www.pcet.org.uk

Cumbria

Lancashire

Gtr Manchester

Merseyside

Cheshire

LANCASTER UNIVERSITY

UNIVERSITY OF CENTRAL LANCASHIRE

THE UNIVERSITY OF Bolton

University of Salford
A Greater Manchester University

Manchester Metropolitan University

JMU

CHESTER

Primary Care Education & Training Project

Shaping the Future for Primary Care Education & Training Project

Finding the evidence for Education & Training to deliver Integrated Health and Social Care:

The Primary Care Workforce Perspective

VISIONS FOR THE FUTURE

Authors: Tony Warne
            Martin King
            Clare Street
            Cath McAlonan

Institution: Manchester Metropolitan University

Vol: 5
2006

Contents

Executive Summary

Introduction

This report is one of a series of outputs from the Shaping the Future in Primary Care Education and Training project (www.pcet.org.uk) funded by the North West Development Agency (NWDA). It is the result of a collaborative initiative between the NWDA, the North West Universities Association and seven Higher Education Institutions in the North West of England. The report presents an evidence base drawn from the analysis of the experiences and aspirations of integrated health and social care, as reported by members of the current primary health and social care workforce working in or with Primary Care Trusts (PCTs) in the North West region.

Methodology

A multi methods approach was used in the research design. This included the use of a survey questionnaire, semi-structured interviews, participant and non-participant observations and a series of workshop case studies. Data were collected largely from participants working at three different levels of organisational, managerial and professional responsibility within PCTs. A conceptual framework was used to explore where participants located themselves on a continuum of fragmentation or integration. A total of 333 participants were involved. In the main these participants worked in or with 18 PCTs. Data were analysed using a thematic approach, developed through a systematic review of the literature, triangulated with a critical rhetorical analysis developed as part of the work of this study.

Findings

No one vision of what primary integrated health and social care services might involve, or how this might be achieved emerged. The evidence base revealed a series of rhetorical justifications representing the gap between espoused theory and theory in use. However, the report notes that primary health and social care services have experienced a period of rapid and often unpredictable change. These changes have resulted in turbulence within the PCTs, and this turbulence appears set to continue as the future role of PCTs is further developed through a movement away from being providers of services to becoming commissioners of services. The turbulent nature of the emergent primary health and social care services that provided the focus for this study has resulted in disjunctions and tensions in and between managerial, educational, political and professional discourses, theories and practices. The rhetoric's were often used as 'smoothing' mechanisms by participants. These smoothing mechanisms belied what for many participants was a very chaotic and messy reality, and not only was an important but utopian vision created, but further gaps between policy, organisational education and professional practice emerged. The evidence base reflects what were often fragmented and contradictory beliefs and perceptions expressed by participants in their accounts of their experiences of integrated health and social care.

The findings 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 makes up this workforce, and of the turbulent nature of the context. A number of educational and organisational development implications arising from this evidence base are noted.

Recommendations

The following should be read as a related constellation of changes, rather than as single and specific items that might be separately implemented 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.

For Improving Team Working

PCTs, future service providers and educationalists should:

- Ensure that all educational and training learning objectives/outcomes reflect national competency frameworks standards;

- Develop change management knowledge and skills at all levels of the workforce, and ensure service users and carers are partners in these processes;

- Undertake organisational culture analysis aimed at promoting a culture which supports greater involvement of the wider workforce in decision-making processes;

- Provide structured and regular 'timeout' sessions aimed at harnessing organisational learning;

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

- Develop systematic organisational evaluative strategies that are capable of evidencing improved team working.

For Improving Communication

PCTs, future service providers and educationalists should:

■ 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;

■ Provide multi-professional and inter-disciplinary Continuing Professional Development activities that aim to enable professionals to better learn to listen to each other in order to better assess what is acted upon or given credence to;

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

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

■ Develop engagement processes that support greater organisational innovation and confidence in how IT systems are used;

■ Develop multi-professional and inter-disciplinary CPD activities aimed at enhancing understanding of how, what and why information might be communicated across all levels of the workforce.

For Improving Role Awareness

PCTs, future service providers and educationalists should:

■ Ensure that all pre-qualifying educational programmes, Continuing Professional Development programmes and activities more effectively promote role awareness and inter-professional working,

■ Ensure there is a explicit requirement to demonstrate the involvement of service users in educational and training activities in commissioning agreements;

■ With service users and carers, develop communication processes aimed at ensuring service users and carers better understand the different roles and responsibilities of the workforce;

■ Ensure that where possible, all Continuing Professional Development programmes aimed at increasing inter-professional working are planned, delivered and evaluated as joint enterprises (with health and social care, HEIs, and service users);

■ More effectively involve HEIs in providing empirical approaches to support service developments;

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

For Improving Personal and Professional Development

PCTs, future service providers and educationalists should:

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

■ Regularly evaluate the impact and use of new workers on the roles and functions of the existing workforce;

■ Increase the awareness within PCTs and future service providers of the scholarship role universities can have in supporting individual practitioners and PCTs;

■ Ensure the development and delivery of both educational and training programmes more effectively reflect practice needs as

well as those arising from academic interests;

■ Increase the opportunities to work together in developing more effective learning environments capable of supporting flexible learning within PCTs and future service providers;

■ Agree a joint framework agreement for Continuing Professional Development that supports in-house Continuing Professional Development activities being credit rated;

■ Work towards the creation and deployment of new joint academic/practitioner roles at all levels of practice;

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

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

■ 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'.

For Improving Practice Development and Leadership

PCTs, future service providers and educationalists should:

■ Develop multi-professional and inter-disciplinary Continuing Professional Development activities that are aimed at strengthening the leadership capacity across all levels of the health and social care workforce;

■ Ensure that practice development

activities are facilitated by leaders skilled in cultural change processes and that these activities are systematically evaluated

■ Ensure protected time is identified specifically for multi-agency practice development Continuing Professional Development activities;

■ Ensure that PCTs, future service providers, educational commissioners and providers work collaboratively in developing new Continuing Professional Development programmes which reflect the changing nature of health and social care practice and the changing environments where such practice is undertaken;

■ Continue to work collaboratively in ensuring national quality assurance processes for educational providers inform the development, delivery and evaluation of educational and training programmes;

■ Improve the opportunities for greater service user and carer involvement in educational and training programmes in order to increase awareness and responses to drivers for practice development.

For Improving Partnership Working

PCTs, future service providers and educationalists should:

■ 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;

■ Develop specific roles to facilitate inter-agency partnership working at the Micro and Meso levels of the workforce;

■ Ensure multi-professional and inter-disciplinary CPD activities are developed that are aimed at increasing the understanding of organisational roles and responsibilities;

■ Develop curricula that explicitly provide learning opportunities for partnership working;

■ Ensure that future education and training competency standards include core requirements for partnership working.

Chapter 1:
The Project Context

1.1 Introduction

Collaboration and partnership working between Higher Education and the NHS is an essential requirement for effective delivery of care (Universities UK 2003). 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 (StF)* is a collaborative partnership between both these organisations and seven North West Higher Education Institutions. In addition, the project brings together for the first time all the 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 North West Region.

These include:

■ The North West Development Agency who are funding the project as part of their key target areas;

■ The North West Universities Association;

■ Three North West Strategic Health Authorities;

■ Primary Care Trusts;

■ Social Services;

■ Higher Education Institutions and Further Education Colleges.

The StF project has a project management and development team and a participative Steering Group whose role included developing closer regional partnership intended to create real synergies at a regional level. For ease of implementation the project has been divided into a series of *Work Packages*, based on the key objectives, each led by one of the partner Higher Education Institutions.

These *Work Packages* were developed to ensure that discrete pieces of the overall work of the project were undertaken and managed by the individual universities making up the research project team. Aims and objectives were agreed for each *Work Package*, and these were mapped against the wider aims and objectives of the overall StF project. This has helped ensure greater coherence and congruence of all the various aspects of the work, an outcome in itself, demonstrative of integrated working. Throughout this report, note is made of where the work of '*Work Package Five*' connects with the outcomes of the other *Work Packages*.

1.2 Aim and objectives

The main aim of the project is 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 Workforce.

The key objectives of the project are:

i. To provide a comprehensive systematic review of the evidence base for integrated health and social care services within the regional, contexts;

ii. To develop a Benchmarking Tool for achieving best practice in collaborative working and delivery of integrated health and social care;

iii. To develop a course finder tool and map the Higher Education/Further Education provision of education and training which can support the integrated health and social care services;

iv. To identify visions for the future, for both the health and social care workforce and service users, on education and training requirements needed to deliver integrated services;

v. To develop and pilot an Education and Training Needs Analysis Model (ETNA) for identifying the education and training needs of the primary care workforce to meet the NHS and social care agendas.

Ensuring that the health and social care workforce is educated and trained to meet changing community needs is essential for current and future delivery of services. This project is an opportunity for a number of key stakeholders in health, social care and education to collaborate in a new and unique way to address this, both directly through the project outcomes and indirectly through creating communities of learning across the North West Region.

Chapter 2:
The Primary Care Workforce Context

2.1 Introduction

Much of the international health care community has been involved in a sustained reform of its health care systems over the last two decades (Warne, 1999). In the United Kingdom (UK), the National Health Service (NHS) has undergone continuous structural changes in its organisation and orientation which have built upon those previously set in motion by the former Conservative administration during the early 1990s and are congruent with similar changes at an international level (Warne, 1999). These changes have reflected a paradigmatic shift in service focus and delivery away from the secondary care sector towards a primary and community care led NHS (Department of Health, 1997). The outcomes of this policy shift can be seen in the structural and functional changes to the organisation of primary and community health care providers. Current policy guidance locates primary care at the frontiers of health care modernisation (Department of Health, 1997; 1998; 2000a, 2005). New organisational structures have brought General Practitioner (GP) practices together as Primary Care Trusts (PCTs) and these new organisational forms now respond to a much larger population group than the more traditional GP practice. PCTs are increasingly the driving force for change across the NHS, with much of the responsibility for commissioning and providing health care shifting to PCTs. These shifts in responsibilities appear set to continue, with future PCTs moving from positions of commissioners and providers of care, to commissioners only by 2008 (Department of Health, 2005).

The changes to primary health care organisations have been accompanied by a need to explore new ways of working and thinking (Department of Health, 1997; 1998; 2000a) and establishing a shared understanding of the national and local strategic policy objectives (Warne, 1999). Greater collaboration and partnership working in the delivery of services, adoption of a lead role in the commissioning of services and the renaissance of a public health discourse underpinning service developments has emerged from these changes.

The first wave of the more autonomous Primary Care Trusts in 2000 required significant changes to the way each of these organisational entities were developed and managed that reflected an emergent discourse from two polarised paradigms: public service values and the dynamism of external management experience (Robinson and Exworthy, 2000). One consequence of responding to the challenges posed by these changes has been a very turbulent professional, organisational and practice environment. This turbulence, for the workforce is likely to continue as the changes to the professional, organisational and practice environment outlined *Creating a Patient-led NHS* (Department of Health, 2005) begin to be implemented (Ham, 2005)

Contributing to this turbulence has been the lack of clarity over how primary care, as a conceptual term, is defined (Howarth *et al* 2004). For example, Summerton (1999:64) describes primary care as a concept:

"*that can be viewed variously as a set of activities, a process, a level of care or even a strategy for organising the health care system as a whole*".

One interpretation of this description that is most frequently and familiarly used in describing the functional divisions of health care provision is primary, secondary and tertiary care. Conversely, the more specific term, primary health care, aids precision in defining how the concept is used in policy and practice. This is a much broader interpretation of the concept that encompasses primary medical services (largely provided by General Practitioners (GP) with other community health care services organised and provided by community nursing services, allied healthcare professions, and so on. In policy terms, this concept has also been extended to recognise the integrated contribution of those providing primary social care services. A new conceptual term has begun to emerge in policy guidance and critiques – this term, out-of-hospital health services – more closely links the integrated nature of health and social care services, and perhaps also reflects a paradigm shift in the locus of organisational and professional power.

It is this latter and broader interpretation that provided the conceptual boundaries for the study. The wider debate as to which professional groups in the primary care workforce could or should be included was reflected in the early discussions of the *Work Package Five* Project Team (see also Chapter Three: Methodology). The team's adoption of the broader concept of primary health allowed for a pragmatic definition to be developed as to whom the current workforce might consist of. As a starting point we determined this group should reflect all those directly employed by or working with a PCT, and this group were likely to include a wide variety of different individual professions, both within PCTs and across PCTs. This group are those that are now seen as providing out-of-hospital health services in a ways that more fully reflect multi-agency approaches to health and social care.

2.2 Defining the Workforce

The following provides a summative overview of key policy documents that reflect the shifts and challenges facing the health sector workforce in the 21st century. Back in 1994, the UK Department of Health published a predictive report (now commonly referred to as the *Heathrow Debate*), which sought to examine the wider economic, professional and organisational challenges facing the nursing workforce as it entered the new millennium. This report provided a vision of a future that has largely come to fruition as the StF study was being undertaken in 2005. This early attempt at identifying the driving forces for change amongst nurses (the largest group of health care workers) was further developed in the *Healthcare Futures 2010* report (Warner *et al*, 1998). This latter report clearly identified a range of future scenarios for healthcare in the year 2010, which, although focused on the educational processes for nursing, resonated with issues facing the wider health and social care workforce. Whilst this report is not examined in detail here, the breadth of focus included[1]:

■ *Economic and political context;*

■ *Demand factors for health care (demographic and epidemiological trends);*

■ *The supply factors (workforce flexibility, boundary blurring, recruitment and retention issues and the informal care dimension);*

■ *Technology (information technology, health care technology, genetics and health service configurations).*

Proving to be accurate in its predictions the various uncertainties explored remain as unresolved now as they were then. Although not taken for granted, the key issues outlined in the conclusion section of this report, provide an implicit contribution to the wider backdrop to the focus, work and outcomes of this report. These key issues include:

■ *There will be more older people as a percentage of the overall population;*

■ *It is likely there will be more diseases of old age;*

■ *Increasing levels of disability from mental illness;*

■ *New genetic approaches;*

■ *Increasing requirements for evidence-based practice;*

■ *More care provided outside of the acute secondary sector;*

■ *New forms of information transfer;*

■ *Changing professional roles (within and between professions);*

■ *Changing workforce expectations.*

Although published after the *Heathrow Debate*, the genesis of these key issues are perhaps better articulated in the outcomes of the more generic report *The Future Healthcare Workforce* published in 1996 by the Health Services Management Unit (HSMU) (see also 2.4 below). Many of these key issues still feature prominently in current health and social care policy within the UK and need to be considered alongside what is known about the healthcare workforce sector.

The Sector Skills Council for Health Work produced a Health Sector Workforce Market Assessment in 2003 – *Skills for Health*. Drawing on data from a wide range of sources this assessment provides both a macro overview of the sector as well as data on specific areas and groups within this sector. The key characteristics of the health sector as summarised by *Skills for Health* (2003:3-4)[2] included:

■ *It is a large and complex sector with a wide range of both employers and occupations. The size is reflected in the spending on health care – spending on health care is over £50 billion a year – (set to rise to £76 billion by 2005/06), investment in health care insurance and independent provision is estimated to be about £8 billion a year and there is a large, if uncosted, spend through voluntary organisations and carers;*

■ *There is steady growth in the workforce (c. 1% per annum) which is set to continue, but there is substantial change in the mix of skills employed at the point of delivery;*

■ *The sector has a predominantly female workforce;*

■ *There is a large number of part-time workers with the numbers (headcount) of the workforce 19% higher than the WTE. Part-time opportunities are steadily increasing;*

■ *Age structure: The majority of the workforce is concentrated between 25-54 years;*

■ *Ethnic mix: over 10% of the English NHS Hospital and Community Health Service non-medical workforce is from ethnic minority groups. Proportions of ethnic minority staff in the other countries are lower – around 5% in Wales and less in Scotland.*

---

[1] Authors Note: It is suggested to readers of this report that the Health Care Futures 2010 report be revisited in order to gain a sense of the detail underpinning these key challenges. Some of these challenges are highlighted in the data analysis and discussion chapters of this Work Package Five Report.

[2] The full report, which presents the data and analysis can be found at http:www.skillsforhealth.org.uk

Ethnic minorities represent a much higher proportion of medical and dental staff and pharmacists, for example Asian staff account for over 8% of the total medical and dental workforce in England and 21% of pharmacists in the retail sector are of ethnic minority origin;

■ *Supply problems: The sector is experiencing major supply problems [in certain groups of the workforce] and is implementing strategies to ensure the supply better matches demand;*

■ *Professional roles: The data in this section is presented in terms of conventional professional and other descriptions. This is the only form in which data is available. However, there is a rapid trend towards blurring and change to traditional role boundaries in many parts of the sector and traditional descriptions increasingly do not reflect the reality of what people do.*

The health sector in the UK currently employs over 2 million people across a wide range of different occupations. Over 75% of these people work within the NHS. The workforce is conventionally divided into four broad categories:

42% clinical practitioners and scientists;

37% work in clinical and technical support;

19% in management and administration;

3% in estates and maintenance functions.

Superimposed upon these categories is a further demarcation resulting from those who possess a professional qualification to practice and the support workforce. Although it is difficult to discover what the

percentages of each might be, it has been estimated that support staff might account for up to 40% of the 'generic carer' workforce (HSMU, 1996). Many of these 'generic carer' roles are those most often referred to as support workers, that is, unqualified health care workers). During the 1990s the split appeared to be weighted in favour of qualified staff, but since this time there has been a sustained movement towards a higher number of support staff within the workforce as a whole.

These categories reflect the NHS as a whole, and they are also reflected in the microcosm of primary health care services. Typically the primary health care team is made up of a wide range of professional groups including Medicine (including for example, GPs with a specialist interest), Nurses, (including for example, District Nurses, Health Visitors, Community Psychiatric Nurses, and General Practice Nurses), Midwives, and other Allied Health Professionals, (including for example, Podiatrists, Occupational Therapists, Audiologists). These groups often work in very close partnerships with Dental and Pharmacist services.

Currently all these different professions have their own professional training and registration programmes despite the degree of similarity in many of the requirements of the various professions (Warner *et al*, 1998). There are some indications that more multi-professional training programmes are beginning to emerge in the UK, but these tend to be few and far between and are generally aimed at the very early stages of basic professional training. Howarth *et al* (2004) provide a detailed analysis of how such polarised approaches inhibit team working, collaboration and promote a lack of role awareness and poor communication within and

across teams and agencies. Thus, while concepts such as 'collaboration', 'partnership working' and 'integration' pervade the policy rhetoric, these are often not embedded into the organisational, professional and practice translations of these policy drivers. This lack of conceptual embeddedness in itself reflects an interrelated conceptual paradox: of unintended histories and idealised futures. Although it cannot be said that there has previously been no collaboration and partnership working or that collaboration and partnership in themselves are a panacea for all the problems facing the provision of health and social care services. Collaboration, partnership working and the development of integrated approaches to health and social care have been generally seen as the most viable way of delivering quality health and social care now expected by health and social care commissioners, providers and consumers (Hutchings *et al* 2003).

The importance of a multi-professional approach to health and social care, predicated upon the concept that those professionals who provide care for individuals work together not just as professional collectives, but inter-professionally in providing seamless services, features in much of the recent literature in this area (Howarth *et al*, 2004). Likewise, recent guidance on the education and training of these professionals has been marked by a move to more shared learning between health and social care professions (Department of Health, 2002). There is an implied assumption in much of this guidance: that those who learn together might work together more effectively in practice. However, many authors (Leathard, 1994; Lacey, 1998; Zwarenstein *et al*, 1999) have noted, there is little research evidence to support this view. More recently,

Warne and Stark (2003) noted that even within the so called *Family of Family Practitioners*, the professional socialisation of individual professions that arises out of uni-professional training continues to influence the working relationships in the practice environment still characterised by effective if somewhat benign demarcations of power. These power demarcations can be pervasive and in some contexts, are actively engaged with by patients and carers as well as health and social care professionals (Warne and Stark, 2004; Warne and McAndrew, 2004a).

So whilst there have been many structural and functional changes to the current health and social care environments, the traditional workforce has often been slow in responding to these changes in a way that reflects what the wider drivers for change entail for a future health and social care workforce.

2.3 Drivers for change in the workforce

Implicit in these structural and functional changes to the organisation and delivery of health and social care is a reduction in the number of different health and social care professionals in contact with individuals at any one time. This has implications for the size and make up of the future health and social care workforce. Perhaps the most significant of these implications is the need for the future workforce to have an improved working knowledge of other team members' roles and function, a theme that came out strongly in the Howarth's *et al* (2004) systematic review of the literature. This will become a crucial aspect of integrated health and social care working as individual members of the future workforce start to be employed by other non-traditional

health or social care organisations (Department of Health, 2005).

There are a number of social, demographic, organisational and professional drivers that have and continue to exert pressure in shaping the future health and social care workforce. These include:

■ The rise of evidence based approaches to care at both a national level (through the work of the National Institute for Clinical Effectiveness (NICE), and the production and implementation of National Service Frameworks (NSF), and at a local level, through the development of clinical protocols and care pathways. The use of these approaches requires effective co-ordination between health and social care professionals and effective communication processes;

■ The rise of health and social care consumerism supported through initiatives such as Clinical Governance, the Expert Patient Programmes, Patient and Public Involvement. These approaches serve to raise the awareness and expectations of quality improvements, but can also help in challenging the relationship between the individual and health and social care professionals. Such challenges are beginning to emerge not only in the delivery and provision of services but in how many professionals are prepared for practice (Harrison and Pollit, 1994; Warne and McAndrew, 2004b; 2005a);

■ The need to address recruitment and retention issues in the health and social care workforce has led to many initiatives aimed at developing the current professions and their roles in the workforce by for example, in the

implementation of the Knowledge and Skills Framework (KSF) (Department of Health, 2003). Concurrent initiatives have been aimed at widening the entry to health and social care professions through the creation of new workers (for example the Assistant Practitioner, and the Graduate Primary Mental Health Care Worker, Nurse Consultants). These initiatives have introduced the concept of the multi-skilled generic health and social care worker and have resulted in the substitution of some traditional professional groups for others (HSMU, 1996; Warne and McAndrew 2004c);

■ The need to respond to European Union legislation and wider health and social care policy (HSMU, 1996). For example, changes resulting from the European Working Time Directive have impacted upon primary and community care services as well as the more familiar secondary care service provision. Likewise changes to public health and health protection guidance and regulations have resulted in new roles for PCTs;

■ New technologies, as a consequence of developments in information and communication technology, as well as those arising from developments in genetics are already starting to have an impact upon more traditional ways of service provision (Kumar, 2000);

■ The emergence of new health care providers, offering the possibility being able to employ and 'contract back' to the NHS those staff traditionally employed within hospitals, community services and GP practices. Such changes to familiar career

structures, once a bedrock of security, have for many public service employees (professions and non-professions) have resulted in many individuals being 'portfolio workers' living and working in so called *Shamrock organisations* (Handy; 1989, Warner *et al*, 1998). Current, Department of Health policy guidance seems set to reinforce such movements in employment practices (Department of Health, 2005).

Against a backcloth of such fundamental drivers for change the importance of continuous professional education and training, and personal development to ensure standards are maintained is brought to the fore. However, what was once seen as being straightforward has increasingly become more complicated and complex.

