' Project.

Work Package 8: Valerie Stead
Biography: Dr Valerie Stead

Valerie Stead is an Honorary Fellow of the Department of Management Learning in the Management School at Lancaster University and a Fellow of the Chartered Institute for Personnel and Development.

Valerie's background includes management and development in the voluntary, health and public sectors. Valerie's experience within Lancaster University has included a particular focus on qualitative evaluation research and action research, and the design and development of new initiatives and accredited programmes.

Her current research interests include the evaluation of learning programmes, mentoring as management development and the experiences of women leaders. Valerie also teaches on the Lancaster MA in Human Resource Development and Consulting, and is co-director on The Health Foundation Leaders for Change programme based at Lancaster University.

Acknowledgements

We wish to thank everyone who has contributed to the success of this project and its achievements. In particular all those who cannot be named due to their involvement in the research elements, the students involved in the inter-professional workshops we held and all those who attended the briefing days. We particularly wish to thank the following organisations:

The North West Development Agency

The North West Universities Association

Greater Manchester Strategic Health Authority

Cheshire and Merseyside Strategic Health Authority

Cumbria and Lancashire Strategic Health Authority

Knowsley Primary Care Trust and Social Services

Salford Primary Care Trust

Bebington and West Wirral Primary Care Trust