2.4 Training the workforce

It can be argued that every aspect of health and social care service provision ultimately depends on the knowledge and skills of individual staff. Warner *et al* (1998) noted that education and training for the workforce is a major industry in itself. The large scale of educational and training processes is matched by a corresponding complexity in the commissioning processes (Department of Health, 2002). It is likely that these commissioning processes will continue to grow in complexity as primary health and social care services continue to develop. There has been a plethora of national guidance and policy proposals including: *A Health Service of all the Talents* (Department of Health, 2000b); *Working together – Learning together* (Department of Health, 2001a), The NHS Plan (Department of Health, 2000a), that set out different proposals from those traditionally associated with the education and development

opportunities for health care staff (See also Howarth *et al* 2004 for detailed analysis). The *Funding Learning and Development of the Healthcare Workforce* report (Department of Health, 2002) explored the possible ways the NHS should use the £3 billion annual funding for learning and personal development more effectively to support the development of staff so that they had the necessary knowledge and skills required for the changing provision of health care. This report argued that properly structured funding is required in order to promote and support an environment in which learning can take place. Although published as a consultation document, the outcomes of the Department of Health project again have been reflected in recent educational and professional developments across the UK health care workforce.

What has emerged in these developments are responses to the drivers for change outlined above. These include:

■ Common core training where future health care workers commence their training with a common training programme that not only includes aspects of the more traditional curriculum but also emphasises aspects such as management and leadership, team working, and other related organisational processes;

■ The evolving Scandinavian model of generic care workers able to provide care in a broad health sectors (such as mental health, elderly care and so on);

■ Specific therapists able to provide (often brief interventions) care and who are drawn from a wider workforce of related professions, and who are able to practice after a much shorter period of training

than that provided to the more traditional health care professions;

■ Continuing professional development, linked to life long learning, and the skills escalator approach;

■ Widening access to both pre-qualification programmes and also post qualification programmes;

■ The use of new information and communication technology to underpin education and training programmes.

The delivery of educational and developmental programmes to support such changes will increasingly involve many different organisations and agencies. There is a clear need for these various stakeholders to develop more effective ways of working in partnership. It is anticipated (Department of Health, 2002) that changes to commissioning and contracting, ensuring a longer-term commitment to developing and delivering effective education and training programmes, will be achieved. However, more recent policy guidance (*Creating a Patient-Led NHS*, Department of Health, 2005) might result in this becoming a more difficult objective to achieve. In the emerging world of patient based commissioning and plurality of service providers there will be a need for partnership working to reflect a higher levels of trust between stakeholders, increased and extensive information sharing and joint problem solving. New educational entities are being created that are aimed at promoting such learning and research. The *NHS Institute for Learning, Skills and Innovation*, for example, will provide more localised support (than the Modernisation Agency) to health care organisations (Department of Health, 2005). Likewise the *National Primary Care Development Team* will continue to

promote the identification and dissemination of good practice. However, we argue that such approaches will fuel the growing demand for educationalists to provide 'quick-fix' skills based training programmes rather than longer-term educational processes. Achieving a balance between meeting the needs of the here and now and those in the longer term will be a crucial partnership task for commissioners and providers of education and training.

Additionally, part of the task facing those engaged in such organisational development, and educational and training activities will be to manage the changes in professional, and organisational culture resulting from the structural and functional changes to PCTs envisioned over the next five years. Partly this task requires a shared values base, and in the context of developing the workforce, the Department of Health (2002) set out a number of values that should underpin the use of Workforce Development Funding in supporting the delivery of high quality services. These included:

■ Transparency – Those responsible for commissioning education should be able to account fully for their use of funding;

■ Equity of treatment – The main driver should be the need to deliver particular healthcare skills. Different support mechanisms and processes for similar educational and training should be avoided;

■ Comprehensiveness – Learning and development support for the delivery of necessary skills should be available for all staff, with or without professional qualifications;

■ Responsiveness to new demands – Learning and development should

be able to support the delivery of new skills quickly as requirements change, so that developing clinical and care approaches may be readily delivered by the workforce;

■ Integration – Effective service delivery requires that staff should operate together in teams and learning together is an important precursor to working together;

■ Partnership working – The health and educational sectors, social care and the private and voluntary sectors should work together to secure the effective delivery of learning and development;

■ Flexibility – The pattern of learning and development increasingly includes the option to step on and off training programmes, with student accumulating credits. Systems of support should reflect this.

The values are to be revisited as part of the wider shift towards a patient-led NHS, but mention is made of these values here, as it is these values that should be reflected in the operational processes underpinning current and future educational and development opportunities for the PCTs workforce. Examples of how these values are translated into the experiences of individuals working in the PCTs will be sought as part of the data collection process.

2.5 Policy/Practice Shifts

The shifts in health care policy and practice over the last 10-15 years have placed primary health care centre stage for the delivery of services to meet the needs of a wider range of patients. This centre stage role is set to continue as the next phase of health and social care service modernisation is being unveiled. These policy/practice developments have occurred as this report was in its final stages of being

drafted. As a consequence, the participants involved in this project have not been able to have their views about these proposals included as part of the outcomes. However, given the focus of the study, we feel it is important that potential issues arising from this latest phase are at least noted here.

In this phase, greater emphasis is being placed upon the need to ensure greater choice is available to patients in terms of where they receive their health care, who provides this and when such care might be provided. Currently, PCTs both commission and provider services to a local population. In collaboration with local authorities, these services are aimed at meeting health and social care needs. Over the next three years, it is intended that PCTs will become fewer in number (with a anticipated cost saving of £250 million pounds) and that they will cease to be direct providers of services. The new role will be to ensure appropriate, high quality services are available to patients from a range of accredited service providers and these services are provided at a NHS rate. The *NHS* logo will become the kite mark equivalent of quality standards being assured. It is not clear who will provide services in the future, although it is anticipated that for example, local authorities might want to employ District Nurses, nurse entrepreneurs will set up nurse led provider organisations, and that emergent new forms of service delivery (such as Independent Treatment Centres, Foundation Trusts and so on) will also want to be involved in providing community based services.

It is possible to view these latest changes to the role of PCTs as being reminiscent of the previous age of District Health Authorities and GP

Fund-holders. The rhetoric of much of the current policy guidance is short on detail and risks being viewed by many managers and practitioners as being disingenuous at best and at least, a process akin to 're-inventing the wheel'. For example, the economic objectives of saving £250 million in management savings through the merger of PCTs appears obscured by the clamour of governmental justifications of the need to promote even greater choice for patients. Likewise, if PCTs are not providing services in the future, they will not need to employ many of the clinical workforce currently on their payrolls. It is possible to envision a future that 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 will be (CPD, registration, personal and professional development), the creation of a new primary health and social care worker would appear to be 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.

Finally, 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. For example,

General Practice Nurses only really secured a future when they gained specialist practitioner recognition, but more importantly, when GPs stopped employing them directly. Up to that point, they were seen as a being the poor relation amongst the primary and community nursing team (Warne *et al*, 1999).

There is a tight time frame for PCTs to develop strategic plans that meet the aims and objectives of the next phase. This in itself adds to the turbulence many members of the current primary health and social care workforce is experiencing (Ham, 2005).

2.6 Summary

Primary health and social care workers aim to provide services against a policy backdrop, which calls for an increasing focus on multi-disciplinary, collaborative team working to provide seamless and effective services to patients. This requires a more effective involvement of a wider workforce that now includes medical, nursing, allied health professionals and other health and social care support workers. 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. The following chapter sets out the conceptual framework developed by the Work Package Five project team that it provided the basis for the methodology used to capture the current and emergent perceptions of integrated working as experienced by the primary health and social care workforce.

Chapter 3:
A Literature Review

3.1 Introduction

This review built upon the systematic review of the literature undertaken by Howarth *et al* (2004), to provide a conceptual framework for different aspects of the Work Package Five project work. For example, it provided the basis for the first level of thematic analysis (see also Chapter Three and Four) of the survey data. In this way the literature review was used both to inform and influence the project team's approach to articulating the context within which we would operate, the development of initial data analysis and subsequent iterative modifications to the data collection processes. Thus it is not our intention here, to try and replicate this literature review and in so doing further deconstruct the issues and concerns involved. Our intention is to 're-construct' the evidence base that more precisely illustrates our '*out of the box*' thinking in relation to the Work Package Five's project approach which occurred as a concurrent process to that of the work of other Work Packages, and in particular *Work Package Two – the systematic review of the literature*.

3.2 Developing a Conceptual Framework

At one level, a theory is a discussion of related concepts, while a concept is a word or phrase that symbolises several interrelated ideas. Generally, unlike a theory, a concept does not necessarily need to be discussed in order to be understood (Botha, 1989). However, it has been argued that such terms as 'conceptual frame of reference' and 'theoretical framework' should be used as broad terms for conceptions of reality, reserving 'philosophy,' 'theory' and 'conceptual model' as more restricted terms for conceptions of reality (Adam, 1985). Whilst recognising, but not wanting to engage with the epistemological and ontological concerns implicit within these statements, we pragmatically adopted a middle ground in our approach. Our starting point in planning the work of the Work Package Five project was to develop an underpinning conceptual framework, upon which our eventual approach could be built. This conceptual framework took as its primary focus the processes of integration, be these organisational, professional or educational. Of these we considered the organisational aspects to represent an overarching series of concerns most likely to influence the professional and educational aspects. For example, *The NHS Plan* (Department of Health, 2000a) makes an unambiguous assertion that more effective team working and collaboration must be reflected in all educational processes if the NHS is to have a workforce '*fit for purpose*'. However, the organisational demands made of staff (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. Against these organisational demands, education alone is unlikely to lead to better collaborative practice (Miller *et al*, 1999; Warne and Skidmore, 2004). Likewise, Glen and Leiba (2004) using the work of Pirrie *et al* (1998) have noted that within educational organisations a number of '*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) work against the successful implementation of inter-professional education programmes. Thus, in the early stages of our thinking we came to see the organisation of health care and health care organisations as being pivotal to our conceptual framework.

3.2.1 Organisational Relationships

Indeed, as Ferlie and McGivern (2003) note, the UK health care field (and we would add 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 [sic] inter-organisation co-ordination remains difficult and problematic (Webb, 1991). 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 (Warne, 1999). The way in which individuals and groups within and between organisations behave in response to these countervailing processes is also important to consider. For example, the ways in which macro level policies are translated by those working at the micro level. There may well be two different perceptions of what is involved and how both groups interpret the underlying policy drivers in terms of importance and relevance. In order to increase collaboration and reduce conflict in such organisational behaviours, Moss-Kanter (1994) noted that organisations' will need to engage with at least five levels of integration in order to achieve and sustain successful collaboration and partnership working within multi-organisational, multi-agency

relationships. She describes these as:

■ Strategic integration – This involves continuing contact among top leaders to discuss broad goals or changes in each organisation;

■ Tactical integration – This involves bringing middle managers or professionals together to develop plans for specific projects or joint activities, to identify organisational or system changes that will link the organisations better, or to transfer knowledge;

■ Operational integration – this involves providing ways for people who carry out the day-to-day work of the organisations to have timely access to the information, resources or people they need to accomplish their tasks;

■ Interpersonal integration – this involves building the necessary foundations for creating future value;

■ Cultural integration – this requires people involved in the relationship to have the communication skills and cultural awareness to bridge any differences.

It can be argued that it is the successful building and maintaining of relationships at various levels across the 'typical' organisation that allows for 'integration' to be achieved. Warne (1999) has argued that at the individual level and organisational level, such relationships are transformational in character, moving between relationships characterised by dependence, independence and/or interdependence. The countervailing processes of collaboration and conflict will largely determine the extent of such relationship transformations at any one point in time. As such, any movement in the relationships that are developed

between individuals and across organisations will be contextually and situationally driven (see also **Chapter Three**).

It is possible to schematically present these three levels of relationship and responsibility. For example, in Figure One the organisation is represented by the square and the Macro, Meso and Micro demarcations represent three levels of management responsibility within this organisation. At the top of the organisation (the Macro level) can be found those charged with strategic management and decision-making.
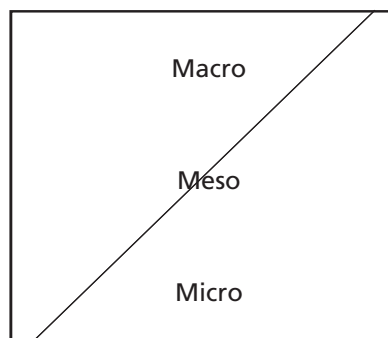
Figure 1: Organisational levels of management and responsibility

Individuals working at the Macro level of this organisation will see the world differently to those working on the shop floor (the Micro level) although it is essentially the same world that both groups inhabit albeit experienced differently. Those in the middle (the Meso Level) are often used as the 'translators' – i.e. to gather information from the micro level and pass this on to the macro level and/or 'interpret' the strategic intent at macro level so that it can be operationalised at the micro level. Alternatively, such individuals have been referred to as 'boundary straddlers' (Stark et al, 2000) or 'linkers' (Ferlie and McGivern, 2003).

These individuals have both the role credibility as well as personal credibility to work across the formal and informal organisational networks.

However, it can be argued that there is plenty of room for misinterpretation and Machiavellian behaviour in such relationships and the processes involved in developing and sustaining these relationships (Warne, 1999). Figure One also illustrates the amount of involvement each group might have in the work of others. For example, while there is still some opportunity for those at the micro level to be involved in the strategic decision-making of the organisation, although rightly the prime responsibility for this rests with the macro group, and vice versa. The NHS Trust Board may like to get involved in the operational aspects and decision making of the Trust, but essentially this is not their bailiwick either (Young and Gould, 1993). Whilst this is one application of the model, it can be used to explore other relationships.

Figure Two expands the simple model of organisational management role and responsibilities. Here the box represents the NHS as a whole organisation and other organisations and agencies that operate at different levels within and with the NHS. In this example, the possible location of the organisations at the Meso level is open to many different interpretations. The point argued here is that each and every one of these organisational entities that collectively make up the NHS not only has a specific set of functions and responsibilities, but also a wider range of expectations. For example, Local Authority Social Services have statutory responsibilities to provide a range of well being services, but they are also expected to provide the

Figure 2:   Expanded organisational model of relationships

Executive and Non Executive Directors,
Professional Leads, Politicians, Public Health
Consultants, Non Statutory Sector Representatives

PCT

| Macro | Prof. Heads, Managers | Macro | LA |

Meso

Micro

Prof. Heads, Managers

Macro

Meso

Micro

Tutors, Researchers, Nurses, GPs, Social Workers, Support
Workers, Pharmacists, Health Visitors, Occupational Therapists,
Voluntary Workers, Housing Workers, Counselors,
Administrators, Students, Carers, Service Users

HEI

Micro

Meso

Macro

Prof. Heads, Managers

Micro

Meso

Macro

Trust

Executive and Non Executive Directors, Professional Leads,
Politicians, Academics and Researchers, Non Statutory
Sector Representatives

'gateway' to other local government services and agencies. In order to discharge these effectively, individuals, groups and organisations will need to develop a series of working relationships that transcend those within the internal uni-organisational environment. Just as relationships within an organisation will be characterised by dependence, independence or interdependence, relationships between organisations are likely to experience the same transformations over time and in response to different factors within their environment (Porter, 1980; Warne, 1999).

Of course it is very difficult, in this one dimensional illustration to represent all the potential linkages individuals and groups might have across both the formal and informal networks (See also Warne 1999) and clearly the level and type of social cohesiveness is also difficult to illustrate in these simple diagrams. They are conceptual maps only. As Granovetter and Swedberg (1992) have noted, the actual outcome is dependent upon being able to trace the 'real life' interactions and measuring the impact such interactions have on individual or organisational performance. For example, Warne (1999) noted that, within the UK GP Fundholding Scheme, informal professional reputation between primary and secondary care doctors was an important, yet largely invisible asset, in terms of health care contracting.

3.2.2 Organisational Leadership

It can be also argued that, within the Macro, Meso and Micro levels of any organisation, networks will be made up of central and peripheral players and that dependent upon the power dynamics and levels of trust in play, it is possible that the focus of effort will move from that involved in responding to the organisations intent (strategic vision) towards individual interests (Stewart, 2002). The paradox in this argument arises in the recognition of effective leadership that is required to ensure partnership and collaborative working (Howarth *et al*, 2004). Effective leadership in each of the three levels is crucial for the development and maintenance of partnerships, particularly because it will allow not only for the mutual recognition of the need to work together, but also to promote acknowledgement of those areas where collaboration is not necessary or appropriate (Glendinning *et al* 2003). In the context of primary health and social care, the development of such relationships has been set against a background of great organisational turbulence. Glendinning *et al* (2003) further note that the changes arising from this turbulence can divert organisational attention from the development of external relationships and disrupt the interpersonal relationships between key individuals on whom the external partnerships depend. In her work which explored inter-organisational working (between public sector agencies), Huxham (2000) noted a number of features that relate to action as well as structure in inter-organisational working which either add to or reduce the impact of this turbulence, including:

- *The number of individuals involved in joint working* – In simple forms, direct interactions

between organisations are limited to those individuals who attend joint meetings as organisational representatives (Macro and sometimes Meso level); in more complex forms, cross-organisational interactions involve a number of individuals from each of the three levels in each organisation, and in different ways;

- *The level of formal organisational status* – For example, some partnerships (such as community groups) may have a more transitory formal organisational status than say an NHS Trust. Interestingly, even where an organisation has high formal organisational status, such as PCTs, this can be hard to detect, sometimes being viewed as 'virtual' organisations;

- *The complexity of the governance structures of the collaboration* – Collaborative partnerships may often involve different management groups and processes, individuals may work for the partnership but be employed by a separate employer with different reporting structures and governance arrangements. The Healthcare Commission have recognised the disturbance this can cause to multi-agency partnership working in health and social care, and new governance arrangements (to be introduced in 2005) seek to find processes of harmonising these differences;

- *The degree of pluralism* – The collaborative partnership may have to relate to other collaborations that have emerged in the same area; the greater the number of such collaborations the greater the complexity and the need to find ways of negotiating the network between networks.

Ferlie and Pettigrew (1996) noted that for managers, trying to promote partnership and collaborative forms of working in such a turbulent external environment required higher levels of 'reciprocity', 'understanding', 'trust' and 'credibility' both within the leadership processes of their own organisation and across other partner organisations. Taylor (2000) raises a related issue as to whether the leadership of such collaborative forms of working is best provided by formal organisations (such as PCTs) or mobilised by more collective but less formalised entities such as those represented by communities of practice.

3.2.3 Communities of Practice

In developing our conceptual framework we were increasingly drawn to the idea of what a 'community of practice' might represent and how useful such a concept might be in planning the work of Work Package Five project. Ferlie and McGivern (2003) describe a community of practice as being:

'a community of individuals, whether a very few or a whole profession, based around a particular practice… they are bound together by a shared knowledge, identity and common language rather than through formal organisation… they must trust in interaction and be able to access the community of practice repertoire and use it appropriately' (page 24)

What makes the concept useful is that effective communities of practice are able to function in ambiguous contexts, and contexts that are different from those expected by the formal organisation. Key to gaining this ability is organisational learning, and this learning is that which largely occurs outside the classroom (Wenger, 2000). This learning is directed knowledge that is concerned

with shared meaning and transformational forms of identity. Both of these are crucial elements in what Howarth *et al* (2004) describe as Role Awareness and its importance to team and integrated working. In extending Stark *et al*'s (2000) notion, we argue, learning about team working, integrated working, partnerships and so on is better 'caught' than 'taught'. These are areas of learning where knowledge is often ambiguous and where performance and competence are hard to demonstrate. Being able to use the right rhetoric for example that represented by the *Knowledge and Skills Framework*, and other similar processes, (see Howarth *et al*, 2004) will increasingly become important. However, recourse to such rhetoric alone will not facilitate the innovative construction of personal and organisational identities and/or effective integrated learning and practice (Alvesson, 2001). In a related area, the reliance on evidence based approaches to practice, and the lack of credible evidence based policy-making, add to how communities of practice respond to the wider turbulent environment (Black, 2001).

3.2.4 Organisational Rhetoric's and Realities

Ham *et al*, (1995) made the link between the rise of evidence based practice exhortations and the corresponding need to develop evidence based approaches to policymaking and service management. This link remains problematical, and Black (2001) noted a number of reasons that contribute to this, including:

■ Policy makers have goals other than clinical effectiveness (social, financial, strategic development of services, terms and conditions of employees, electoral);

■ Research evidence dismissed as irrelevant (from different sector or speciality, practice dependent upon tacit knowledge, not applicable locally);

■ Lack of consensus about research evidence (complexity of evidence, scientific controversy, different interpretations);

■ Other types of competing evidence (personal experience, local information, eminent colleagues' opinions, medico-legal reports);

■ Social environment not conducive to policy change;

■ Poor quality of knowledge purveyors.

Warne *et al* (2002) notes that the consequence for practitioners, when factors as those outlined above are not addressed in policymaking, is often a healthy rhetoric but an unhealthy reality. For example, in an analysis of the impact of the NHS Plan, it is argued that whilst most health care organisations (and the individuals within them) welcome the firsts real strategic plan for the UK health care system, the reality has often been problematic. Organisations have had to respond to a plethora of new national standards and targets, creating a perverse effect on what activity takes place, i.e. what gets measured is what gets done. Over time, such organisational responses to external demands for change will impact upon the individual organisational structure and functioning in terms of formal organisational approaches (Quinn, 1988; Silverman and Baum, 2002), and equally, organisational culture manifests in the type of relationships informally experienced and utilised to ensure the organisations aims are met (Warne, 1999; Ferlie and McGivern, 2003).

3.3 An Emergent Conceptual Framework

The result of the team's review of the literature, (undertaken concurrently with the Howarth *et al* 2004 systematic review) was a conceptual framework that can be presented schematically (Figure Three).

We argue that at any one point in time, either individual organisations will inhabit one of the different quadrants, or will be in a process of transition from one quadrant to another. Thus, individuals and the organisations they worked for, and who might participate in the work of the project, were likely to be able to be placed upon the Fragmentation/Integration continuum dependent upon how, as individuals and as an organisation they interpreted and responded to the rhetoric and realities of the organisational context.

In accepting this premise, a number of epistemological concerns became evident that would need to be responded to in the research methodology and design process. These are explored and discussed in the following chapter.

Figure 3: A Schematic View of the Conceptual Framework

Collective
Multi-professional
Transactional leadership
Language interpretations
Expert Knowledge
Lateral organisations
Independant relationships

Rhetoric

Community
Community of Practice
Transcendental Leadership
Shared language
Expert, tacit and Patient
Experience Knowledge
Virtuous organisations
Interdependent
relationships

Evidence based policy and
practice

Organisational learning,
professional and personal
development

Fragmentation ← ——————————— → **Integration**

Policy and practice
ambiguity

Organisational, professional
and personal tribalism

Conflict
Uni-professional
Management
Uni-lingual
Tacit Knowledge
Vertical organisations
Dependent relationships

Reality

Collaboration
Professional Partnerships
Transformational
Leadership
Multi-lingual
Expert and Tacit Knowledge
Virtual organisations
Transformational
relationships

Chapter 4: Methodology

4.1 Introduction

This methodology chapter aims to provide the reader with insight into the overall approach adopted, the original research design, how this was changed in response to being in the field, how data was handled and analysed and some of the limitations that have arisen during the research process.

There was a great deal of cross fertilisation of ideas and approaches both within the Work Package Five project team and across the other partners working on the overall StF project. In an overall sense, the StF Project adopted quantitative and qualitative approaches to the exploration of the various sub-projects. This triangulation of approaches was reflected in the Work Package Five project. As noted above, a conceptual framework was developed that posed a number of epistemological issues for developing our methodology. For example, the conceptual framework challenges the positivist premise that it is possible for a single objective reality to exists which can be discovered by scientific investigation. Conversely, the conceptual framework provides for the possibility that objective reality (or truth) is a much more intangible notion. Thus we argue that individuals, and the organisations they collectively form, are more likely to construct their own adaptation of reality. Such realties are built upon knowledge that consists of various interpretations of phenomena that are themselves, part of the social and cultural context in which such phenomena occurs (Kim, 2003). In such circumstances, the focus is likely to be case specific offering little opportunity for generalisablity – which was a crucial aspect of the StF Project as outlined in the brief provided by the research commissioners. However we argue that the conceptual framework, analysis and discussion of the findings will resonate with the experiences of many of the participants and non-participants engaged in the StF project.

4.1.1 Ways Forward

The work involved in developing the conceptual framework, and being cognisant of the emergent findings of the concurrent review of the literature (Howarth et al, 2004) allowed the project team to adopt a position congruent with Rossman and Rallis (1998) assertion that [qualitative] researchers should pursue multiple perspectives about the phenomenon – that is the project team should search for realities or truths not one reality or truth. Thus in working towards the overall aims of the StF project (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 Workforce), we elected to adopt a multi-method approach that would be realistic, flexible, politically aware and reflective.

4.2 Research Aims and Objectives

The aim of Work Package Five project was to:

- Identify the views and experiences of a staff working in primary health and social care settings of integrated health and social care.

- A number of specific objectives were developed in order to structure the approach to meeting this aim. These were:
    - To explore the perceptions of the strengths and weaknesses associated with integrated health and social care education and training;
    - To explore the perspectives on future training requirements needed to deliver the health and social care agenda;
    - To examine the level of dissonance between perspectives of the Primary Care workforce and service users about the quality of current health and social care service and education and training needs.

4.3 Research Design

Eisner (1991) notes how proposals should not function as recipes or scripts, and perhaps should be best seen as projections or suggestions. The research design outlined in the original bid was amended and changed in response to (1) developing the conceptual framework; (2) the real life challenges faced by the team in collecting data.

Originally, the research design proposed utilising two approaches. The first was the development and administration of a survey to all PCTs that would capture the perceptions and experiences of staff at working at the three different levels with each PCT. The second approach was to undertake a series of focus group interviews that would address the outcomes of the survey analysis. Although, this original proposed approach was largely adhered to, due to problems with the administration, response rates and analysis of the survey, the second aspect of the original research design was expanded to include, single and group semi-structured interviews, workshop case studies and participant and non-participant observation (see also 4.5; and 5.8).

4.3.1 Survey

The survey was designed using the conceptual framework and themes as these emerged during the literature review process. The survey was piloted with a group of 32 primary health care workers from various nursing and non-nursing backgrounds using an opportunity presented through a research methods workshop held at Manchester Metropolitan University in the Spring of 2003. The results of this piloted version of the survey have not been included in the presentation of the findings. Analysis of the survey from the data set is presented at 5.2 in Chapter Five.

The feedback from the pilot questionnaire was generally positive although some respondents felt it was an overly long questionnaire. This feedback was responded to and a shortened version produced. However, following discussion with the whole StF Project Management Team, this version was reviewed and much of the original areas covered in the piloted version were re-instated. The final version (see **Appendix One**) was ready for administration in April 2003.

With the benefit of hindsight, it is clear that the length of the questionnaire, and the fact that many PCTs declared themselves 'research saturated', possibly contributed to some of the problems experienced during the questionnaire administration and completion. The alternative data collection approaches, developed subsequent to the survey administration, provided the Team with many more opportunities to collect data, and may well have been a better alternative overall approach.

We argue, however, (see **Chapter Six**) that a revised version of the questionnaire would be useful to primary care organisations as they engage in the organisational development work associated with becoming more integrated.

4.3.2 Semi-Structured Interviews

The initial analysis of the survey data provided a series of issues that formed the basis of interview schedules for the individual and group interviews. These interviews were undertaken either opportunistically, (for example, a key participant invited team members into their organisation to meet with a self-selected group of staff) or purposefully, where an individual was identified as being willing to be involved in the project. The latter tended to be senior staff from the Macro and Meso levels of the various organisations (see **4.4**). Transcripts were prepared of these interviews and provide the data set presented from 5.9 in Chapter Five.

4.3.3 Workshop Case Studies

These workshops were arranged to specifically examine different emergent issues with invited groups of staff. These groups included students from various different professional backgrounds (at different stages of their training), educationalists and qualified practitioners. Typically, these events were held at a neutral venue (university premises), were organised to run either for a full day or half day, and notes were taken and collated during and immediately after the sessions. These notes were worked up as analytical memos and provide the data set presented from **5.9** in Chapter Five.

4.3.4 Parallel Processes

Although the term is used here drawing on psychodynamic concepts (Warne and McAndrew, 2005b), it can of course refer to organisational, physical, professional worlds as well as the more familiar personal, psychological and emotional usage. At times such parallel processes come together to span more than one element. For example, at a time when the team were trying to gain access to the PCTs in order to administer the survey, one team member found themselves impotently standing outside a PCT headquarters whose electronic door refused to work (for the researcher and the PCT staff) despite there being a welcome sign stating "*Welcome, this door will open automatically – please do not push*". Here the parallel process of gaining access to the PCT staff and gaining access to the PCT building reveal an almost ironic symbolism. Drawing on Flick (2002) we argue that the teams' reflections on their actions, observations in the field in this way, their impressions, irritations, feelings and so on, become part of the data in their own right. In so doing they form part of the overall interpretations made and drawing on field notes made to capture these interpretations, we intend to use this data along side other data to further illuminate our analysis. This approach has been used in particular to explore levels of congruence and dissonance between the experiences of the service users and the primary health care workforce.

4.4 Sample

Primary Care Trusts (PCTs) were selected as the main organisational form where participants from the three organisational levels (Macro, Meso, Micro) were invited to be involved in this project. This was a decision taken by the overall StF management group, and clearly is challengeable in terms of representativeness of the what might be construed as the health and social care workforce sample. The decision was taken, largely on the basis that

PCTs were new organisations, not yet fully formed, and who were having to 'grapple' with the complexities of developing more collaborative forms of working which might eventually lead to more effective integrated working. Thus they could be conceived as organisations in transition, but where such stages of transition might also prove useful in providing the evidence of how individuals and groups perceived and experienced different aspects of integrated working, and aspirations for the future.

A limitation of adopting this approach was identified early on. It became evident that many staff from social care backgrounds were 'transient' members of the core PCT workforce and gaining access to these staff was very difficult at times. For example, the eventual sample of participants only included a few individual's from social care organisations who held a

care organisations that worked at the micro level. The one exception to this was in the area of children's and young peoples services. During the data collection period, significant changes to the way in which health, social care and educational services were provided emerged. The response to these national policy initiatives provided the opportunity for involvement of not only Macro level staff, but also participants working at the Micro level (see **5.8**).

At the start of the project there were 37 PCTs in the North West region and it was originally intended that a weighted sample of participants would be drawn from each PCT (Table 1).

Collectively this would amount to a sample of 3000 participants to whom the survey could be administered. Both the projected size and mix of the sample proved to be over ambitious due to problems with

gaining access, and an indifferent response rate to administered questionnaires. In June 2003 all PCTs

- One has had the survey administered and returned the completed questionnaires;
- Two started the process of administering the survey but did not return any completed questionnaires;
- Three eventually completed some questionnaires but only following the intervention of a senior manager working at a Strategic Health Authority;
- Two stated they did not want to participate at this stage as they had been inundated with questionnaires from the centre (CHI and the Department of Health) and felt staff were suffering from questionnaire fatigue.

Despite many different attempts of administrating the survey, email, internal distribution and so on, only 100 useable questionnaires were returned. This was a considerable disappointment given the sample size noted above. There might be a case to answer in terms of how representative these survey results are of the wider and potential PCT sample. If this was the only data relied upon, then such a challenge would be legitimate, and difficult to refute. However, this data, although derived from a very small percentage of the overall potential sample, is in itself valid (see 5.2) and when presented with data from other sources provides for an interesting analytical juxtaposition. Interestingly, when the data from the survey was tested for correlation and goodness of fit generally all the groups are strongly associated in terms of agreement with no significant differences being found – The

Table 1: Sample Frame

	Macro Level	Meso Level	Micro Level
Managerial	3	4	4
Medical	2	6	8
Nursing	2	4	18
AHP	2	2	6
Education/Research	1	1	2
Other	2	3	4
Sub Total	12	20	42
Total (all PCTs)	504	840	1764

senior (Board level equivalent) position. Thus gaining data on the strategic vision, policy formulation

and strategic management experience of these social care organisations was very difficult. Likewise, it was often difficult to find and involve participants from social

were contacted by email and followed up with hard copy letters sent out in November. There was not one response The PCTs were contacted again in January 2004 in a second attempt at establishing contact by email and telephone. Eight PCTs responded. Of these:

pattern of SD, D, A, SA between Macro, Meso and Micro level responses with Spearman's Rho indicating a result of 0.6....0.9. Likewise, with Chi Square (for example, Question 4 Meso v Micro; $x2 = 2.1$ and Question 9 between Macro versus Meso; $x2 = 3.26$) the P values showed no significant differences-thus we argue the survey can be considered as belonging to one group making the results more solid (see also 5.8).

4.4.1 Participant Involvement in the various data collection processes

Although the response from the potential participants to requests to administer the survey was very disappointing, an early multi-professional workshop provided the impetus to develop alternative approaches to the Team's data collection. The final number of

Table 2: Breakdown of participants by level and activity

Survey	Interviews	Workshops
Macro = 12 Macro = 8 Macro = 16	Meso = 28 Meso = 10 Meso = 24	Micro = 60 Micro = 33 Micro = 142
100	51	182

participants involved in the work of Work Package Five project was (see table 2 below):

These participant groups represented a total of 18 PCTs. The remaining PCTs either declined to become involved or by default were not included due to a lack of response to attempts made to engage them in the project.

4.5 Gaining Ethical Approval

The overall Shaping the Future Project submitted an ethics approval application to the North West Multi-

centre Research Ethics Committee (MREC) in April 2003. This was in line with the prevailing guidance provided by the Department of Health (2001b) and in line with the research governance framework (Department of Health, 2001c) pertaining to any research being undertaken in health and social care organisations. These arrangements and the various committees involved in this work were developed in response to the unsatisfactory situation with regards to the work and responsiveness of the ethical approval review process in the early 1990s' which had resulted in a spate of empirical research outlining disgruntled researchers' complaints about the system (Cave and Holm, 2002). These complaints revolved largely around the response times involved in gaining approval, the cost of making an application and problems of diversity in approach across various local ethics

committees. Much of this work involved clinical trials, although ethics committees were required to review a wide range of other research proposals from epidemiological studies to qualitative studies. New guidelines were produced in the late 1990s', and following changes in European Union directives, the UK government introduced the present system in 2001 in an attempt to ensure homogeneity within the European research communities. This brief historical foray into the origins of the current system is by way of contextualising the difficulties

encountered by the Work Package Five project research team as they started working on addressing the aims and objectives.

There was a considerable delay in the Shaping the Future project overall gaining ethical approval. This was finally granted in late June 2003 (some 3 months after the original application. Part of this delay was caused by the need to make relatively minor changes to associated information formats (Participant Consent Forms and so on) and partly to do with misunderstandings over whether patients were to be included. The Work Package Six project team aimed to gain service users views through the involvement of user groups. This raised an interesting, but not strictly helpful debate on when does an individual become a patient or stop being a patient!

However, despite this delay causing problems in keeping to the scheduled research design, it was nothing compared to the next series of delays encountered by the team resulting from both the clinical governance and research governance processes in each PCT.

Each member of the Work Package Five project team was allocated a number of individual PCTs to work with. The problems in initially gaining entry (finding the appropriate gate keeper) were noted above. Once the door way had been opened however, the next stage of the process often (but not always) involved having to submit an application to the PCT research or clinical governance department. This process required the completion of a non-standard application form, submitted along with various, accompanying information. This requirement proved to be problematical in a number of

different ways. It slowed down the whole process of working with PCT staff considerably. For example, two PCTs took several months to process the application. They made many additional demands for further information (including details of the funding organisations financial viability!) during this time. Responding to these demands used up much time. Although the overall project had been given MREC approval this appeared not to be considered relevant or important. Frustratingly for the researcher involved these two PCTs then declined to be involved in the project on the grounds that they had many other organisational issues to deal with at that time.

A related issue to the examples used above is the apparent level of knowledge and awareness of those individuals the team were communicating with within these departments. Often it was the case that these individuals displayed very good administrative skills, but appeared to have limited knowledge, awareness or understanding of what is involved in the research process.

However, the majority of PCTs who eventually contributed to the project work did so in a way that made the research team feel very welcome. Written consent was obtained in most cases from the appropriate level of the organisations management, and verbal consent was obtained for all the individual participants who took part in the interviews and or workshops. Those participants who completed and returned the survey were deemed to have given their de facto consent.

Finally, some organisations insisted that an honorary contract be issued to the researcher before the researcher was able to make contact with the organisations staff working

in any of the organisations premises. There are obvious health and safety/ insurance reasons for this. However, eventually many staff were interviewed either on the university premises or at a neutral venue, so this was a relatively minor problem.

4.6 Summary

The research methodology described here reflects the intended approach and the eventual emergent research design. Due to unforeseen factors concerned with gaining ethical approval and initially gaining access to the research sites, the intended research design was reviewed and revised. These revisions not only ensured a representative sample was eventually achieved, but also that the experiences of the participants were captured in a way reflective of the phenomenological approach aspired to.

Chapter 5:
Congruent Themes

5.1 Introduction

The overarching focus for the StF project is integrated health and social care. It was interesting that in the review of the literature (Howarth, 2004) no one definition of this concept could be found. So whilst the term was often mentioned in policy statements and guidelines, this was often open to interpretation. The StF project team developed their own definition, which was used as a working definition for all the sub-projects:

'Care that is determined by partnerships between health agencies, social care agencies and users and carers for the health and well being of the local community'

community health practitioners) were asked to consider:

This was an important starting point in the data collection and analysis. In a number of different ways, participants were asked explicitly and implicitly to describe what integrated health and social care as both a concept and reality meant for them. At the conceptual level (illustrated by the definitions provided in the survey) there was a general and shared understanding of what integrated working might mean.

3 key outcomes that might best illustrate an effective integrated health and social care service.

'Q10 – Which one of the following definitions of 'integrated health and social care' would you most closely agree with?	
Care that is determined by partnerships between health agencies, social care agencies and users and carers for the health and well being of the local community'	Macro Meso Micro 5 11 26
'An organisation that is made up of different health and social care agencies able to plan and deliver a range of services to meet the needs of a local community'	7 8 23
'Service provided by a multi-professional team working towards meeting the needs of a local community, although sometimes, having different bosses makes life difficult'	5 10
'Realistically, there is no such thing as integrated health and social care services'	2 1

This was a definition that allowed for the multi-methods approach described above to be grounded in the participants experience. It provided an anchor point for discussion, but also was indicative of the rhetorical nature of the early data gathered (see also **5.8**). For example, in one group workshop, the participants (all primary and

Their responses included the following:

- Improved services (shared and agreed referral thresholds);
- Faster service responses to individual needs;
- Higher patient satisfaction);
- A shared vision of what the service was about;

- More effective integrated team working;
- Improved information and communication sharing;
- Effective and efficient service provision;
- Positive feedback from service users;
- Reduced duplication of workload (reduced stress, happier workforce);
- Seamless pathways of care;
- High staff morale;
- Single and shared assessment processes.

Thus at a largely rhetorical level, these data appear to suggest that most PCTs are actively engaged with the processes required to achieve effective integrated health and social care services. There is a great deal of congruence across all levels of the workforce at all levels of organisational and professional responsibility. In presenting the data, we have chosen to start with this first level of analysis, drawing on the survey data which is presented using an expanded version of the thematic framework that emerged in the systematic review of the literature undertaken by Howarth et al (2004):

Team Working, Communication, Role Awareness, Personal and Professional Development, Practice Development and Leadership and Partnership Working.

5.2 Presentation of Data

We argue that data from the survey, although largely rhetorical in nature, is worth presenting here to provide the reader with one view of the way in which many practitioners and managers from a range of different professions chose to articulate their lived experiences. It is clear from the accounts of our respondents that they locate their practice (and organisational) experiences on a countervailing continuum of espoused theory and theory in use (Argyris and Schon, 1978). Espoused theory can be said to represent the worldviews and values individuals believe their behaviour to be based upon, whereas theory in use is the world view and values implied by their behaviour or the knowledge maps they use to take action. Thus, in the first data set presented here for example, in terms of effective communication, 78% of all the survey respondents reported that meetings were held with sufficient regularity and with the right people to ensure effective communication, yet we also had a plethora of data that suggested often many individuals struggled with poor communication processes, being 'kept in the dark' by their managers and/or had to use information systems that did not communicate with each other. The lived experiences reported here (espoused theory) are further unpacked in the second data analysis, which was informed by data collected in subsequent interviews, workshops and observations, and adds a richness and authenticity to these early accounts (theory in use).

5.2.1 Team Working

This theme had three aspects to it:

5.2.2 Formal and informal rules

54% of respondents A/SA that their PCT had written agreements for how individuals and different groups should work together and these agreements were used consistently. Although this aggregated response appears positive, there were differences within and across the different organisational levels, with the majority of those working at the Macro level disagreeing with this (*60% Macro D, 50% Meso D and 28% Micro D*). Interestingly 71% of all respondents A/SA that their PCT uses the diverse skills, knowledge and backgrounds of its staff to formally organise the service it provides.

Likewise, there was evidence of informal rules applying in the work of individuals and groups, for example, 62% of all respondents A/SA that individuals help others who are experiencing problems in meeting deadlines or outputs. However, a rather more neutral response showed that 54% of all respondents A/SA that individuals are willing to compromise or sacrifice self interest so that the needs of others in the PCT can be met.

5.2.3 Adding Value/Agreed Values/Being Valued

It became clear during the early data collection process that many of the new PCTs were like virtual organisations. They existed – out there somewhere, but at the time of administering the survey, many were relatively new organisations, mainly made up of previously autonomous and much smaller general practices and/or community services. It was surprising therefore to find that 62% of all respondents A/SA that the PCT created new value. This was described as a new feeling of value that individuals and groups could not achieve on their own. Likewise some 88% of respondents A/SA that individuals in their PCT shared and acted according to agreed values. Rhetorically, this data was triangulated with data on how such shared values were transposed into action, with 72% of all respondents A/SA that other individuals in their PCT consistently delivered on promises and commitments made to others.

5.2.4 Problem Identification/ Problem Solving

However, whilst 65% of all respondents A/SA that all the different groups in the PCT were able to participate in the definition of problems or issues to be addressed only 45% of all respondents A/SA that individuals across the PCT use a common and shared approach for addressing problems or issues as these arose.

5.3 Communication

This theme had four aspects to it:

5.3.1 Meetings, meetings, meetings

Linked to the previous aspect, 78% of all respondents A/SA that meetings were held across the PCT frequently enough to ensure effective communication. In particular, 66% of all respondents A/SA that these meetings were used to ensure adequate problem solving and 71% A/SA that the meetings were used to ensure efficient progress being made towards the PCT goals.

5.3.2 Integrated partnership strategic plans

In relation to working in partnership with other organisations and agencies, 72% of all respondents A/SA that the published plans (Service development, strategic plans and so on) from other partnership organisations reflected their PCTs own strategic plans. These did not appear to be one off plans as some 59% of all respondents also A/SA that regular monitoring and evaluation meetings were held with partner organisations.

These were used to monitor progress against the shared objectives.

5.3.3 Transparency/Availability of information

Access to information is often seen to be the lifeblood of effective communication processes. 61% of all respondents A/SA that individuals and groups within their PCT give appropriate and timely feedback to each other. What wasn't clear from the survey data was what this feedback consisted of. However, a similar number of all respondents (69%) A/SA that in meetings held across the PCT, openness and respectful sharing of ideas is emphasised, although only 50% of all respondents A/SA that individuals within their PCT respond to critical feedback without getting defensive.

5.3.4 Feedback/Fighting/ Friendships

This shared commitment to working 'inter-professionally' was also evidenced by 65% of all respondents who A/SA that individuals across their PCT keep other staff within the PCT appropriately informed about their work, problems and progress towards objectives. Again, there is clearly an issue about what might be agreed as being 'appropriate'. Interestingly, 50% of all respondents A/SA that within their PCT there are explicit agreements on how to handle the public visibility and achievements of staff.

5.4 Role Awareness

Despite the wealth of other empirical evidence that suggest that role awareness is a crucial element of effective team working (Stark et al, 2000) and by implication, a crucial element of integrated working (Howarth et al, 2004), there was a surprisingly high level of agreement over how aware individuals were of others that worked in their

organisation in different roles from their own. This theme had four aspects to it:

5.4.1 Shared understanding of roles

In terms of understanding the various roles of different staff groups, only 50% of respondents A/SA that the different roles of staff working in their PCT were clearly understood by staff from other professions. However, a slightly higher percentage (69%) of all respondents A/SA those individuals' do acknowledge the contribution of others to the work of the PCT. It is difficult to reconcile these two data, as the second aspect is often dependent upon the first being more widely agreed. However, this data might also suggest that one experience is informed by functional outcomes, that is, how their work contributes to the team in everyday experiences without there necessarily being any understanding of what the formal role entails.

5.4.2 Organisational politics

Likewise, despite the often-noted prevalence of tribalism in health and social care professionals, 65% of all respondents A/SA that individuals in their PCT are open about organisational interests and expectations and that in dealing with other, covert agendas are kept to a minimum.

5.4.3 Learning from others

There was further evidence of this apparent lack of tribalism in the respondents accounts of their experience, as 88% of all respondents A/SA that individuals in their PCT actively seek to learn from the experience and knowledge of others working across the PCT. A similarly high percentage (80%) also reported that they learn from others working in partner organisations.

However, whilst 98% of all respondents A/SA that wherever practical, education and learning opportunities should be shared by different professions, some 58% D/SD that multi-professional training was the norm in their PCT. In terms of actual participation in such learning and educational opportunities, only 25% of all respondents reported that they have regularly participated in inter-professional training, and some 35% reported that they had never participated. Likewise, 50% of all respondents reported that they had never participated in training provided by other health and social care organisations.

5.4.4 Generic and generalist working

Respondents were asked about the emergence of the generic worker in the health and social care workforce. 66% of all respondents A/SA that primary health care services should become more specialist and less generic in terms of services that might be provided. Implicit in this data is the wish/need for some staff to develop more specialist roles, and the development and deployment of more generic and less qualified workers would be one route to achieving this. In supporting this idea, 79% of all respondents A/SA that the development of a generic health and social care support worker would enhance the role of current health and social care professionals in enabling them to develop and provide a more specialist role.

5.5 Personal and Professional Development

This theme had six aspects:

5.5.1 Life Long Learning

Despite the somewhat contradictory data noted above, 67% of all respondents A/SA that inter-professional training for integrated working was actively promoted in their PCT. Likewise, some 86% of all respondents A/SA that '*life long learning*' should be a central feature in the development of the PCT and service improvement activities. Interestingly some 64% of all respondents felt that integrated working is better '*caught than 'taught*' (i.e. learning on the job) raising potential issues for the current and future provision of educational and training programmes provided by the various Higher Education Institutes (see also 5.5.6 below).

5.5.2 National competence standards

There appeared to be wide recognition of the need to standardise how 'fitness for practice' should be agreed. For example, 93% of all respondents A/SA that future educational approaches should be based upon national competence standards (such as the Knowledge and Skills Framework). However, in noting the processes that might be involved in this, 90% A/SA that each professional group should be allowed to decide the best way to teach, learn and assess professional practice. It was not clear from this data how such a strategy could promote integration of the generic an specialist aspects of the work of health and social care providers or integration across the professions.

5.5.3 Professional networking/Development

A strong commitment to individual professional groups was reported. 68% of all respondents A/SA that individuals within their PCT keep their professional bodies informed about various PCT activities, challenges and progress towards the PCT's overall objectives.

5.5.4 New workers

Some new workers (for example, Assistant Practitioners) were welcomed by many of the respondents who represented the more traditional and familiar health and social care workforce, although the general perception was that these new workers were being better used in primary care than in the secondary sector. These data are congruent with that noted in 5.4.4.

5.5.5 Education Training Needs Analysis (ETNA)

There was some data that suggested often, an unsystematic approach to supporting individuals training and development was the norm. For example, whilst 85% of all respondents A/SA that their PCT encouraged them to pursue their own personal development, only 54% A/SA that all requests for training and personal development are discussed with the PCT education and training manager before a decision over support was given. There was little evidence of education and training needs analysis tools being used.

5.5.6 Ivory Towers

In support of the data in 5.5.5, 100% of all respondents either A/SA that access to education, training and development should be as open and flexible as possible. There were several suggestions as to what worked best in promoting this (see 5.6). However, 64% of all respondents A/SA that current educational and training courses offered by universities are effective in meeting the current service needs despite the data presented in 5.5.1.

5.6 Practice Development and Leadership

This theme had five aspects: **5.6.1 What worked – and what didn't**

In terms of rating what inter-professional training and education worked well, the following:

- *Sharing professional experiences;*
- *Multi-professional problem solving;*
- *Sharing and agreeing best practice.*

all scored highly, with:

- *Ensuring a user led focus was maintained;*
- *Organisational boundary crossing.*

being seen as the least successful in terms of inter – professional training and education, by all groups.

5.6.2 The ubiquitous Personal Development Review

Although there was little evidence that systematic approaches were being used in decision-making processes over personal and professional development, 82% of all respondents A/SA that their manager had a good understanding of their competence and skills base. How this understanding was achieved was not declared, but as a proxy indicator, 60% of all respondents reported having annual Personal Development Reviews (PDR). Perhaps given the numbers of individuals working at each level it was not surprising that of this group, 80% of those working at the macro level reported having a PDR in the last 12 months compared to only 40% at the micro level.

5.6.3 Some Essential/Desirable development activities

In terms of rating what practice training and development activities worked well, the following:

- *Self study;*
- *Away days;*
- *University courses.*

were rated the highest, with:

- *Uni-professional training and development;*
- *Modernisation Agency sessions.*

rated the lowest.

- *Team briefing meetings;*
- *Away days (multi agency);*
- *Self Study.*

were reported as being essential, with:

- *University courses;*
- *Modernisation agency sessions.*

as being desirable.

5.6.4 Being prepared for change

Change was recognised as being a constant feature of everyday practice. However, 50% of those working at the micro level, felt either completely unprepared or only partially prepared for the introduction of new initiatives. Despite this, some 85% of all respondents A/SA that individuals within their PCT had the skills necessary to achieve the overall PCT goals, even where this involved a change in the way practice was carried out.

5.6.5 Drivers for change

Perceptions over who was driving these changes were largely focused on the Macro level of the organisation. 75% of all respondents reported that it was the PCT Board that were responsible for driving forward new integrated health and social care initiatives. However, 55%

D/SD that PCT leaders ensure all voices are heard before such decisions are made. This data appeared to contradict, albeit rhetorically, the data showing that 58% of all respondents A/SA that the strategic management of the PCT fully involved patients and carers.

5.7 Partnership working

This theme had two aspects:

5.7.1 Keeping the vision in view

Again at a rhetorical level, 87% of all respondents A/SA that within their PCT there was a clear vision of what partnership working involved. Examples from the data to support this include:

- The vision being used to prioritise activities (92% A/SA);
- The vision being used to prioritise resources (93% A/SA);
- The vision being used to keep the PCT focused (82% A/S).

Likewise, 81% of all respondents A/SA that their PCTs vision was known to other health and social care organisations, and this was not passive knowledge. For example, 68% of all respondents A/SA that use is made of other partnership organisations to ensure a comprehensive skill base is available to meet the strategic aims of the PCT, and 63% of all respondents A/SA that their PCT uses other partner organisations to bench mark best practice.

5.7.2 Service User Involvement (in decision-making, service development, training and education)

The other group that should be considered as being partners are the patients and carers. However, data to support this appeared less rhetorical than that presented above. For example 11% of all respondents

reported that within their PCT, service user involvement was confined to consultation with those representing a special interest. In terms of service development, training and education, 54% of all respondents D/SD that training and personal development provided by the PCT involved service users. In particular, only 8% of all respondents reported that service users had delivered the training and 20% of all respondents reported that service users had been participant learners in any training or service development activity.

5.8 Understanding the sub-text

In analysing and presenting the data above, the team were cognisant of the mediating axis contained within their conceptual framework that of countervailing forces generated by interpreting and acting upon the rhetoric and reality of everyday practice and organisational life. What we are left with was a sense that the data presented above represented a collection of communities of practice, all of which had a shared vision, a shared language and a number of ideological and procedural assumptions. These shared aspects, communicated as they were through the survey data in a rhetorical fashion, are congruent with what Warne *et al* (2002) describe in their analysis of the underpinning political processes involved in the modernisation of the UK NHS, as convergence theory. This theory is predicated on the basis of a need to provide ontological security (Warne *et al*, 2002) for those involved in major change. Individually and possibly collectively, convergence theory is based upon the belief that communication (in this case rhetorical communication Foss, 1999) creates reality, reminiscent of Argyris and Schon's (1978) espoused

theory/theory in use approach. Unconsciously, such an approach enables the individual and the group they are affiliated with to make sense of what is occurring and frame their understanding accordingly (Stake, 1995). However, both the shared and individual experiences of working in primary and community care accumulated by the team generated the need to find ways of exploring this 'sense making' by individuals who completed the survey. We believed that this would involve finding alternative ways in which the sub-text of what was being said in the survey could be better understood.

It was in employing the second approach to data collection i.e. the interviews, workshops and observations that we began to identify the level of congruence between what was being espoused (in the survey) and what was happening in practice. In order to present this data in a way that illustrates the level of congruence between these two registrars, we have used the thematic framework employed to present the data above. Data fragments are used to illustrate the experiences of those working at the Macro, Meso or Micro level.

5.9 Team Working

It is worth making the point that in understanding and reading the subtext, even in the more personal interviews and case studies, the rhetoric often re-appeared. However, this often provided an opportunity for the participants to engage in a process of deconstruction that used their practice experience to provide reflective explanations.

What was interesting about this part of the data collection process was the high level of congruence between what staff described as being

important for them and the organisations they worked in and what they saw as outcomes and consequences for patients and clients. For example, in one case study workshop the groups were asked to discuss and report back on what three key factors would facilitate more effective team working in their practice area. The overall responses from the groups were presented as follows:

■ *Non-judgemental environment;*

■ *Clear understanding of roles (x2 groups);*

■ *Recognising the role of others;*

■ *Understanding own role;*

■ *Clear aims and objectives as to how the team will progress;*

■ *Agreed vision and goals;*

■ *Effective style of leadership (transformational not transactional);*

■ *Effective communication (x 2 groups);*

■ *Collaboration.*

It is interesting to note that participants chose to differentiate out '*understanding*' and '*recognising*' the role of others, and did so in relation to understanding their own role.

Likewise participants were asked to discuss three key factors that could be used to demonstrate the benefits of team working on patient care. The responses were:

■ *Increased quality of care;*

■ *Patient empowerment;*

■ *Continuity of care (x2 groups);*

■ *Initiate and develop new services;*

■ *Communication and continuity (corporate case load management, care path ways, holistic care, faster responses to needs) (x3 groups);*

■ *Seamless services (x 2 groups);*

■ *Appropriate skill mix used;*

■ *Increased choice;*

■ *More knowledge used to ensure better outcomes for patients.*

These two responses serve to illustrate the high degree of overlap between the desired process elements and process outcomes involved in the work of professionals and patients. However, as the discussions progressed the perspective shifted back to the individual professional, the ways in which they worked and the organisational constraints and opportunities that shaped this work. Unfortunately, in some of these accounts, the patient often disappeared from view. The Team Working Theme had three aspects to it:

5.9.1 Formal and informal rules

The data from the interviews appeared to support that collected in the survey. There was wide spread acceptance that there were guidelines, procedures and polices governing most aspects of clinical practice and organisational life. For example, typically we heard variations of the following response:

We have loads of policy and procedures for everything, but nobody really uses them cos, you just do what you have to do because that's what everybody else does, people know what should be done, the problem comes when things go wrong and then you get the book thrown at you (Micro).

In terms of how the formal rules are applied by the organisation, particularly in how individuals and groups are currently used, one set of guidelines in particular appeared to dominate the discussion. This was the work currently being carried out as Agenda for Change is implemented:

The Agenda for Change is demoralising and divisive, It's already setting people off against each other, people feel devalued and I think they will start to work to their competencies (Micro).

This type of response was common within the Micro participant groups. At the Meso level, the individuals undertaking the assessment work for allocating bandings there was a similar response:

Some of my staff see Agenda for Change as just another re-grading system and they feel demotivated. I think it will be a long time before that motivation comes back. It is hard to get them to see Agenda for Change as providing opportunities for the future (Meso).

It is difficult given this perspective to gauge the impact upon the 'good will' apparent in many of the reported experiences of the survey participants. If *Agenda for Change* continues to be viewed negatively, some of the reported help offered by individuals to others who were perhaps struggling will be lost. There are some short-term implications for moving forward on integrated working as individuals from different professional groups (and perceptions of what they bring to the multi-professional team) are banded together. However, it could be argued that as pre-qualifying training programmes start to reflect the competencies in the *Knowledge and Skill Framework* that the current difficulties will lessen.

At the macro level, there was a large amount of agreement about the relationship between the formal and informal structures and rules. For example, one PCT Chair noted:

We work hard at being a team and we enjoy success in spite of, and not because of, our formal structures (Macro).

5.9.2 Adding Value/Agreed Values/Being Valued

The widely supported view that PCTs added value noted in the survey data was not contradicted in the interviews, although there was no data specifically related to this issue. Likewise whilst many participants reported their organisation had a value statement, and that this was used in documents such as annual reports, there was little data that suggested this was something individuals used to shape their practice or how the organisation utilised them. Generally, there were two camps that reported on the theory in action approach as opposed to the espoused theory data from the survey, and this data showed a polarisation of experiences, for example:

Improving Working Lives hasn't really affected me, I think it's great if you have young kids or you're a senior manager, but it doesn't do anything for the rest of us (Meso).

Primary care is great for working mums as I can work flexible shifts, which I couldn't do when I was working in my previous job [at an Acute Medical Unit], and our team is good at covering for each other when you have problems or during school holidays when it can be difficult to get child care (Micro).

In terms of feeling valued, there was much data that showed individuals did not always feel valued by their managers (and by extension, by their organisations), for example:

I think we [Assistant Practitioners] are undervalued, overworked, and underpaid (Micro).

I don't think many people in our practice appreciate what I do… I became a Mentor about a year ago because I had such good experience

when I was doing my training, but I don't think people understand what is involved, you know working with students and making sure they get good learning experiences… I think they feel my life must be easier because I've got someone to help me (Micro).

At times I feel we are still treated as the doctors handmaiden by some of the GPs (Micro).

We don't get told anything; we are just expected to get on with whatever new change is flavour of the moment (Micro).

We have to work with 4 other PCTs and 4 Acute Trusts, and you just feel lost and insignificant in the greater scheme of things… I just keep my head down (Micro).

Possibly because of what individuals had experienced in preparing for Agenda for Change (see 5.9.1 above) there was some data that had possible implications for the future workforce. For example, one District Nurse reported that:

Its going to be harder still to get funding for courses in the future… and why will a PCT want to invest hundreds of pounds in you if you can then leave to get a better job somewhere else? (Micro).

This participant's observation casts doubt on how successful the wider NHS has been in getting the workforce to see themselves as belonging to a national health service, rather than just one particular organisation in the NHS. Additionally, this response casts doubt on how successful the wider NHS has been in providing integrated education and career opportunities.

5.9.3 Problem Identification/ Problem Solving

In the survey data, 65% A/SA that all groups in the PCT participated in being able to define problems or issues to be addressed. Participants in the case studies were less certain. Whilst some participation was reported, individuals often noted that this was experienced as being somewhat tokenistic, for example, one Team Leader noted:

I think the only way we will ever get a real idea of what the strategic aims of the PCT are is when we have a two way process that genuinely involves people at the Board level and the workers. At the moment everything is presented as a fait accompli or maybe you get asked for possible solutions, but it feels like the decision has already been taken. It just makes people suspicious of what the PCT is really wants to happen. So potential opportunities are missed because people feel threatened and don't believe what they're been told (Meso).

Likewise there was some evidence that individuals are being involved in decision-making, particularly where this involved service redesign. However, such processes, if not handled well, might lead to disinterest and a lack of involvement. For example, a Nurse Team Manager noted:

We are still struggling on with our service redesign but we are not making much progress with the decision making processes in terms of agreement on many issues related to the proposed framework of core contacts…over time it has become noticeable that many staff are no longer engaged in the process, seem to have lost interest and don't attend the meetings…I think there is a general feeling of disappointment

that after 16 months of work there is still little movement forward (Meso).

One Social Worker noted that it was often difficult to be involved and contribute to problem solving because of the different people and processes involved in being able to take a decision across different organisations:

We need more clarity about our decision-making processes, particularly joint decision making between different organisations (Meso).

This last point illustrates the difficulty there can still be in ensuring effective communication processes are in place to effectively support the development of integrated working.

5.10 Communication

The basic principles of effective communication involve ensuring that appropriate ways are found through which people can give and receive information effectively. This interactive process can be hampered or enhanced by individual beliefs, attitudes and behaviours. Each of these factors will, at different times, impact upon the effectiveness of communication processes between individuals, teams and between organisations. As Howarth *et al* (2004) noted, communication is one of the major indicators of effective team working and there is a plethora of evidence suggesting that where teams do not communicate effectively, then service fragmentation is likely to occur. It is therefore a somewhat strange paradox that effective communication, vital in clinical practice, often fails to be exercised in team working relationships. For example, one participant noted:

People need to spend more time talking about how to talk to each

other, we get taught how to talk to patients but not how to talk to each other (Micro).

The importance of effective communication was recognised, as were the difficulties in achieving this. For example, one Integrated Pathway Manager noted:

Integrated health and social care is about the multiplicity of different agencies that all use different languages…different languages are the reality of joint working, but make joint working more difficult (Meso).

This data, although concerned with the difficulties in joint working, is equally representative of many participants everyday working within their own teams and departments.

The communication theme provoked a great deal of strong feelings, perhaps further illustrating the level of awareness there was about the importance of achieving effective communication. The theme had four aspects to it:

5.10.1 Meetings, meetings, meetings

The survey data revealed that 69% of all respondents A/SA that in meetings held across the PCT, openness and respectful sharing of ideas is emphasised, but was not always experienced. At times, just being heard could take a long time. For example, an experienced District Nurse noted that:

I tried to get the rest of the team to think about Clinical Supervision as a way of helping us deal with the changes in our PCT, but this was rejected on the grounds that most people were too busy already to take on anything else, it took many months before anyone really listened to what I was saying and started to think about how we could do things differently rather then thinking about

*it as being something additional…
(Micro).*

Thus even where regular meetings were being held, these might not, in themselves, promote effective communication. For example one Community Drug Team worker, talking about her regular weekly team meetings noted:

I have known people to fall asleep at some of our meetings, they are so boring – much of the stuff talked about is not understood by others or it doesn't involve them... …people just turn off and it can be a bit of a waste of time…the client stuff is OK, you know who's doing what, where we are up to with each of our clients and all that, but anything else gets lost or doesn't get discussed properly (Micro).

Such meetings might not always lead to more effective team working. For example, one Community Psychiatric Nurse noted:

Our meetings are…well like multi-agency meetings but no real team working happens because we all get up and then just do our own thing anyway…care co-ordination was supposed to sort this out, but like the old CPA [Care Programme Approach] the reality is that most of the time it's still only a paper exercise…(Meso).

Although many respondents reported that they were often able to attend lots of regular meetings, some of these, (often those used to discuss organisational developments or changes) were viewed with suspicion. Typical examples of this view were (see also **5.10.3** below):

We have meetings within meetings, like they only tell you what they want you to hear (Micro).

Its like a game we all play, you go along and listen to what's being said and you know that anything you say

will be ignored but everyone has to go so management can say staff have been consulted (Micro).

Conversely, there was data that suggested that some individuals found some of the meetings they attended rewarding and helpful, particularly when these involved patient care. For example, one Student Nurse describing her experience on a community placement noted:

It was frightening when I got asked about what I'd being doing with my patients, but everyone was really good and they were really interested in what I said…and it made feel more like I was part of their team…it's different from when you get asked about patients on the wards…like there nobody pays you any attention (Micro).

5.10.2 Integrated Partnership Strategic Plans

We found that several PCT and other partner organisations published minutes of monitoring meetings that set out to monitor progress of joint initiatives, and these were available on the Internet. This appeared to support the evidence collected in the survey of active monitoring processes being set up and used on a multi-agency basis. However, the examples of these minutes we looked at did not specify the reasons for any lack of progress against agreed milestones, but it was clear that when joint projects had been set up (often with a variety of different aims and objectives that reflected the particular interests of each agency), monitoring meetings were built into the process of implementation and were being used as an attempt to assess progress. There was also evidence of how some of these strategic plans were translated into operational practices. For example one Team

Manager talking about her PCTs strategy on improving patient and Public involvement noted:

We are trying to improve communication between the hospital ward staff and the GPs and Practice Nurses… there are no real communication systems in place and often we end up having to ask the patient what is going on…our PCT red hot on involving patients in all service developments… and we can use this to get the new Passport system going…this will provide information to all the different groups…it's a bit like the single assessment but will compliment this as that has missing information (Meso).

So at one level there is evidence that shared and joint strategies are being translated into practice, although the effectiveness of such communication on terms of promoting integrated working is, as yet, untested.

5.10.3 Transparency/Availability of information

Many of the participants complained that they were often 'bombarded' with information from different parts of their organisation:

There is too much information, you are drowning in emails and so on, and just because it's been given to you, you are expected to understand it all (Micro).

As in **5.10.1** above, many participants remained sceptical as to the purpose of some of the information communicated and how this was communicated. For example, one Occupational Therapist noted:

Our information systems are transparent, you can see right through them. We have a weekly communication letter, but its like a glorified births, deaths and marriages…they [PCT Board Directors]

do not tell us anything useful, like why some decision has been taken or whatever, if you ask them for this they say they don't know… like as if you believe that (Micro).

Some individuals felt they didn't always get the information they required from their organisation. For example, an Audiologist noted:

I found out what our PCT was planning for the next 12 months by reading a pamphlet I found in our local Pharmacy, up to that point I didn't know what was happening to our service (Micro).

There was evidence, however, that many PCTs had developed information systems to communicate what was planned, what changes were happening and what the PCT had achieved. The team examined many PCT web sites and these often contained a range of information about the work of the PCT. Typically this included information on:

■ General Information about the PCT, clinics, location, other partner organisations and contact details;

■ Strategic Plans;

■ A Who's Who of PCT Staff;

■ Clinical Governance;

■ Feedback from Patients and Carers;

■ Minutes of meetings;

■ Notable achievements.

Some participants noted that incompatible information systems or information systems that were not shared impacted upon effective joint working and developing more integrated ways of working. So, for example, whilst PCTs had their own web home page, operational systems were often individualised to the PCT, with other partner organisations using their own systems. For example, one PCT Chair discussing the lack of

progress with the implementation of Locality Working noted:

Locality working offers great potential for developing more effective partnerships, but this potential is blighted by a constant lack of effective support services, for example IT services [Information Technology]… this lack of support means health and social care is not as integrated as it could be (Macro).

There was evidence, that within PCTs, there were communication systems developed to ensure information was made available to all staff. However, some data suggested that these systems did not always result in the information being translated into understanding and knowledge in a way that would inform practice. For example, one Nurse Manager noted:

We use a cascade system of communication, so I go to a meeting with other managers and then take that information back to my team, this can work well but it can be difficult to effectively communicate the overall plans for the PCT, my staff are only really interested in what affects them directly (Meso).

5.10.4 Feedback/Fighting/ Friendships

The survey data appeared to demonstrate very positive organisational cultures derived from general PCT staff experiences. There was a shared commitment to work inter-professionally with respondents agreeing that individuals keep each other appropriately informed about what they are doing, problems they experience and progress towards shared objectives. However, in the case studies, some participants provided a different view:

I would describe my team as being integrated, but the PCT is not, too many people work for themselves

and not for the wider organisation, but justify this by saying they are responding to patients needs. I think that most people don't want to change things in case they lose their job, so it makes you more defensive when you're asked to work with different people or in a different way (Micro).

The concept of 'being vulnerable', implicit in this participants account was reinforced by other data:

Everything comes down to money… however they dress it up, some of things that have happened here have been because the PCT wanted to save money although it's always denied of course…these days, if they can find someone cheaper to do your job, they will and that's it, you're out… maybe you get protected salary but you lose your status and end up doing a job you don't want to do… (Micro).

One participant who was a non-traditional member of the primary care workforce illustrated the other side of this story:

I think my role as a TAP [Trainee Assistant Practitioner] is seen as a threat to some of the other team members, and I feel some of them will try and block my potential (Micro)

Likewise there was some data from 'transient' members of the primary care workforce that revealed in some cases, primary care could be experienced as hostile and unpleasant, for example, one Student School Nurse noted:

There was a lot of bitchiness and I was not made to feel very welcome…I had a big problem talking to my tutor about the placement, and was just glad when it finished and I could move on… (Micro)

This data provided a mixed picture of

different organisational cultures. To some extent, this is not an unexpected finding. Many of the PCTs were new organisations made up of pre-existing small organisations. As groups (or organisations) are brought into existence, they will often go through a range of different developmental states, described as *forming, storming, norming and performing*. We argue that this data illustrates that these various states are being experienced by participants' repositioning their roles and possibly this requires further investigation outside of the StF project. However, a crucial element in understanding group working is the need to recognise the importance of gaining a working awareness of the roles, backgrounds and responsibilities of the various team members as they are brought together for a unified purpose.

5.11 Role Awareness

We argue that to work well in multi-professional team, knowledge of different disciplines (rational) and knowledge of people (personal) needs developing. Understanding group and inter-group dynamics is equally important, for example, the different way languages are used and the different models of practice being pursued. The acquisition of such knowledge and understandings is the vital ingredient to promoting not only an effective learning culture, but also effective integrated working.

The survey data provided a mixed picture of experiences. There was data that suggested there were high levels of agreement over how the role and work of other professions is understood and reflected in everyday practice. However, some respondents questioned whether, given the rapid pace of changes in primary health care, any shared understanding of what the services were aiming to

achieve existed, for example a Health Visitor noted:

We have discussed what is now meant by 'public health practice' in our team, and we couldn't agree, most of our work is with individuals or maybe groups and rather than being at a community level...I am not sure how we gain a better understanding of what is expected from us now (Micro).

Despite there being a confusing conceptual understanding of what service provision involved, the majority of respondents saw value in learning from others. However, there were hints that this was more aspirational than a reflection of current experience. For example, there were very few that had participated in any form of multi-professional, multi-agency training or development activities. In the second stage of data collection, these experiences were often congruent with the survey data. For example, one Allied Health Professional Manager noted:

Role awareness raising is difficult because often practitioners work alone and also because there can often be different perceptions of what each professional should be doing within individual professions themselves (Meso).

This data illustrates a barrier to integrated working that confirms what the survey data revealed – that only half the respondents A/SA they clearly understood the roles of staff from other professions that worked in their organisation.

5.11.1 Shared understanding of roles

In the case study data, participants appeared to recognise the importance of better understanding the roles of other workers, but also revealed the

difficulties in achieving this:

I think there are too many assumptions about different professional roles, even within the professions (Micro).

Putting names to roles helps, but just knowing faces and who does what helps you know who to talk to when you want help with something (Micro).

Given that patients should receive a seamless service (well that's the vision), it's strange that not many others in the PCT understand my role. I think that many still see me as being unqualified (Micro).

Participants also described the difficulties there were in being aware of what different individuals working in other organisations did:

I find it difficult to know who is my opposite number in partner organisations, even within my PCT it can be difficult, for example Central Services are divided up into smaller services and you never know who you're talking to...it is even worse when you involve voluntary organisations or the private sector, making continuity of health and social care difficult to achieve (Meso).

The consequences, in terms of the patient experience, of this lack of role awareness is well documented, for example, Howarth *et al* (2004) noted that effective referral systems can only be achieved when a shared understanding of different professional and organisational roles exists. This assertion was supported by the reported experiences of the participants, for example, a Specialist Nurse Practitioner noted:

We need better referral processes, you know agreement on who should be referred to what team member, this would reduce inappropriate referrals and would make life less

stressful for all… I've known many patients who get caught up in the referral loop and never really get what they need (Micro).

likewise, a Service Manager noted:

Government targets force different organisations to come together, but people still have different ideas about what they should be doing, for example, in my PCT Ambulance staff and nursing staff have very different ideas about what unscheduled care involves and how we should be providing services even though we are allegedly both working for the same patients (Meso).

There was, however, evidence to suggest that as well as recognising the need to better understand each other's roles, practical attempts were being made to address these issues.

Within all clinical settings today there is a need to look at boundaries and a multi-disciplinary approach should mean handing over within these boundaries, professionally as well as practically, no one can do and be everything. I think the new common assessment we are using in children's and young peoples services is a good example of what can be achieved, although I think it does rely on their being an effective communication protocol in place, we haven't quite got there yet (Macro).

5.11.2 Generic versus Generalist Working

In the survey data, there was a clear desire for primary health care services to become more specialist and less generic in terms of the services provided. Nearly 80% of respondents felt that to make this possible, the development of a new generic primary health care worker would be required. Such a development was seen to enhance the existing roles of the more traditional members of the

workforce. Whilst in some PCTs such developments have yet to be made, in some, the development and use of the Assistant Practitioner have begun to emerge as the fledgling generic primary care worker, able and equipped to take on some aspects of the more traditional primary health care worker's role. The experience of some of our participants working in this role would appear to suggest there is still a long way to go:

I felt when I had started on the course to become an Assistant Practitioner it was to become a generic worker, but in reality, at least in primary health care this has not been the case, for example, employing AP's has not resulted in a decrease in the number of professionals going into a person's house (Micro).

I thought that the Assistant Practitioner was the 'ideal' in terms of being the complete generic worker, but in reality this is not possible as too much specialist knowledge and skills would be needed, if we had this we would be a super generic worker (Micro).

Although the possible reasons for this apparent lack of progress are explored below (see **5.12.4**.) the current state of play appears equally frustrating to other workers. For example, one District Nurse noted:

The original vision was of a generic worker going in to provide a holistic assessment, …and even though skills exist to meet most of these needs with the new workers, they are not being used…referrals for specialist needs are still made and you end up being just as busy…(Micro).

Perhaps the experience of another participant points to a way forward:

The Assistant Practitioners are the way to achieve integrated care. We

have started from the point of developing job descriptions and competencies in terms of what we think these new workers could do, and then we recruit them and train them up. Otherwise you just get a higher paid Nursing Assistant and nothing changes (Meso).

This data reinforces the need to consider the use of these new workers through the adoption of a 'blank sheet of paper' perspective rather than thinking about using them as a 'replacement' or 'substitute' for members of the existing workforce (Warne and McAndrew, 2004c). Such an approach would help ensure the following experience, noted by a disillusioned Assistant Practitioner, becomes a thing of the past:

Sometimes I think the Assistant Practitioner is just cheap labour, it cost less to do visits etc, we are not really anything different from health care assistant's (Micro).

An important factor in achieving progress in this area, and one that was alluded to in 5.9.1 above, is gaining an understanding of how organisational politics inhibit or enhance such changes.

5.11.3 Organisational politics

Organisational politics can be experienced as different organisations try to work together in achieving a joint approach, and at different levels:

We are not tackling the Public Health agenda, what we do is not really working well mainly because of a lack of any real partnership, disputes over cash, the personalities involved and because we essentially can't agree a common agenda (Macro).

I think we have to become more aware of how some of the new approaches to healthcare work such as Sure Start need to be embraced

more positively if we are going to have a future as Health Visitors (Micro).

But more often organisational politics is associated with the dynamics in play within an organisation. The data collected in the case studies revealed a pragmatic awareness of how organisational politics could be experienced by individuals and teams. For example, a Nurse Manager discussing why some of her nurses responded negatively to having to take students noted:

People need to think more about the students they get, they need to recognise them as being future colleagues, and remember that what they teach is what they are going to get in the future (Meso).

On a wider level, the often rhetorical nature of organisational politics, was also revealed in the experience of participants:

I think we have a tick box approach to integration…we invite representatives from social services to our meetings but its just because we have to, not because we want to (Micro).

People in our PCT have no idea whose in charge or what the corporate plans are (Meso).

At a more practical level, an Assistant Director of Human Resources noted:

People don't like to work together… in the Green acre Project [pseudonym] for example, we experienced lots of resistance from different professionals although this was not unexpected… the universities need to forewarn students that they are going to experience this as they move out into practice, its no good pretending anything different (Meso).

The suggestion that organisational politics, in this case, in the form of resistance to change, being part of everyday practice has some appeal. It resonates with the argument made in **5.9** of the need to bring together the rational and the personal in terms of achieving a better understanding of the realities of organisational life. How such a rhetoric-reality gap can be bridged is considered further in Chapter Six, but a starting point, particularly given the data presented above, suggesting integrated working is better 'caught' rather than 'taught' (**5.5.1**), might be to consider the value of learning from others and where and how this can be facilitated.

5.11.4 Learning from others

Learning from others is an explicit requirement of the Knowledge and Skill Framework (Department of Health, 2003). This requirement advocates the development of learning opportunities that underpin their own and others knowledge and practice. Such learning opportunities should be developed both within individuals' practice organisation as well as seeking out opportunities elsewhere (university courses for example). In the survey data, 88% of respondents A/SA that individuals actively seek to learn from the experience and knowledge of others working in their PCT. In the experiences of some of the case study participants who were working in primary care as part of their training, this appeared to be true. For example, a Junior Doctor noted:

I learnt a lot from the Midwives, they were good at showing you the whole patient journey, it taught me that to be a good Doctor, I'd need to make sure I knew more about the patients life, not just what brought them to the surgery (Meso).

Other students did not always have the same experience:

I think you have to be very assertive when you go on placements, I think that a lot of the trained staff don't like us students, so unless you are really pushy you go there knowing nothing and stay knowing nothing (Micro).

When I went out with the CPN, he wouldn't let me go in his car, he was dead funny about…so I had to use my own and I kept getting lost driving around and around… I hated being in the community, for me it was a waste of time (Micro).

A more methodical programme is required…often things were chaotic…staff in the practice areas did not know what to do with us…I think most Assistant Practitioners needed clear, concise information and guidance around assessments, what's needed, how the college work is supposed to be used in the clinical placements and so on, and this information could be provided in more user-friendly way…the college stuff was too hospital based for working in primary care (Micro).

It can be argued that these experiences might stem from the often-traditional pedagogical nature of the teaching and learning relationships:

There is a dichotomy of languages used in terms of training, this works against individuals from different professions gaining an understanding of the basics, this problem is compounded for students going out to practice because there are so many different guidelines for practice that they have to be work to (Meso).

For more permanent members of the primary care workforce, the experiences reported appeared different, with the more informal

aspects of organisational life again coming to the fore:

The key thing for me that facilitates learning is being recognised as being part of the team and having what I do valued (Micro).

You need a supportive culture, which is knowledge based to really make learning through work effective (Meso).

However, doubt is raised by the survey data as to how much learning is undertaken through either formalised or informal approaches. For example, although 98% of the survey respondents A/SA that wherever practical education and learning opportunities should be shared by different professions, very few respondents had actually participated in any such activities. There was little evidence of vibrant communities of practice that could support such learning and development despite the survey data suggesting 67% of respondents worked in a PCT that actively promoted inter-professional training for integrated working. Data presented in the following theme provides the basis for exploring the issues involved in why the rhetoric of what is espoused remains so different from what many participants in the case studies experienced.

5.12 Personal and Professional Development

The need for all practitioners and managers to undertake continuous personal and professional development is well documented. Howarth et al (2004) note the importance of ensuring such developmental opportunities are available (and used) to promote integrated service approaches. This theme had six aspects:

5.12.1 Life Long Learning

In the survey, 86% of respondents A/SA that life long learning should be a central feature in the development of the PCT and service improvement activities. However, data from the case studies again provided a mixed picture as to how this was being carried out in practice. For example, we often found very contrasting attitudes to what life long learning involved:

You have to take responsibility for your own learning; nobody is going to do that for you once you stop being a student (Micro).

Its all about life long learning and CPD and all that rubbish, but when it comes down to it the whole thing is very restrictive, you can't really do what you want to do, only what you are told you can do (Micro).

I decided a long time ago that I needed to become a life long learner, it doesn't just happen you have to work at it… and I like practice based learning best because it comes out of the need to change practice and also drives practice change (Micro).

Informal learning is as important as formal learning (Micro).

I thought I'd be too old to start doing the degree [Foundation degree], but they took me on… I wanted to develop a more holistic role, and this helped me… I'm glad I was given the chance… I found the whole thing very rewarding (Micro).

I couldn't get any time off to do any training; there's no such thing as protected time for nurses, until we get this, like the doctors do, we're always going to be lagging behind (Micro).

The last participant's observation is interesting when set against the context of equal opportunity

legislation, and the various national competence standards frameworks. Organisations are being required to develop continuing professional development approaches that promote all staff having equal access to all training and development initiatives. However, there was also some evidence to suggest that some participants were happy with this situation:

I think its hard to work in a service which is changing its function, there are so many changes right now… and we are trying to get established in our roles, getting to know the new staff, the service still has to run, patients still have to be seen, and CPD, if your looking priorities is right at the bottom and is likely to stay there unless someone pushes me (Micro).

There was more evidence that many individuals were trying to develop learning opportunities within and outside of their organisational area of responsibility, although at times there did appear to be a lack of organisational commitment in supporting such local initiatives.

I have been offered lots of opportunities to meet with staff from social services, and I try and make sure all my staff get similar opportunities… and although we have done this, for example District Nurses working with CAT [Community Alcohol Team] we haven't really carried on doing it on a regular basis due to a lack of money for backfilling… I don't think my boss sees this as proper training… but I keep trying (Meso).

I had to pay for my own degree, and it was really hard to get time of for the college days… my trust were not really that interested in whether I got a degree or not (Micro).

I have started to develop and use my portfolio to shape my personal development, it took me a while to start to write down all my experiences in a reflective way, but now I've a record of where I have come from, and its something I can use to plan where I want to go…nobody has asked to see it but I am not sure if I would like them to see it (Micro).

However, one participant, an Occupational Therapist, talking about her experience of personal development, and what motivated her, revealed a wider issue:

As well as the personal stuff, I think it is very important for professional development and also, I think as a profession, it [CPD] will make Occupational Therapy stronger because we will become more aware of ourselves and we need to make other professionals and people aware (Micro).

There was also evidence that in some PCTs work is being started on developing systems that will promote life long learning, and promote this in a way that connects directly to the organisational current and future needs, for example, a District Nurse Manager noted:

Skills and knowledge is context driven, integration is also about this and there is a need to co-ordinate working practices at one level and process a map what is going on at another level so that you can work towards better integration …its about managing the here and now while at the same time managing a potentially different future (Meso).

This participant's observation that "skills and knowledge is context driven" 'fits' well with the underpinning approach to the Knowledge and Skills Framework and other similar approaches to ensuring national competence standards are

being used to inform, and develop personal and professional development activities.

5.12.2 National competence standards

There was wide agreement within the survey data about the need to standardise how continuous professional development activities would be recognised. Some 93%

A/SA that future educational approaches should be based upon national competence standards. As Howarth et al (2004) note, there are now a wide range of such frameworks available. The Knowledge and Skills Framework featured often in case study participants accounts, possibly because of its link to Agenda for Change (see also **5.9.1** above), for example:

I think the KSF [Knowledge and Skills Framework] is a double edged sword, you will be forced to work to whatever competencies the PCT think you are worth, I don't believe it will do everything we were told it would do (Micro).

It's supposed to be used to get you through the gateways and move up the bandings but I'm sure they won't make it easy for us to do that (Micro).

Health Care Assistants in primary care have no career structure if want to continue to become 'something' with a status, for example a Practice Nurse, you can't… I am not sure the skills escalator thing really exists (Micro).

You used to be able to be a rubbish practitioner but if you could spin a good story and get things to look good you would be OK, you won't be able to do that now with Agenda for Change (Micro).

I think this new process is just as bad the old system… you could never prove anything just by a certificate,

how can they judge if you are competent or not it's the same thing (Micro).

However, there was also data that recognised that the use of such frameworks needed to reflect how organisations were working at integrating competence frameworks with other organisational processes, particularly those to do with governance and performance management:

We have been working hard at making sure all our governance processes, corporate and clinical are in place and that staff understand how these need to work together to ensure effective governance, staff development and succession planning are part of this work… and although we have not met all our targets we are getting there at long last (Meso).

One problem we have here is that a lot of our front-line staff work around specific issues only as and when its seen by them to be necessary… so our task is to work at getting this group to understand how what they do is important in achieving the overall PCT goals… if we can do this then we have a much better chance of developing effective performance management processes that can more appropriately feed into service developments and changes (Macro).

This data illustrates the need for organisations to foster a culture that allows for individuals and teams to develop links across their organisation and by extension develop links with other partner organisations.

There was evidence that some PCTs were already actively engaged in developing such a culture. For example, at one collaborative event, the participants were asked to discuss the question of what essential knowledge and skills are considered vital to deliver effective integrated

health and social care. The responses included:

- *Good strategic planning and clarity of vision (across all levels of staff);*
- *Organisational development, workforce development and team development;*
- *Robust communications;*
- *Specific skills such as customer care, effective team working, finance, evidence based practice, IT and communications skills.*

Some of the issues raised by these responses are further explored in the data used in the remaining aspects of this theme.

5.12.3 Professional Networking/Development

Within the survey data, a strong commitment to individual professional groups was noted. Such commitment, whilst being useful in terms of facilitating a wider awareness of different professional activities and how these interact with the professional activities of others, might also result in the continuation of 'silo' thinking. Generally though, most data from the case study participants revealed a healthy picture of this type of activity being used in various ways within the PCTs:

I use my manager to agree how my time is used and to ensure that non-clinical work is given equal value. This works well and allows me to legitimately work on things that perhaps normally I wouldn't… at the moment, I am working with a group developing an integrated pathway for the dying, and this is a really good way of sharing best practice, you find out a lot about what's going on out there, who does what and who should be involved… when we finish this project, I think the pathway will be good for the patients and it will

allow the staff involved to see the outcomes of their effort for once, you know, to be able to say I was involved in developing this… which will be a great motivator (Micro).

What we need to do is develop a much better understanding of what our local needs are and use this information more effectively in our planning processes… I had to do a local needs analysis as part of my university work and I was surprised at how much I didn't know about the area I work in… I had to talk to a lot of people to get this information, some of whom I didn't know even existed before… when you think about primary health care you tend only to think about the colleagues you work with on a day to day basis, but there's loads more people involved… this type of activity should be a regular part of everyone's work (Micro).

Integrated pathways help ensure integrated working, all of ours are regularly reviewed by the Whole Systems Group who help provide the analysis of whether each pathway is working or not (Meso).

The Whole Systems Group referred to by this participant was a model that appeared useful in promoting networking. It was made up of representatives drawn from different professional and non-professional backgrounds, all of whom, worked at different levels of operation within the PCT. The group had a structured programme of work, and reports of this work were said to be widely disseminated across the PCT.

Other participants also recognised the importance of introducing the concept of networking at an early stage of individual preparation for practice. One Nurse Lead, for example, noted that:

We need to get students better prepared; they need to be able to see the bigger picture, like the importance of governance processes to their everyday practice (Macro).

There was a minority view that networking, as a method of contributing to individuals' personal development, was not valued:

Networking is down to individuals, so it either works or it doesn't… there is no support for this in our PCT (Meso).

I'm not sure what networking is, but I think it's the way some people justify going on course and having a good time, and being paid for it (Micro).

Incompatible information systems were also seen as a barrier to more effective networking across different organisations (see also 5.10.3 above). One Operational Manager discussing capacity management problems within their PCT noted:

We have real problems with our information systems not being robust enough to provide us with up-to-date and useful information when we need it. This slows decision making processes down, and it doesn't help when we look at service developments… for example, we are working on changing the focus of Health Visitors and District Nurses to work more with the Public Health agenda, but even basic information about what's going on now can be difficult to get, making planning and changing things very frustrating… and we are not alone, some of my colleagues in social services have the same problems, so when we try to work together it can be like the blind leading the blind (Meso).

As is noted in this participant's comments, traditional roles in primary health care are changing as organisations seek to develop more

integrated working. Likewise, new workers have been introduced, whose roles are intended to compliment the more traditional primary care workforce.

5.12.4 New workers

The survey data revealed that generally, new workers coming into primary care were welcomed as an additional resource to the traditional workforce. In particular, it was the Assistant Practitioner role that most participants were familiar with:

Trainee Assistant Practitioners and Advanced Practitioners are being used in our PCT to release the talents of other staff; there are more opportunities now to develop new roles. I think part of the attraction of this for some staff is they see it as a way to avoid the mundane aspects of day-to-day practice, but it could be a case of the grass is always greener (Meso).

However, when the Assistant Practitioner participants were asked about their experiences, it was clear that many felt dissatisfied with what they were doing, and how the role was being viewed:

The title hinders, nobody knows what an 'Assistant' Practitioner means... ...The tag 'assistant' really causes confusion amongst other staff and the public over what we do, I don't think the role has been properly established to know what it is (Micro).

I don't think the Assistant Practitioner potential has been fulfilled and my role is still limited... the role is prescribed because we are neither registered as a professional and because the Practice Nurses still does lots of the work we could do... so I think that the full range of skills I've obtained are not being used... I feel I'm qualified within my own role, but

over qualified for the job (Micro).

It is clear that the role is still not clearly understood. The data noted in 5.11.2 above revealed the need for new thinking in terms of how these new workers might make an effective contribution to the future primary health care workforce. The Assistant Practitioner participants were frustrated by the apparent lack of such 'blank sheet' thinking:

I've found that I am over-trained for what I'm currently doing, but this is not recognised and I am still not allowed to do some things... professional registration would help although I think we are still seen as being a threat by some professionals (Micro).

There is a big gap between 'where we are now' and 'where we could be' in relation to what our training and education has enabled us to do (Micro).

It would be easier to become a nurse at least in terms of energy, effort, and the level of performance and the academic requirements of the training... and at least people know what nurses do (Micro).

This is clearly an area that needs a great deal more working on if PCTs are to benefit from the development of these new workers. The somewhat ad hoc approach to the developments to date, as experienced in many of the participants' accounts, will ultimately be counterproductive.

Those participants engaged in thinking more laterally about how such new workers could be more effectively used, are doing so in a generally systematic way. For example, a Specialist Practitioner working in children's community services, talking about being engaged in developing a new service provision in her locality for children confined to

their homes because of a chronic illness notes:

We originally started by looking at who is working in this area now and what resources did they represent, and to some extent we were forced to do this because there was no new money for the service, even though everybody agrees there is a need for the service... anyway this did not get us anywhere, so we then moved to thinking about what type of service should we be providing, and eventually we got to a point where we are engaging all stakeholders in this process, including the children themselves. It's taking a while, but we hope this way we can say what the new service should being doing and only then make decisions about how and who should be providing this... a lot of the things the children said they wanted could be provided by unqualified staff, and that surprised us because we thought we knew what was required from our many years of experience (Meso).

Whilst this participant is referring to developing a relatively specialised service, it is interesting to note the movement from the professional as the expert to professionals recognising the expertise of the patient in her account. Likewise, there is a movement from a largely unstructured approach to working on the service development to one that becomes more inclusive and systematic in terms of involving all stakeholders. We argue that just as the new workers and new service developments would benefit from a more systematic approach to decision making, existing workers and existing services would benefit from a similar approach. In the survey data, there was evidence that currently such an approach is not often used in planning many professional development activities. What

evidence there was of systematic approaches appeared largely dependent upon enthusiastic individuals.

5.12.5 Education Training Needs Analysis (ETNA)

At a collaborative event facilitated in one PCT, the participants were asked to discuss the question of how organisations should determine the specific workforce needs with regard to knowledge and skills. The responses (which showed a significant similarity across all five groups) were:

- *Consultation process within the organisation and involving users and carers;*
- *Training needs analysis linked to business planning;*
- *Strategic planning and sharing across organisations;*
- *Respecting diversity;*
- *Identifying skill mix and gap analysis;*
- *Appraisal systems.*

This data presents an approach that would require a great deal of effective leadership and one that would require managing at all levels of the organisation. In some PCTs, there was little evidence of this occurring. In the survey data, 85% of respondents A/SA that their PCT encouraged them to pursue their own personal and professional development, although not all case study participants experienced it in this way:

I think you should be able to choose what courses you go on and not just be told what course the trust wants to send you on or not (Micro).

If I wanted to do a acupuncture course or something like that I would probably have to pay for it myself as in my PCT, I'm not sure I would be able to persuade them that it was a

legitimate course… and I know there is research to say that it can be used in all kinds of conditions now, but it would still be seen as being too wacky (Micro).

Just over half of the survey respondents reported that requests for training and personal development are discussed with their PCT education and training manager before a decision is taken to support the activity or not. Perhaps this further illustrates the lack of organisational processes available to provide effective leadership and management of the acquisition of the skills and knowledge required by each PCT.

Indeed, funding for developmental activities, as noted in the participants account above, was a bigger issue for many participants:

Its quite a problem getting permission to go on a course, its the luck of the draw and usually if there is any money available, which is not often, whenever things get tight, the training budget is the first to get frozen (Micro).

If you have all your core competencies then it's difficult to get funding for any training (Micro).

We had a PCT wide training event where lots of things were raised, but so far nothing has been done about any of them, it still a case of being in the right place at the right time if you want to get money for courses (Micro).

I was told nobody could go on any more conferences after Christmas because the funding had been frozen because we had to make savings (Micro).

The need to develop a structured approach to joint training both within individual organisations and partner organisations was recognised:

If staff have their jobs enriched there is a need to backfill through training others and increasing the skills of others. I believe this should be done in a planned way so that the overall workforce becomes more skilled and flexible. If it's done on an ad hoc basis people will soon get fed up and lose interest (Meso).

Much current training exists in silos within organisations and across our partner organisations… we need to develop joint training programmes if we're ever going to integrate health and social care work (Macro).

There was evidence that in some PCTs a more systematic approach was being undertaken, with hard and soft systems approaches being used:

We have started to actively promote processes of role design, so all vacancies have to be reviewed in terms of role and responsibilities, personal specifications and so on before they can be advertised, and as part of our approach to Agenda for Change, we are slowly working through all staff job descriptions as each group of staff comes up for review (Meso).

Shaping Working Lives helps create a culture of fairness and equal opportunities, which includes the recognition of providing protected time for non-clinical activities such as training and personal development… but you have to be careful about raising unrealistic expectations of what is possible… lots of other things have to be put in place first (Meso).

Participants in the case studies were also asked about their experiences of undertaking courses in universities, often where these were funded through Continuous Professional Development (CPD) monies and which also required organisational commitment in terms of secondment or clinical placements.

5.12.6 Ivory Towers

In the survey data, some 64% of respondents A/SA that current educational and training courses provided by the universities are effective in meeting current service needs. The case study participants were not always so sure:

I still think there is a real problem of ensuring what gets taught in the university matches what practice requires, this is long standing problem and I don't see anyone trying to resolve it (Macro).

The course work at XXX is too academic and obscure for TAP's… I've struggled sometimes about knowing what we get taught on the study days has to do with what I do in my job (Micro).

There could be much better communication between XXX [University] and our PCT but this could be better both ways… it would help if there was better availability of staff at XXX to respond to queries etc (Micro).

The last participants account also points to an issue around the relationship between the universities and the various organisations they work with. At times these concerns appeared to be about the practicalities of working together in supporting students, but at other times, the data pointed to a more fundamental range of issues to do with the changing nature of educational processes. For example, one Practice Nurse noted:

The universities should be the ones to provide underpinning knowledge… it is still the case that on the job training is OK but clinically it doesn't count for much… unless you can produce the piece of paper everything else you do is seen as being second best (Micro).

This data is somewhat ironic given that the quality of many university programmes is now judged according to the ability to deliver programmes grounded in practitioner experience.

5.13 Practice Development and Leadership

It was Swanson (2000) who noted that effective leaders are both life-long learners and teachers and are seen as a crucial element in the development of integrated working. Likewise, leadership features in all the competence frameworks (Howarth et al, 2004). Effective leadership is critical at all levels of the organisation, although some of the case study participants clearly did not recognise the importance of this assertion. For example, one Health Visitor noted the following:

Many of our senior managers don't have a clinical background and this makes understanding what we are trying to do more difficult (Micro).

Setting to one side in this participants account, in which management and leadership have been conflated as being one and the same concept, it also illustrates where many individuals see the locus of leadership being at the top of the organisation, or a specific designated role (as within the context of training and education):

I don't think we have a training lead in our PCT, if we have they have never asked me what I want or need (Micro).

This data is represents a familiar approach to leadership. For example, at one case study workshop, participants were asked to discuss and agree three key organisational factors that might support how they and their team could work in a more integrated way. Although the responses were interesting in terms of what emerged:

- *Integrated information sharing and IT systems sharing (x 2 groups);*
- *Shared location (geography);*
- *Employment by one organisation;*
- *Shared and agreed strategic plan;*
- *Shared records;*
- *Group/joint supervision;*
- *Continuity of practice;*
- *Common workplace;*
- *Single point of access to team;*
- *Single assessment tool;*
- *Joint training;*
- *Pooled resources;*
- *Shared philosophy.*

There was not one group that chose effective leadership as being a key organisational factor in supporting their team to work in more integrated ways. When this omission was pointed out to them, the response was that the factors noted above would only happen if senior managers were doing what they should be doing in providing effective leadership. Whilst there is an element of truth in this assertion, it does appear to miss the point about who should be involved in providing effective leadership. There was little recognition of such training initiatives as *Leading at the Point of Care* **(Reference needed)**, although such programmes appear to be widely available to health care organisations. We argue that apart from possibly being employed by one organisation and having a common workplace, all the other factors noted above are within the individuals and their team's area of ability to influence and change. It was disappointing to find such limited understanding as to what being a leader and providing leadership might entail.

The same group were also asked to consider what three key educational

factors would be required to prepare practitioners in their team to work in more integrated ways. The responses included:

- *Joint training and development activities (x 2 groups);*
- *Protected time for learning and development, group training, team building, away days, identifying skill deficits (x 4 groups);*
- *Training in organisational structures/functions;*
- *Shared learning;*
- *Structured Professional Development;*
- *Trust research interest group;*
- *Fairer access to resources;*
- *Developing an awareness of team dynamics;*
- *In-service training (MDT);*
- *Role awareness/mutual respect;*
- *Use of a common language.*

Some of these factors have been explored in the data presented above; the remainder are explored in the following five aspects of this theme.

5.13.1 What worked – and what didn't

The top three rated approaches to inter-professional training and education in the survey data were:

- *Sharing professional experiences;*
- *Multi-professional problem solving;*
- *Sharing and agreeing best practice.*

These were generally confirmed by the data collected in the case studies. For example, one Nurse Team Leader's response was typical, she noted:

We've had a few away days where we've looked at where we want to go and where we are now and how

we get there… these worked well and they were good because people from all over the PCT took part… we were able to hear about what other people were doing that worked well, look at all common problems we all face but think its just us… and best of all, it was just good to get away from ringing phones, clinics and just have time to think (Meso).*

There was some data that suggested that such approaches were not always very successful:

We were treated more like students not like experienced professionals and the practical arrangements were sometimes poor… and generally the input you got was very disorganised (Micro).

Cascade training doesn't work as at each step down the line you get a watered down version, it's like Chinese Whispers (Micro).

Other areas seen as not being successful in the survey data related to:

- *Ensuring a user led focus was maintained;*
- *and organisational boundary crossing.*

These were confirmed in the case study data:

We talk about being client centred but I've never seen a patient at any training course I've been on (Micro).

Practice Based Commissioning is proving to be problematical, and its not leading to integration, for example, in some of the planning days we have struggled even to understand the general principles, who should take responsibility for what, how do we build up joint expertise in being able to deal with a world where the familiar organisational responsibilities are up for grabs, and who should be taking

a lead over what (Macro).*

One of the problems we have which impacts upon integrated working is the minefield of different terms and conditions of employment, if one of our staff works in a service where Social Services is the lead organisation, there are all kinds of problems about pensions and pay differentials, who takes managerial responsibility or provides professional support… we have tried to resolve this through agreeing general principles, but these can be hard to put into practice other than at a individual level (Meso).

These approaches to inter-professional working appeared to be provided in response to what might be considered a macro level policy objectives of improving collaboration and partnership working at the individual level, such activities were largely guided through the Personal Development Review (PDR) or Appraisal processes.

5.13.2 The ubiquitous PDR

In the survey data, 60% of respondents reported having annual personal development reviews. However, when this data was examined by level, there were differences. At the Macro level, 80% claimed to have had a review in the last 12 months compared to only 40% of those working at the micro level. There was clearly much activity in regard to this in the data from the case study participants. For example:

In my PCT team we have achieved a 100% of staff having had a PDR this year, I think the drive for this was for us to become a learning organisation, we've had some work done by the Modernisation Agency, but I am not sure where the rest of the PCT is up to (Meso).

I have just had my appraisal done,

and I think they are a great opportunity to let your appraiser know what you want to achieve and how you feel… it was agreed with me that I needed to develop more in some areas, one was in diabetes practice, but the other was in how I communicate with other staff, some people feel I can come across as being aggressive, although I was not aware of this… but this is the first one I've had, and I think I only got this because of Agenda for Change (Micro).

However, there was also data that pointed to some underlying issues in how PCTs were approaching these processes, some of which were positive in terms of what the experiences represented conceptually (although, not always expressed in this way by the individual participant) and some not so. For example, one Head of Allied Health Professionals noted:

I have just had a 360° appraisal for the first time, which I have to say I found quite frightening… its when you find out how people at different levels to you view you and what you do that makes it interesting, you are quite happy going along believing you are a fair manager and you have this view of yourself which gets challenged, I guess it could be quite risky and I guess you have to have a lot of trust in those running it (Meso).

Whereas a District Nurse Team Leader noted:

All training these days has to be linked to your PDR and staff have to demonstrate what competencies they get by going on it, if they can't do this they don't get on the course… on one hand I think this is long over due as it can be difficult to judge the value of sending someone on a course or to a conference, but on the other hand I can see some of my

manager colleagues using this as a reason not to release staff (Meso).

and a Occupational Therapist noted:

Since Agenda for Change we can all demand a PDR, but I am not sure who would do this if we all asked for one… it would be interesting to see what would happen if we all did (Micro).

There was a clear recognition to ensure that PDR systems become a fundamental factor in future training approaches. Macro and Meso level participants most often noted this:

In our PCT, training and the PDR system is not linked enough… I believe that individual development plans are a potential area for looking at achieving integrated working (Macro).

The desire to address these issues comes through strongly in the data, and in both the survey data and the case study data a number of essential and desirable approaches were noted.

5.13.3 Some Essential/Desirable Development Activities

Essentially, having protected time (for self study), time out, away days and similar developmental activities were seen as being both essential and desirable by both the survey respondents and the case study participants. There were many examples of what this could involve and why these approaches were seen as being essential and/or desirable. For example:

There needs to be better mapping of the skills needed for a role within primary health care and study leave (time out of work) needs to be formally recognised, at the moment I feel the academic work has to be 'fitted in' around clinical/work responsibilities, and no allowance is made for this (Micro).

There is no back fill built in for cover when someone goes on a training course, this is needed if staff are going to be able to develop… perhaps away around this is to shut the services for half a day, like banks do, and then we can all get away together (Micro).

I did go on a away day with all our GPs and practice staff, but it was at the weekend and although I am glad I went it was difficult at home with the kids (Micro).

We need protected learning time, there are loads of courses available, but you can't go on them because you can't be released (Micro).

Practice based learning is essential as a way to develop the team, you can focus on real life situations and problems, and it helps you understand your role better and the rest of the team, I did some time at a Walk in Centre and this is the way they taught us. I think all the staff had up-to-date knowledge and you don't always get that (Meso).

It is difficult to facilitate training within a professional group and even more difficult to extend this to include other agencies, even though we know we should be doing this… part of the problem is that we have to attend so many mandatory courses that there is no time or staff to send to other training… there should be a better balance of mandatory training and developmental training opportunities, both are important so why aren't they treated as such (Meso).

There is some data that also point to other related issues, for example, one Training Manager noted:

Training for integrated working is about process, and so all such training should be developed in a strategic way first, even if it is delivered separately for each

profession later on… having a shared strategic vision is the important first step and achieving this needs to involve all stakeholders whether they work for us or not (Meso).

Likewise, a Service Modernisation Manager noted:

Pooled resources is the key in deciding what training to invest in… but you have to have a lot of inter-agency trust for this to happen… the trust comes out of hard evidence, but because we are so poor at evaluating new initiatives I guess it will be difficult to get this… we need to make sure that PDR plans are properly evaluated for against agreed targets and then we can ensure a more effective system is used for prioritising resources (Meso).

5.13.4 Being prepared for change

Despite change being a constant feature of everyday practice, in the survey, only 50% of the micro level respondents felt prepared for any new initiatives as these were being introduced. One Nurse Manager noted:

My nurses are not interested in change, just Agenda for Change (Meso).

Some of this apparent unpreparedness was due to making the initial transition from secondary to primary care:

I don't think I was really prepared for working in the community, it's very different from the acute setting and I am not sure what transferable skills I had that I could bring when I first started (Meso).

Some of it arose from a lack of what was perceived to be necessary updating of skills and knowledge:

We are all too busy going on mandatory course to do any other course (Micro).

You need to train people to be prepared for change, and training is not a priority in this PCT, and I don't think you will ever achieve integrated working without good training (Meso).

Change requires individual approaches at a clinical and organisational level, but should be facilitated by the organisation for the organisation (Micro).

There was some data that illustrated the risks facing some PCTs of not being prepared and able to change. One PCT Chief Executive noted:

PCTs are the vehicle for transition, from secondary care to primary care, I think if we don't get it right, we may lose some services to the private sector, because they will be able to deliver (Macro).

This view, of the risks in not being able to recognise the need for change and the consequence of not being able to change was, perhaps, to be expected from someone working at this level of the organisation. Indeed, in the survey data, 75% of respondents reported that they felt it was the PCT Board that should be responsible for driving the change agenda forward. The case study data presented an alterative and more inclusive view of what the possible drivers for change might involve.

5.13.5 Drivers for change

In a collaborative workshop, participants were asked what determines the knowledge and skills required to deliver integrated health and social care services. The issues identified were:

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

■ *Professional role needs;*

■ *National drivers and legal frameworks;*

■ *Health promotion, education and disease management;*

■ *Organisational Vision.*

Many of these issues were confirmed in other data from the case study participants:

Focusing on providing better patient centred care is the key (Micro).

Our vision is to find ways of providing patient centred services in the way that patients want, for example, our One Stop Resource Centre gets rated highly by patients, it reduces assessment times and procedures for patients and staff can be a lot more responsive to meeting individual needs. When we set this up we developed clear objectives as to what the service should be doing, patients were involved in this process right from the start (Macro).

We are developing our long-term care services with other agencies and it's clear that staff can see the benefits for patient of working together in this way (Meso).

Different agendas impact upon what gets done when, for example, care co-ordination should promote integrated working, but I don't think we have started to think about the implications of this in our PCT, although there is some talk about co-locating members of the multi-professional team and so on (Micro).

Other perceived drivers for change, however were sometimes reported to have a negative impact upon integrated working, and economic drivers were often cited in this regard:

Things started to fragment when we started to develop some services with social services, they have to put things out to tender, and whoever

wins the tender might not be accountable in the same way we are, so some staff lose out on supervision, management support and so on, I can understand the need to make sure things are efficient but low cost doesn't always make for high quality services (Meso).

Because the new GP contract means they get points for COPD work now there is a big push to develop these services now…its all driven by money (Meso).

5.14 Partnership Working

Participants at a workshop were asked to discuss and present three key issues that they felt inhibited effective partnership working. The responses included:

- *Non-sharing of information and IT systems;*
- *Lack of a shared vision;*
- *Protecting own role;*
- *Poor understanding of each other's role (duplication of effort);*
- *Lack of effective communication (x 2 groups);*
- *Low morale and motivation;*
- *Different localities;*
- *Lack of collaborative working;*
- *Top down approach to decision making;*
- *Poor dissemination (of plans, problems and so on);*
- *Poor leadership (autocratic leadership in a professionally driven culture).*

Although some of these issues are stated here in a largely rhetorical way, many have also been explored in the presentation of other data above. What this data suggests is a high level of awareness amongst staff of what is involved in partnership working, as one PCT Chief Executive noted:

I think that many of our staff have an understanding about what integrated working is, but the demands of getting the job done can sometimes make it difficult to see the wood for the trees (Macro).

Likewise when the same question was asked of a PCT Chair, the following responses were given:

- *Suspicion;*
- *Power differentials;*
- *Reporting practices;*
- *Budgets;*
- *Attitude/culture;*
- *Personalities.*

Thus we argue that much is known and perhaps understood about the difficulties of partnership working, be this in the tangible and everyday elements of service delivery and provision, or of the less tangible and yet equally important range of sociological, psychological and emotional factors that shape individual and organisational behaviour. Against this backcloth, keeping in view, the vision of what effective partnership working can achieve, can often prove difficult.

5.14.1 Keeping the vision in view

Much of the data presented here comes from the macro level participants. Essentially they are the group largely responsible for this aspect of partnership working. The data suggests they are aware of this as a responsibility and are also equally aware of the potential barriers to achieving this, for example:

There is still a great deal of fragmentation within the PCT, but this possibly matches a similar situation with other partner organisations, and with our relationship with some of these (Macro).

I still think there is too much attention given to hospital agendas (Meso).

The potential for joint working still largely relies on personalities and building relationships, yes there needs to be an understanding of what the joint agenda is but this id best arrived at through building strong relationships (Macro).

The biggest challenge is to get GPs to attend joint training events, even if you have to pay them to do so, it's worth it (Macro).

Health Improvement is the wrong approach. It [the work of the PCT] should be about trying to improve quality of life and well being from a Local Authority perspective…PCTs can only achieve this if they are able to develop wide-ranging partnerships…what needs to be developed is a more effective public – patient interface...this needs to be linked to staff development and the aims and objectives of the PCT (Macro).

One participant, who did not work for a PCT, but was responsible for a volunteer sector organisation working with children and young people, described what he thought achieving partnership working involved, he noted:

I think of 'quilting' you know, going out and finding all the little pieces you need to stitch together to provide an effective cover…unfortunately some think this has to be done at the widest level possible to ensure the best possible cover, when I see it as being an individual thing (Macro).

Achieving such individual cover may not always be easy. Developing partnership working has to be undertaken in a way that reflects the national and local contexts:

We are compelled to achieve government targets… but it is because so many of the targets are political that they disenfranchise the staff…and it can be difficult to persuade the staff that some of these targets might be 'our' targets as well (Macro).

One CPN participant told of his difficulties when trying to take the team he worked in forward in line with the PCT strategy for developing services for those in contact with the Criminal Justice System:

It's like they don't seem to want to move out of their comfort zone, they [other CPN's] block everything at the planning meetings and we just go round and round in circles, it's really difficult to get them to understand why we should be developing this service (Meso).

Likewise, one participant working in a Local Authority Social Services noted:

Balancing the books in Social Services and Health is done at different times of the year, this can limit the resources needed for integrated working, we have to find a way around this (Meso).

Additionally, there was some data that suggested these issues were not confined to the more traditional partner relationships:

There are too many ideological and economic tensions involved in developing effective working relationships with the private and voluntary sector (Macro).

The last data presented in this aspect comes from a Practice Nurse, who at the micro level ought to be a good indicator as to how widely across the organisation the vision for the future is shared. In her particular experience, it doesn't seem to be that far:

I don't think I know much about what our PCT is doing let alone what other organisations working with us do (Micro).

In **5.13.5** above, it was noted that PCTs need to become more patient centred. The final aspect of this data presentation examines some of the experiences reported of how patients are involved or not in the various processes of the PCT.

5.14.2 Service User Involvement (in decision-making, service development, training and education)

There is, despite what the survey data implied, evidence that PCTs were including patients in many activities of service delivery, development and evaluation, and although some of this appears aspirational:

We encourage partnerships to be developed at all levels…in so doing we believe we are increasing intellectual and social capital…it [Partnership development] enables us to start to re-define the boundaries… for example, what is the role of secondary care in health improvement... how can we work with patients in building supportive communities (Macro).

some is clearly more practical:

We have developed a very successful caring for carers group, for people who have had a coronary, they meet for exercise, to share experiences and offer support, I set it up but its now largely self-sufficient, we advertise it in the surgery and all the GPs recommend it to their patients (Micro).

There are the many of the same tensions in developing partnerships with patients as those noted in 5.14.1 above with other organisations:

It needs to be restated that PCTs operate at both the health system level, that is, in the environment set out with secondary and primary care demarcations, and also at the programme level, for example, working with care pathways… …thus there is a need for a transparency framework for accountable decision making that includes both a professional, organisational and patient perspective… this is difficult to achieve (Macro).

What we are trying to achieve with the PCT is equity… …to us this means maximising the welfare of individuals and communities… … within this task is the need to consider how staff and users can influence the service agenda and to achieve this within the resource envelope we have been given (Macro).

The focus for PCTs must be on improving the quality of life as experienced by services users and their communities… I am not sure people think that Shifting the Balance of Power includes trying to involve patients, there is a lot of talk about giving people more choice, but it is always on our terms (Meso).

5.15 Summary

This chapter has presented the findings from a wide range of participants involved in Work Package Five project. An approach that both attempts to differentiate and integrate these findings in order to illustrate the experiences, expectations and aspirations of the various individuals and groups that made up a number of communities of practice. The presentation of findings in this way revealed, at a rhetorical level, a great deal of shared experiences and expectations, but at the reality level, a corresponding amount of diversity in terms of experience and aspiration. For example, generally there was

evidence of continual processes of change in the reported experiences of many working staff in the PCTs. The extent and pace of these changes often resulted in many staff perceiving PCTs as being transient and virtual organisational entities. The consequential felt experience for many staff was that often the changes they had been through were going through or envisioned for the future were not felt to be underpinned by anything other than rhetorical values. This example highlights the tensions that can accrue when espoused theory and theory in action conflict in the experiences, expectations and aspirations of staff. The next chapter explores in more detail the implications of these findings for individuals and the organisations they work within.

Chapter 6: The Evidence and Vision(s) for Future Education and Training Provision to Deliver Integrated Primary Health and Social Care

6.1 Introduction

The findings presented in **Chapter 5** are of the experiences of individuals working in the current PCT system. The findings point to a high level of awareness amongst and across all participants working in each of the three levels of health and social care of the need to develop more integrated ways of working in primary health and social care. The level of this awareness, however, was seen to be variable. For example, there was evidence that concepts around multi-professional working, multi agency working, partnership working and collaborative working were conflated, used inter-changeably by participants.

In this regard, such narrative accounts generally reflect the different aspects from each of the four segments making up the conceptual framework presented in Chapter 3: 3.3. We argued above, that these four segments appeared often to represent the felt experiences and perceptions of the participants and collectively, their organisations. Such experiences and perceptions were located on an axis polarised by either fragmentation of integration. The mediating axis was how these experiences were perceived and responded to in terms of healthy rhetoric's or unhealthy realities.

An overarching feature of these perceptions was a concurrent set of beliefs and attitudes underpinning individuals' experiences and behaviours – what we have referred to as espoused theory and theory in use. For example, in relation to how prepared individuals felt or would like to feel prepared for a different future, the participants noted tensions involved in what was espoused theory and theory in use which revolved around balancing, at any one point in time, each of four inter-related needs:

- The individual's professional developmental needs;
- The individual's personal developmental needs;
- The development needs of the individuals community of practice;
- The developmental needs resulting from organisational strategic planning processes.

We argue that how these needs are recognised and responded to, by the individual, the professional group and the organisation they work in, is likely to be affected by a number of internal and external factors. These include:

- National and local policy directives and guidance;
- The current stage of organisational development (in terms of capacity and capability);
- The organisations requirements for a competent workforce (capable of delivering evidence based effective care);
- Resource availability;
- The prioritisation and the personal perceptions of individual staff (resulting from their felt experience of practice).

This chapter seeks to explore how responding to these tensions (illustrated by the evidence base) of what is currently being experienced give rise to a number of implications for all those stakeholders involved (or responsible for) shaping the future of integrated primary health and social care.

Included in this discussion is a brief comparison of how service users have reported their experiences of integrated health and social care with those reported by staff as presented in **Chapter 5**. Illustrative data, representing one view of the service user experience, are drawn from the outcomes of the Work Package Six project. Clearly these data are not our data and we have been careful to try and not impose our interpretations to far on the published analysis prepared by the members of the Work Package Six project team[4].

Due to methodological differences and differences in research design between the two work packages, what is presented in this chapter simply uses an analytical approach designed to explore the congruence, in terms of parallel processes, of the service users experience and the evidence base representing the staff experience. Only the basis of the evidence used in developing the staff evidence base is discussed here.

6.2 Scope of the Evidence

The evidence base presented in **Chapter 5** was congruent with that developed through the systematic review of the literature conducted in Work Package Two. Data were collected from a wide range of individuals working at the Macro, Meso and Micro level within a representative range of different PCTs in the North West region and these data provide the basis of the evidence base. Although data collected in the ways noted in 4.3 are authentic, there can be no guarantee that they are representative of the participants experience. However, the evidence base represented by these data is largely qualitative in nature and provides a collective evidence base that is made up of a number of different rhetorical forms:

- **Rational rhetorics**: Those that are used by individuals in making

---

[4] For a full analysis of these data, reference should be made to the Work Package Six Final Report.

sense of wider expectations and ideas, which collectively provide a discourse of rationality. For example, team working is the preferred way of working because it represents a more effective form of collaborative working. Ontologically, there is a wider evidence base that supports this belief, even although the individual experience might point to a different reality. The espoused theory approach.

- **Technical rhetorics**: Those that are used by individuals to describe the technical discourses in use that promote a particular approach to organisational processes, such as Total Quality Management, but which often discount or do not include the social processes involved. The espoused theory approach.

- **Normative rhetorics**: Those that are used by individuals to explain why unintended outcomes for a given range of inputs are the norm which rely on the ontological appeal of bringing about changes through winning the hearts and minds of individuals. For example, the belief that a supportive organisational culture will impact upon the individuals' response to adopting life long learning approaches to their professional and personal development. The theory in use approach.

- **Fantasy rhetorics**: Those that are used by individuals in providing explanations for the lived reality they find themselves in. This approach is rich in the identification of heroes and villains, emotions and attitudes, which make up the individuals social reality. The theory in use approach.

We argue 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. Drawing on the work of Jackson (1999), we argue that such rhetoric's thus serve to provide the individual with a sense of community, and also allow observers of these communities to be able to differentiate between hierarchical (and quantitative dimensions – how much, how often, how high) and the transcendental (and qualitative dimensions – how good, how grand, how noble). This is an important distinction to make in terms of how this evidence base might be viewed and used. In terms of education and training, hierarchical approaches might suggest that individuals might get more or less education and training; transcendental approaches might suggest that they might or might not become better practitioners.

Hierarchy suggests how people can improve; transcendence suggests why they should. 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.
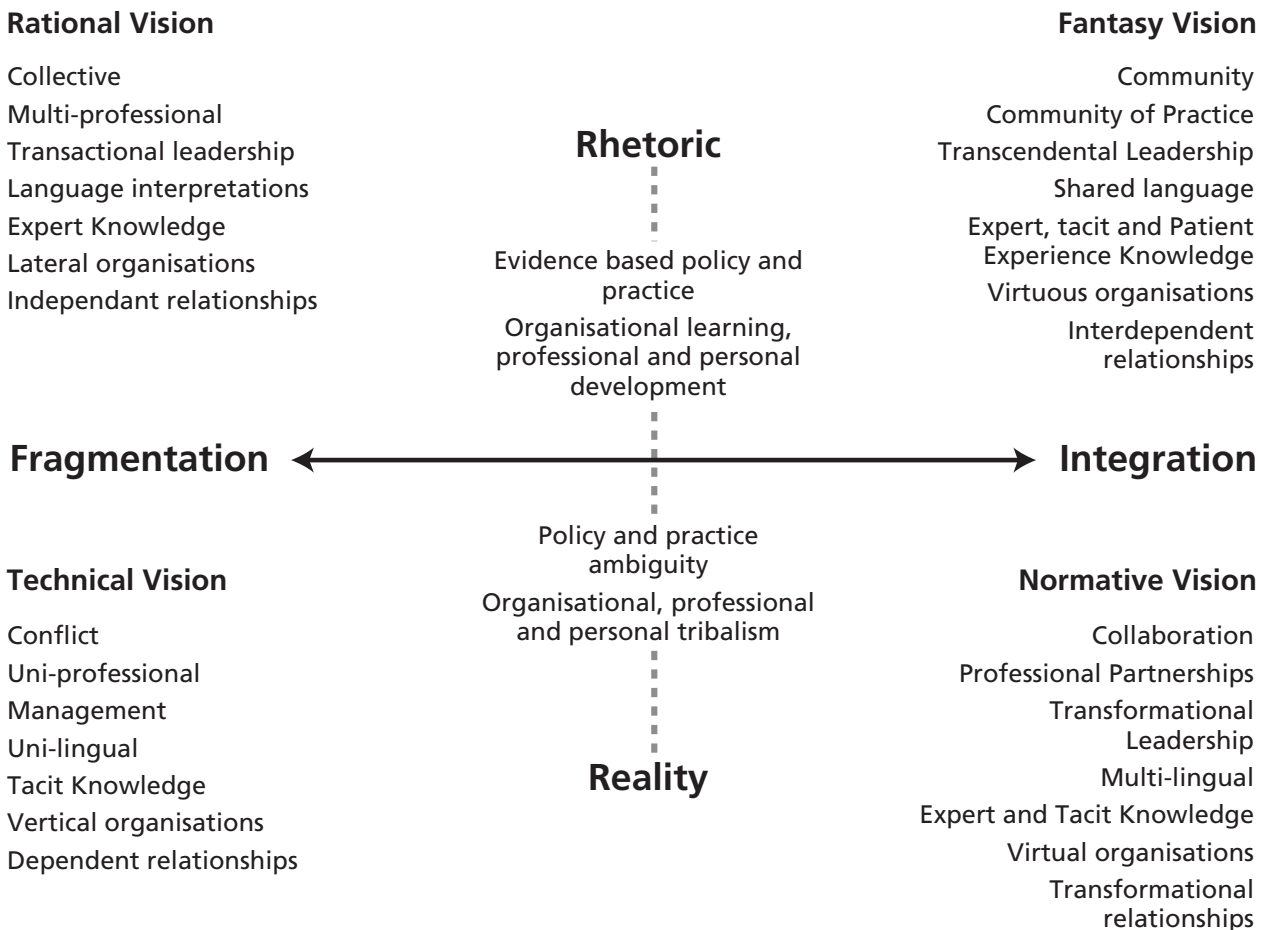
Within the evidence base there was data that supported the realisation of the current governmental vision of increasing partnership working and collaborative approaches in many areas of work carried out by PCTs. Somewhat paradoxically, there was also evidence of 'silo thinking' albeit, perhaps unintentional, which points to a somewhat more limited vision for

future integrated working. Other evidence to suggest that future primary health care services would be working to redress the balance between continuing to provide a wide range of general services and the provision of more specialist services reinforced this latter vision. There may well be many reasons why some PCTs are moving in this direction, and although these reasons are tacitly acknowledged, they are not discussed here. However, even where more specialisation replaces genericism in terms of future working, integration, per se will be required to ensure 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.

The value inherent in a vision of becoming more integrated was widely recognised at by participants working at the Macro and Meso levels in many PCTs, whereas, at the Micro level, the evidence base would point to a general lack of awareness of what is involved in achieving such integration. Thus, it may be possible to argue that within individual PCTs, there might not be any one-shared vision of the future. In mapping the four rhetoric's described above against our conceptual framework, it is possible to conceptualise what each of these visions of a future integrated health and social care service might involve. See Figure 4.

The assertion that there maybe 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

Figure 4:   Rhetorical Visions

Rational Vision

Collective
Multi-professional
Transactional leadership
Language interpretations
Expert Knowledge
Lateral organisations
Independant relationships

Rhetoric

Evidence based policy and practice
Organisational learning, professional and personal development

Fantasy Vision

Community
Community of Practice
Transcendental Leadership
Shared language
Expert, tacit and Patient Experience Knowledge
Virtuous organisations
Interdependent relationships

Fragmentation ←——————————→ **Integration**

Policy and practice ambiguity
Organisational, professional and personal tribalism

Technical Vision

Conflict
Uni-professional
Management
Uni-lingual
Tacit Knowledge
Vertical organisations
Dependent relationships

Reality

Normative Vision

Collaboration
Professional Partnerships
Transformational Leadership
Multi-lingual
Expert and Tacit Knowledge
Virtual organisations
Transformational relationships

conceptual transitions. The resultant picture is one characterised by turbulence and change. We argue there are a number of implications arising from the analysis of these data that need to be considered by managers, educationalists and practitioners if the future workforce is effectively going to be prepared for future service provision. These implications however, are not simply concerned with educational and training approaches. Jordan (2000) notes the plethora of studies for example, that note improvements to patient care and organisational effectiveness (in terms of practice development) are more likely to be

attributable to financial incentives than education programmes.

6.3 The wider implications of the Vision(s)

Whatever the current and future [sic] vision for the future is, it is clear that a number of organisational, professional and personal development factors will need addressing as well as those concerned solely with educational processes. We argue that these will require a simultaneous approach that may, at this point in time, be beyond the organisational and managerial capacity of many PCTs. Howarth *et al* (2004) developed a series of

arguments that captured the nature of what might be involved in developing an approach to achieving a shared vision of integrated health and social care service. However, they did not comment on the time frame required to progress either achieving this shared vision or in realising the vision as a shared way of working. Likewise, they did not discuss possible constraints that might be involved in working at achieving these outcomes over time. We believe this is a crucial factor for both employer organisations in considering how they prepare and shape the workforce for the future, for commissioners of education and training programmes

and for educationalists in the type and range of educational and training programmes they develop and provide. Some of these constraints will be beyond the individual organisations' ability to effectively manage or influence. For example, the length of time it takes to train a traditional member of the present workforce is nationally determined. So whilst the content of curriculum, how programmes are facilitated and who is given access to these might be amenable to changes, the outcomes of these changes will only be seen over time.

The additional dimension in this example is that concerned with the evaluation of the relationship between the intended outcomes of any changes introduced and the unintended changes in outcome as these are realised over time. Many other variables may contribute to the long-term outcome. For example, Jordan (2000) notes that systematically constructed outcome evaluations are required to ensure that health care professionals educational and training programmes are designed so that patients' and not just students benefit from the resources expended.

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 and training coincide. In this wider sense, the rhetorical conceptual framework above stands to remind us of the need to keep 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 here following the analysis of the data. Whilst advocating a whole systems approach as an aid to

understanding the interrelationship of these implications, these are presented here using the disaggregated thematic analytical framework employed in **Chapter 5**.

6.3.1 Implications for Improving Team Working

The literature clearly indicates there is a need for organisations to develop more effective teams with the appropriate skills and knowledge. These teams need to be able to liaise and work, collaboratively across organisations and agencies. This aspect features in many versions of the vision of integrated health and social care and was also recognised by the participants and respondents in the telling of their experiences. Factors that worked against achieving effective team working were, generally well known and articulated by many of the participants. Where examples of effective team working were reported, these often tended to have resulted from the influence of a particular individual, a finding that resonates with the transcendental nature of some of the normative and fantasy rhetoric's. For example, in appeals such as the need for managers and leaders to have a clinical background or to be able to demonstrate an understanding of what is involved in clinical practice in order to ensure more effective team working.

The projection of such ideals onto others in this way might also suggest that individuals experience difficulty in employing the competencies they use within their clinical practice with other colleagues. This clearly has implications for individuals and teams when considering how to respond to the implementation of national competency frameworks. There is a need for those engaged in these processes to enable individuals to make integrated connections

between those competencies used specifically in relation to clinical practice with those that are employed in a more general sense. The implications for educationalists in facilitating this throughout all education and training programmes are clear. Whilst ensuring that learning objectives and learning outcomes reflect these competencies will help team members achieve a greater awareness of other members of the team and their role functions and professional backgrounds (see also 6.3.3 below). There is also a need for teams to work in a systematic way at agreeing clear team aims and objectives that explicitly reflect the contributions that might be available and how such contributions might most effectively be made. Again there are educational, training and organisational development implications for how this might be undertaken. For example, in the development of change management, knowledge and skills across the workforce.

Whilst such work should, perhaps rightly, involve the application of professional knowledge, there are implications as to how such processes could more tangibly involve the patient. Educationalists might have an important role here. For example, most will be familiar with the need to involve their students in the design of the curriculum, its facilitation and evaluation of learning outcomes. This expertise might be transferred to similar work with professional/patient relationship processes. Such activities are firmly located in organisational development work. In recognising this, there maybe an opportunity to address some of the '*softer*' cultural issues that participants noted in their accounts, for example, the way that individuals feel valued or not for the work they are engaged in, feeling

involved in problem solving, decision making processes and so on. Thus, a further implication of the data analysis is concerned with how some individuals experience their organisational culture.

It appeared in the evidence base that often many organisational cultures were still hierarchical (individuals often felt that changes were imposed upon them). To a lesser extent, there was evidence that where the organisational culture promoted involvement in such activities as service design, this was generally in an isolated way and again dependent upon specific individuals, who in this context, act as interpreters for those at the Macro level of the organisation.

Several of the case study workshops illustrated the way in which organisations might want to approach this. For example, at one collaborative event, the value of the event reported by the participants was more to do with being given time out to look at the future needs of individuals and organisations than the knowledge gained at a more tangible level through the discussions and activities of the day. There was evidence of developmental activities occurring to promote more effective team working, but these were not always predicted on the concept of integrated working. This observation might also reflect the different stages of organisational development that PCT's find themselves in. We argue the implication of this, for both service managers and educators, is to work more closely together in ensuring the realities of team working across professions and agencies features in all education and training programmes. We would argue that this is particularly important in those educational and training programmes that involve pre-qualification

programmes, where integrated working should be seen as a core skill and be embedded in the processes involved in 'becoming' a professional.

We argue that rather than teaching about team working per se, the emphasis needs to shift to include learning about *how to deal with the realities* of team working. The implication for educationalists PCTs and future service providers involved in shifting the educational emphasis in this way might require the development of evaluation strategies that are capable of effectively demonstrating improved team working. Both the outcomes of Work Package Seven and Eight projects and the survey questionnaire used in this project might provide the basis for developing such an evaluative tool.

These are developmental processes that often only occur iteratively over time. So over time, these changes to teaching and learning, aimed at a greater convergence between the rational and fantasy rhetoric's would go some way in either providing a common language that could be used by all in more effectively working as a team or at the very least, provide the opportunity for the development of greater understanding (working knowledge) of the *many different* languages being used within and across the various professionals making up any team.

6.3.2 Implications for Improving Communication

For staff learning to work in integrated ways the need to ensure well developed communication skills that enable them to work within and across inter-professional and inter-agency boundaries was widely acknowledged in the evidence. Likewise, the difficulties in achieving this were also freely acknowledged. As noted above, the prerequisite for

staff being able to demonstrate more effective communication is the development of a common language that can be used by those working in either health or social care organisations. However, the implications of achieving this reflects the complexity of professional and organisational socialisation processes; in other words, it will only happen over time, and possibly only as a consequence of a greater awareness of the need to work in this way. We argue that the work of those involved in *Expert Patient Initiatives* illustrate some of the implications involved in promoting an awareness of the need to work in this way. Not least of which is the need for professionals (in learning to communicate with each other more effectively) to learn to hear what it is the patient is saying within consultations and therapeutic encounters. Learning to listen and then responding demands a different approach by professionals to the consideration of what is deemed important and what is given credence in both patient and professional encounters. The implications for educationalists, PCTs and future service providers are in how to promote and support such approaches.

The evidence base revealed that there appeared to be many opportunities to develop more effective forms of communication across teams and organisations. Whilst the more traditional forms, such as planning meetings (both clinical and organisational), and different approaches to cascading information through the different level of the organisation, appeared to have been experienced in often negative ways, newer forms of communication, for example, web home pages, appeared to promote greater transparency in the exchange and access to information.

There is a parallel process here illustrated in the way new technologies are being harnessed to both promote greater patient and public involvement, which could be used to gain the more effective involvement of staff. One implication of this however, is that progress may be slowed down as a consequence of poorly developed or in-effective IT systems. The evidence base points to a gap between the aspirational and the achievable in terms of how new technology is being used to promote better communication between individuals, organisations and agencies. Partly this appears due to poor infrastructure constraints and appropriate software (which might be addressed as the new EMPIRIC (Effective Methods of Providing Information for Patient Care) system becomes more operational) but partly it appears due to a lack of organisational innovation and confidence in terms of how IT might be used.

A related implication for PCT managers arises from data, which suggests that often individuals do not trust some of the information given to them by their organisation. Greater awareness on the part of PCT managers of how individuals might perceive not only the message but how this might be delivered is required.

Some participants felt bombarded with information; others felt they didn't receive enough information. Thus we argue that the potential gains arising from making more information available to more people are only likely to be achieved if communication processes are tempered with greater transparency over how the messages are communicated. Such an approach would see individuals and organisations moving towards

balancing the employment and reliance on technical rhetoric's with more effective forms of normative rhetoric. There is an opportunity for educationalists to assist PCTs and future service providers gain this understanding through the provision of focused and targeted multi-professional and inter-disciplinary CPD activities specifically aimed to promote more effective communication processes.

6.3.3 Implications for Improving Role Awareness

Overall the evidence base pointed to a general level of agreement that individuals could do more to understand other staff members working in their organisations and in partner organisations. There was much evidence to suggest that individuals and organisations were actively working towards (and in some cases) achieving greater understanding of the roles of others, although this was acknowledged as being a difficult task. Howarth *et al*'s (2004) assertion that providing opportunities for promoting more effective role awareness should be a central part of all pre-qualifying educational programmes was only partially supported by the evidence base. Other training and educational processes should also recognise the importance of this awareness and it should feature as an essential aspect of all CPD programmes. There was not a great deal of evidence, however, to suggest that this was currently the case, either in pre-qualifying programmes or CPD activities.

We argue that if staff experiences this lack of understanding about different team members' roles, it is likely to be a similar experience for patients and the wider public. There are ethical implications for PCTs and service providers where the roles of various

professionals are not clearly understood by patients. For example, data presented in **5.12.4** with regard to new workers revealed issues of role identity confusion for Assistant Practitioners arising from their title and role expectations. If the current workforce experience this confusion over role identity and role, it is likely that patients will. They may think the person providing them with care is someone from a different professional group, with all the expectations such perceptions involve. This point perhaps illustrates the added value of involving patients and carers in educational and training activities. We argue that this might represent a parallel process of raising role awareness for service users, and ensuring that representatives from patient groups are more effectively involved in all staff educational and training activities. There are implications for service providers and educationalist in developing the involvement of patients that are concerned with: issues of representativeness, timing of involvement and resources to support such involvement. Responses to the challenges of these implications need to be developed using uni-professional and multi-agency approaches. Where possible, we argue that all such programmes aimed at improving role awareness should be delivered as joint initiatives involving health and social care organisations, and HEIs.

The involvement of HEIs is particularly important in the context of ensuring an empirical approach is used to inform service developments, for example, how primary health and social care services might best address the issues involved in moving from generalist to more specialist approaches to service delivery.

There was little evidence of formal educational and learning approaches being used to support staff achieving greater role awareness. There was some evidence however that suggested a desire for informal educational approaches becoming more structured and more effectively linked to strategic organisational objectives. In responding to this suggestion that PCTs need to develop a more structured approach to informal learning (such as that enabled by learning from others), managers and practitioners would need to concurrently work at developing an organisational culture capable of promoting and more effectively supporting the resultant communities of practice. Clearly as members of the current practice workforce begin to be employed by other organisations and not PCTs, the role of the PCT will change. There will be a need for PCTs to ensure and support the development of such learning organisational cultures. Again, whilst this might be organisational development work that occurs over time, educationalists have a role to play at different points in time through supportive CPD activities aimed at organisational change and development.

6.3.4 Implications for Improving Personal and Professional Development

The evidence base suggests that rational and technical rhetorics dominate approaches to personal and professional development activities. Life long learning was readily articulated as an orientating concept, although the implications resulting from embracing such an approach were not so readily recognised. This was interesting data given that during the data collection phase of the work, many individuals and organisations were caught up in the

implementation work of the *Agenda for Change* process. This process clearly illustrated many of the issues involved in promoting and supporting life long learning as an organisational reality. These issues included: ensuring compatibility of what are seen as desirable and essential competencies across the various national competency frameworks, managing individual and professional expectations and demands, adequately resourcing educational and training strategies, both in terms of direct and indirect costs, working at developing supportive organisational cultures capable of promoting learning, embracing opportunities to develop the workforce through the introduction of new workers and becoming more systematic in identifying training needs.

There were implications for universities arising out of the role they should adopt in supporting individuals and PCTs. Poor communication between many practice areas and universities was evidenced. There was also evidence to suggest that practitioners and managers do not always understand what the university role involves. There was some evidence to suggest that universities need to become more innovative and creative in terms of the educational programmes offered and how these are promoted, and delivered. Provider organisations wanted more say in what education and training programmes were being offered by universities.

Conversely, we argue that universities also have an important role in helping PCTs ensure that effective learning environments are developed in future service provider organisations that are capable of supporting more flexible learning opportunities for staff. For example, participants at the Micro

and Meso levels in many PCTs reported that professions and organisations often do not value in-house courses as much as those courses accredited through universities. There is an implication here for universities arising out of the need to consider how in-house CPD activities might be credit rated.

A further implication of developing such an approach is that universities need to be both more inclusive in the design and delivery of the curriculum and more innovative in the development of new roles for academic staff. We argue that universities themselves need to work more effectively together as providers of higher education in order to *develop* such roles in the future. In this sense, the university needs to move its classrooms out to the practice community.

Future education and training programmes should be capable of responding effectively to personal and professional development processes. There was evidence that many individuals were now accessing personal development reviews and/or appraisals, although there was also evidence to suggest that this was often a consequence of having to respond to the implementation of *Agenda for Change.*

However, it is encouraging that whatever the driver for these changes, some work is beginning to be undertaken in order to better understand the skills and knowledge base of the workforce and how this might feed into skill mix reviews and service development. There was some evidence linked to this around the development of new job specifications and role-redesign. We argue that being able to demonstrate the skills and knowledge required to work in integrated health and social care services through all levels of the

organisation should be the basis for designing future job descriptions and role specifications.

The implication for provider organisations, inherent in achieving an approach of integrated personal and professional development strategies, is the need for these strategies to be explicitly linked to both organisational change strategies and business planning processes. Drawing upon technical and rational rhetoric's, there is a concurrent need for PCTs to develop more formalised ways of assessing educational and training needs in relation to stated organisational aims and objectives. This raises the implication over what is seen as being 'useful knowledge'. Many participants felt the opportunities for personal and professional development were limited by the value placed upon particular courses by their organisations. As was noted in 6.1 a number of internal and external factors will impact upon the way in which PCTs develop and use educational and training needs analysis in structuring future workforce personal and professional development processes. There is a clear implication for PCTs in how to develop transparent and effective decision making processes that are capable of handling the personal, professional and organisational tensions involved. These same factors apply equally to the way in which PCTs support practice development and leadership.

6.3.5 Implications for Improving Practice Development and Leadership

The evidence base suggests that within PCTs more could be done to identify, educate and support individuals in leading integrated teams. This was often predicated upon the use of rational and

normative rhetoric's. We argue, however, that just because prevailing policy guidance requires organisations to work in more collaborative ways, many of these organisations will not have the necessary management and leadership capacity and capability to work in this way. This raises implications for how PCTs strengthen the leadership capacity within the different areas of the organisation, again a crucial task given the proposed changes in structure and function for future PCTs.

We argue that practice development will need to be facilitated by leaders skilled in cultural change processes. This requires knowledge and skills, which have not always featured as an essential aspect of many pre-qualification professional educational programmes. The evidence base suggests that much of the education and training for this type of practice development occurs within CPD activities. However, in a recent report prepared by one Strategic Health Authority in the North West, it was noted that Change Management was an under subscribed CPD area during 2004/05. It can also be argued that such skills are not easily *taught* in any event.

There was evidence however, that at least informally, many PCTs recognised the need to improve educational and training opportunities in this area. Inter-professional learning and training was most often noted as being the preferred approach to achieving this in CPD programmes and courses. However, reliance upon rational and technical rhetoric in this way has implications for PCTs, not least of which are the needs to consider how to provide protected time for such activities, the need to recognise and value time spent on these activities and the need to ensure inter-agency

trust is developed and nurtured. We found limited evidence that individual GP practices in some PCTs provided notice to their patients of regular education and training days used to provide the opportunity to ensure staff had 'protected time' for staff development. It was unclear what this protected time was used for, but other data in the evidence base would suggest that such training days were used to ensure all staff were able to participate in mandatory training courses. There are implications for GP practices providing protected time in this way to develop a structured approach to personal, professional and practice development opportunities that reflect the four interrelated needs noted in **6.1**.

Likewise, greater collaboration is required between practice organisations, commissioners of educational programmes and educational providers, so that all programmes, whether internal or external, more effectively reflect the changing nature of integrated health and social care practice, and the changing environments where such practice is undertaken. Monitoring and evaluation of educational and training programmes are now largely standardised across the UK. The implications of working within these approaches should promote more flexible approaches to the ways in which educational and training programmes are developed and delivered.

Unfortunately, given the strong national policy guidance, there was a paucity of evidence to support the active engagement and involvement of patients and carers in many of these educational and training activities. Working in this way (largely without the active involvement of patients) reflects the presence of

normative and fantasy rhetorics. The implication of such approaches for individual professionals and PCTs are that it is less likely that the drivers for practice development and change will be widely understood and the level of workforce preparation for change decreased.

6.3.6 Implications for Improving Partnership Working

A number of normative and fantasy rhetorics were employed by many participants in describing the current state of partnership working within and across the PCTs and other stakeholder organisations. The importance of partnership and collaboration between health and social care was widely recognised as being an essential and permanent part of current service delivery. However, there was little evidence of a shared definition of what integrated health and social care was, and/or how this might relate to practice. Keeping the vision of what integrated health and social care might involve in view appeared difficult. In particular, the Micro and Meso participants experienced the greatest difficulty with this. The evidence base points to a number of reasons for this including national policy demands dictating practice, the comfort zones of individuals (and their professional community of practice), the support for partnership working not always being effective (the availability and use of IT for example) and a lack of understanding around organisational roles and responsibilities. Many of the Macro participants felt that although many of the staff working in their PCTs had an understanding of what integrated working was, but the demands resulting from the concerns noted above often meant that they could not translate this understanding into new practices. The implications of this represent a massive

organisational development challenge for many PCTs as they work towards becoming commissioners of services and staff currently employed by them move to other service provider organisations. PCTs will need to ensure current service provision continues whilst simultaneously working at developing and supporting new ways of working – and taking health and social care staff with them in this change process. Not only do Macro level staff need to develop such organisational development approaches within their organisations, but this work also needs be to undertaken with other agencies and organisations. We argue this will require the creation of specific roles within PCTs that are aimed at facilitating both aspects of this work.

Just as there is an implication for clinical teams to more effectively understand other team members' roles, there is an implication that organisational roles need to be better understood before effective integration can occur. One Macro level participant illustrated this in his concept of 'quilting' – that is stitching together all the little pieces of service required to ensure the individual was 'covered'. In order to stitch together such a quilt requires those involved knowing what different bits of material are available. Extending the analogy further, the art behind the science in such an endeavour is to know which pieces of material (services) best complement each other. The evidence base suggested that the necessary information and communication processes underpinning such approaches were often absent or ineffective.

There is a related set of implications for educationalists. In order to help develop and maintain these communication, role awareness and

organisational change processes, it is essential that the development of curricula for integrated health and social care working reflects partnership working approaches. Thus future education and training standards from professional bodies should include core requirements for partnership working to deliver integrated health and social care. Educational providers need to respond more effectively to such professional standards and consider compulsory elements of study that reflect integrated working in all educational programmes. Finally, the implication for both service providers and educationalists is to ensure that patients are involved in any educational and training development that promotes partnership working.

6.4 Parallel Processes II

With few exceptions, it can be argued that many education and training programmes have been introduced and continue to be perpetuated without any form of evaluation of their impact on patients being undertaken. One of the aims of this Work Package project was to explore the relatively under researched aspect of how knowledge and skills are transferred into clinical practice through a comparative review of the level of congruence between the professional staff experience and those of the service users. The focus was on how each had experienced integrated health and social care. This aim was found to be difficult to achieve because of the existing resources available, the differences in research design and methodologies and the difference in emphasis with regard to Work Package Five and Six project's primary aims. However, as part of the work of this Work Package Five project, we felt it would be helpful to explore any congruence between what service users

experienced and what the Micro level participants were reporting. We were looking for evidence of any parallel processes in the experience of both groups.

We are mindful that the service user data is used here in a way that may well be divorced from the original data collection context. This has limitations on how such data can or should be used, and for the outcomes of this analysis. However, the following two examples of the potential parallel processes are offered here:

6.4.1 Communication

There were data that suggested, at times, service users experienced similar problems with communication just as the staff participants did. For services users, these included incomplete or ineffective communication between different members of the care team and the patient and/or carer, a breakdown in the level or quality of care received and meetings only being called when patients asked for them. For staff, the problems were around attending meetings with hidden agendas, the communication of selected information, a lack of involvement in decision making processes and poor access to planning information. The parallel process thus revolves around both groups in not getting the information they want in a timely way, in a way that allows for understanding, and in a way that promotes effective decision-making. We argue that just as patients and carers often experienced this from the professionals involved in their care, many micro level participants had similar experiences with their managers and organisations.

6.4.2 Partnership Working

This appeared to be a more positive experience for the service user,

although some service users remained doubtful as to the sustainability of joint working experiences. There were some reports of individual service users being pushed from one agency to the next on the grounds that their problem was better suited to a different agency. However, there was a degree of congruence between these experiences and those of the staff participant. Both groups were able to recount the rhetoric of integrated and partnership working and both groups were also able to describe situations where this was not working and might never work. The parallel process involved how such rhetoric's were translated into experiential realities.

6.5 Conclusions

Despite the plethora of national guidance on the modernisation of the NHS, the introduction of educational and training competency frameworks and the proliferation of related empirical studies noted in this report, much of the work, to date, in developing integrated health and social care remains unsystematic and under evaluated.

Data was collected largely from participants working at three different levels of organisational and professional responsibility within PCTs in the North West of England. A conceptual framework was used to explore where individuals and organisations engaged in shaping the future for primary health and social care workforce might locate themselves on a continuum of fragmentation or integration. The six themes developed, initially through the systematic review of the literature, had a high degree of congruency with data used in developing the workforce evidence base.

No one vision of what primary

integrated health and social care services might involve, or how this might be achieved has been developed. The evidence base pointed to a series of rhetorical justifications of where individuals and their organisations currently located themselves professionally and organisationally. They were also employed when describing where they saw themselves or their organisations being in the future. These rhetorics ranged from the rational, technical, normative and fantasy in terms of their use and focus. The evidence base provides an opportunity for managers, practitioners and educationalists to gain greater understanding as to why these rhetorics are articulated by those involved in working in health and social care.

We have argued in this report that 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 PCTs role changes to reflect a service commissioning role and not a provider of services. Such changes impact upon individual members of the current workforce, and have resulted in turbulence within professional communities of practice and the related organisational environments. The evidence base suggests that this turbulence has given rise to disjunctions and tensions in and between managerial, educational, political and professional discourses, theories and practices. We argue that often the use of these rhetorics act as 'smoothing' mechanisms by individuals and their organisations. However, as these smoothing mechanisms encounter what for many participants is a very chaotic and messy reality, not only is a important but utopian vision

created, but further gaps between policy, organisational education and professional practice emerge. The evidence base reflects what was often fragmented and contradictory beliefs and perceptions expressed by participants in their accounts of their experiences of integrated health and social care.

Our findings 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 makes up this workforce, and of the turbulent nature of the context. The rhetorical conceptual framework is a reminder of the need to keep a whole systems approach to planning and facilitating a more integrated approach to health and social care. A number of educational and organisational development implications arising from the discussion of the evidence base were noted. These are implications for all those concerned with the provision of primary health and social care services, and those involved in the commissioning and provision of educational and training programmes aimed at developing the workforce.

6.6 Recommendations

The following should be read as a related constellation of changes, rather than as single and specific items that might be separately implemented. However, we argue that there is a need to develop methodologically appropriate evaluative processes as individuals and organisations start to respond to these recommendations.

6.6.1 For Improving Team Working

PCT's, future service providers and educationalists should:

■ Ensure that all educational and training learning objectives/ outcomes reflect national

competency frameworks standards;

■ Develop change management knowledge and skills at all levels of the workforce, and ensure service users and carers are partners in these processes;

■ Undertake organisational culture analysis aimed at promoting a culture which supports greater involvement of the wider workforce in decision-making processes;

■ Provide structured and regular 'timeout' sessions aimed at harnessing organisational learning;

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

■ Develop systematic organisational evaluative strategies that are capable of evidencing improved team working.

6.6.2 For Improving Communication

PCT's, future service providers and educationalists should:

■ 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;

■ Provide multi-professional and inter-disciplinary CPD activities that aim to enable professionals to better learn to listen to each other in order to better assess what is acted upon or given credence to;

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

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

■ Develop engagement processes that support greater organisational innovation and confidence in how IT systems are used;

■ Develop multi-professional and inter-disciplinary CPD activities aimed at enhancing an understanding of how, what and why information might be communicated across all levels of the workforce.

6.6.3 For Improving Role Awareness

PCTs, future service providers and educationalists should:

■ Ensure that all pre-qualifying educational programmes, CPD programmes and activities more effectively promote role awareness and inter-professional working;

■ Ensure that there is an explicit requirement to demonstrate the involvement of service users in educational and training activities in commissioning agreements;

■ With service users and carers, develop communication processes aimed at ensuring service users and carers better understand the different roles and responsibilities of the workforce;

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

■ More effectively involve HEIs in providing empirical approaches to support service developments;

■ Develop more structured approaches to supporting and recognising the value of informal

inter-professional and organisational learning.

6.6.4 For Improving Personal and Professional Development

PCTs, future service providers and educationalists should:

- Continue to develop meaningful opportunities that promote life long learning and the systematic identification of training needs;

- Regularly evaluate the impact and use of new workers on the roles and functions of the existing workforce;

- Increase the awareness within PCTs and future service providers of the scholarship role universities can have in supporting individual practitioners and PCTs;

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

- Increase the opportunities to work together in developing more effective learning environments capable of supporting flexible learning within PCTs and future service providers;

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

- Work towards the creation and deployment of new joint academic/practitioner roles at all levels of practice;

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

- Ensure that integrated personal and professional development

strategies are explicitly linked to organisational change strategies and business planning processes;

- 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'.

6.6.5 For Improving Practice Development and Leadership

PCTs, future service providers and educationalists should:

- Develop multi-professional and inter-disciplinary CPD activities that are aimed at strengthening the leadership capacity across all levels of the health and social care workforce;

- Ensure that practice development activities are facilitated by leaders skilled in cultural change processes and that these activities are systematically evaluated;

- Ensure protected time is identified specifically for multi-agency practice development CPD activities;

- 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;

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

- Improve the opportunities for greater service user and carer involvement in educational and

training programmes in order to increase awareness and responses to drivers for practice development.

6.6.6 For Improving Partnership Working

PCTs, future service providers and educationalists should:

- 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;

- Develop specific roles to facilitate inter-agency partnership working at the Micro and Meso levels of the workforce;

- Ensure multi-professional and inter-disciplinary CPD activities are developed that are aimed at increasing understanding of organisational roles and responsibilities;

- Develop curricula that explicitly provide learning opportunities for partnership working;

- That future education and training competency standards include core requirements for partnership working.

References

Adam E, 1985 Toward more clarity in terminology: frameworks, theories and models. *Journal of Nurse Education*, 24(4):151-5

Alvesson M., 2001 Knowledge work: ambiguity, image and identity. *Human Relations* 54 (7) 863-886

Argyris C., and Schon D., 1978 *Organisational Learning: A theory of Action Perspective*. Addison Wesley, Massachusetts.

Black N., 2001 Evidence based policy: proceed with care. *British Medical Journal* 323, 275-279

Botha M., 1989 Theory development in perspective: the role of conceptual frameworks and models in theory development. *Journal of Advanced Nursing* 14(1) 49-55

Cave E., and Holm S., 2002 New Governance arrangements for research ethics committees: is facilitating research achieved at the cost of participants' interest. *Journal of Medical Ethics* 28 318-321

Department of Health. *The challenge for nursing and midwifery in the twenty first century: the Heathrow debate*. London: HMSO, 1994

Department of Health, 1997, *The New NHS: Modern and Dependable*. The Stationary Office. London

Department of Health, 1998, *Working Together*. The Stationary Office. London

Department of Health, 2000a, *The NHS Plan*. The Stationary Office. London

Department of Health, 2000b, *A Health Service of all the talents: Developing the NHS workforce*, The Stationary Office. London

Department of Health, 2001a, *Working together, learning together - A framework for lifelong learning for the NHS*, The Stationary Office. London

Department of Health, 2001b *Central Office for Research Ethics Committees: Governance arrangements for NHS research ethics committees*. The Stationary Office. London

Department of Health, 2001c *Research governance framework for health and social care*. The Stationary Office. London

Department of Health, 2002, *Funding Learning and Development for the Health Care Workforce*. DoH, Leeds

Department of Health 2003 *The Knowledge and Skills Framework and Development Review Guidance – Working Draft*, The Stationary Office. London

Department of Health 2005 *Creating a Patient-led NHS: Delivering the NHS Improvement Plan*. The Stationary Office. London

Eisner E., 1991 *The enlightened eye: qualitative inquiry and the enhancement of educational practice*. Macmillan, New York

Ferlie E., and Pettigrew A., 1996 Managing through networks – some issues and implications for the NHS. *British Journal of Management* 7 (S) 81-99

Ferlie E., and McGivern G., 2003 *Relationships between Health Care organisations. A Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation*. Imperial College, London

Flick U., 2002 *An Introduction to Qualitative Research* Sage, London

Foss S., 1999 *Rhetorical criticism*, Waveland Press, Prospect Heights, Illinois

Glen S., and Leiba T., 2004, *Interprofessional post-qualifying education for nurses*. Nurse Education in Practice, Palgrave, London

Glendinning C., Coleman A., and Rummery K., 2003 Looking Outwards: Primary care organisations and local partnerships. In B., Dowling and C., Glendinning (eds) *The New Primary Care*. Open University Press, Berkshire.

Granovetter M and Swedberg R., 1992 *The Sociology of Economic Life* Westview Press, Oxford.

Ham C., Hunter D., and Robinson R., 1995 Evidence based policy making. *British Medical Journal* 310, 71-72

Ham C., 2005 Primary care workforce awaits its rescue. *Health Service Journal*, September, 10-11

Handy C., 1989 *The Age of Unreason*, Hutchinson Business, London

Harrison S and Pollit A., 1994 *Controlling Health Professionals: the future of work and organisation in the NHS*, Open University Press, Buckingham

Howarth M., Grant M., and Holland K., 2004 *Shaping the Future for Primary Education & Training Project: A Systematic Review of the Literature*. University of Salford, Salford

HSMU, 1996, *The Future Workforce: The Steering Group Report*, University of Manchester Health Service Management Unit, Manchester

Hutchings S., Hall J., and Lovelady B., 2003 *Teamwork: A guide to successful collaboration in health and social care.* Speechmark, Oxon

Huxham C., 2000 The challenge of collaborative governance *Public Management* 2 (3) 337-358

Jackson B., 1999 The Goose that laid the Golden Egg?: A rhetorical critique of Stephen Covey and the Effectiveness Movement. *Journal of*

Management Studies 36 (3) 354-377

Jordan S., 2000Educational input and patient outcomes: exploring the gap. *Journal of Advanced Nursing* 31(2) 461-471

Kim S., 2003 Research paradigms in organisational learning and performance: competing modes of enquiry. *Journal of Information Technology Learning and Performance* 21 (1) 9-18

Kumar S., 2000 The new genetics and general practice: revolution or continuity? In P. Tovey (ed) *Contemporary Primary Care: the challenges of change*. Open University Press, Buckingham.

Lacey P., 1998, Interdisciplinary training for staff working with people with profound and multiple learning disabilities. *Journal of Interdisciplinary Care* 12 (1) 43-52

Leading at the Point of Care, 2003, Leadership Centre, Department of Health, London

Leathard A., 1994 *Going interprofessional: working together for health and welfare*. Routledge, London

Miller C., Ross N., and Freeman M., 1999, *Shared learning and clinical teamwork: new directions in education for multi-professional practice.* English National Board, London.

Moss-Kanter R., 1994 Collaborative Advantage: The Art of Alliances. *Harvard Business Review*, July-August, pp. 96-108

Pirrie A., Elsegood J and Hall J., 1998 *Evaluating multidisciplinary education in healthcare*. Final Report for Department of Health, London

Porter M., 1980 *Competitive Strategy* Free press, New York

Quinn R., 1988 *Beyond rational*

management: mastering the paradoxes and competing demands of high performance. Jossey-Bass, San Francisco

Robinson R., and Exworthy M., 2000 *Three at the Top: Preliminary Report on Chief Executives and Board Chairs at First Wave primary Care Trusts*, LSE, London

Rossman G., and Rallis S., 1998 *Learning in the field – An introduction to qualitative research*. Sage Publications, London

Silverman B., and Baum J., 2002 Alliance-based competitive dynamics. *Academy of Management Journal*, 45 (4) 791-806

Skills for Health, 2003 *A Health Sector Workforce Market Assessment. Skills for Health*, Bristol

Stake R., (1995) *The Art of Case Study Research*, Sage publications, London

Stark S., Stronach, I., Warne, T., Skidmore, D., Cotton, A., & Montgomery, M. 2000 Teamworking in mental health: zones of comfort and challenge. *Research Professional Education* 17, ENB, London.

Stewart M., 2002 *Systems governance – towards effective partnership working*. Paper for the Health Development Agency Seminar Series on Tackling Health Inequalities, The Cities Research Centre, Bristol.

Summerton N., 1999 Accrediting research practices. *British Journal of General Practice* 49 (438) 63-64

Swanson J., 2000, Zen Leadership: Balancing energy for mind, body and sprit harmony. *Nursing Administration Quarterly* 24 (2) 29-33

Taylor M., 2000, Communities in the lead – organisational capacity and social capital. *Urban Studies* 37, 1019-1035

Warne T., 1999 *Customs and Contracts in the UK GP Fundholding scheme*. Unpublished PhD thesis, Manchester Metropolitan University

of *Psychiatric and Mental Health Nursing* 11, 654-661

Warne T., Stark, S., and Street C., 1999 *A study of workforce planning issues of nurses working in primary care*. St Helens and Knowsley, Liverpool, and Sefton Health Authority, North West Education and Training Consortia, Merseyside

Warne T., Skidmore D., and McAndrew S., 2002, *The NHS Plan: a Policy-Practice Tension*, phoenixtn.net/evora/papersOriginal/presentation

Warne T and Stark S., 2003 The Family Practitioner Family – the use of metaphor in understanding changes in PHC organisations. *Primary Health Care Research and Development* 4:4 292-300

Warne T., and Skidmore D., 2004 *Evaluation of a multi-professional Cadet Scheme*. Greater Manchester Workforce Development Confederation, Manchester.

Warne T., and Stark S., 2004, Service Users, metaphors and team working in mental health. *Journal*

Warne T., and McAndrew S., 2004a *Overcoming Service User Anomie in promoting choice and equity in mental health care*. Conference Proceedings: World Association for Social Psychiatry, 1st regional congress of social psychiatry, Johannesburg, South Africa.

Warne T., and McAndrew S. (Eds) 2004b *Using Patient Experience in Nurse Education* Palgrave Publishers.

Warne T., and McAndrew S. 2004c The Mental Health Assistant Practitioner: An Oxymoron. *Journal Of Psychiatric and Mental Health*

Nursing 11, 179-184

Warne T., and McAndrew S. 2005a Improving PPI: as easy as ABC? *PPI Monitor*, February.

Warne T., McAndrew S., 2005b *Mel K's Breasts and other tales of heroes and villains*. Conference proceedings, 10th RCN European Mental Health Nursing Conference, Amsterdam.

Warner M., Longley M., Gould E., and Picek A., 1998 *Healthcare Futures 2010. Report for the UKCC Education Commission*, Welsh Institute for Health and Social care, University of Glamorgan, Pontypridd

Webb A., 1991 Coordination – a problem in public sector management *Policy and Politics* 19 (4) 229-241

Wenger E., 2000 *Communities of practice – learning, meaning and identity*. Cambridge University Press, Cambridge

Young D., and Gould M., 1993 *Effective Headquarters Staff - A guide to the size, structure and role of cooperate headquarters staff*. Ashridge Strategic Management Centre, London.

Zwarenstein M., Atkins J., Barr H., Hammick M., Koppel I., & Reeves S, 1999 A systematic review of interprofessional education. *Journal of Interprofessional Care* 13 (4) 417-424

Appendix 1:
Vision of the Future for Integrated Health and Social Care the Primary Care Workforce Perspective

Thank you for taking the time to complete this questionnaire. It is made up of a number of short sections. Apart from **Q1** and **Q2**, you need only to either tick a box or circle the point that most closely fits your point of view based upon your experience of working in your current organisation. For example:

I love to fill in questionnaires	**S/D**	**D**	**(A)**	**S/A**

where S/D = strongly disagree and S/A = strongly agree

Q1   Personal Details

Age:		Sex:	

Your professional background:	
Your current role:	
Type of organisation:	
Length of time in this organisation:	Length of time in Health/Social Care:

Q2   Organisational Roles

Which individual(s) in your organisation works in the following ways?	Job Title	Role
Participates in partnership working with other individuals and groups		
Participates in partnership working with other individuals and groups, communities and agencies		
Develops, sustains and evaluates partnership working with other individuals and groups, communities and agencies		
Enables individuals and groups, communities and agencies to work effectively in partnership		
Supervises the work of a team		
Plans, allocates, assesses and provides feedback to team members		
Allocates, co-ordinates, monitors and assesses the work of teams and individuals		
Delegates work to others		
Develops, implements and evaluates policies and strategies for recruiting, deploying, developing and retaining staff		
Leads work teams in the development of knowledge, ideas and work practice		
Leads multi-agency teams and communities in the development of knowledge, ideas and work practice		
Comments:		

Q3   How many staff in your organisation have separate (different) employers?

None   1% – 10%   11% – 25%   26% – 50%   51% – 75%   All   Don't know

Q4   How many staff in your organisation have separate (different) managers?

None   1% – 10%   11% – 25%   26% – 50%   51% – 75%   All   Don't know

Q5   Strategic Working

The organisation has a clear vision of partnership working	S/D	D	A	S/A
The organisation vision is known to other health and social care agencies	S/D	D	A	S/A
The organisations vision is used as a reference point in:	S/D	D	A	S/A
■ prioritisation of activities	S/D	D	A	S/A
■ prioritisation of resources	S/D	D	A	S/A
■ keeping the organisation focused	S/D	D	A	S/A
Leadership functions are shared across the organisation	S/D	D	A	S/A
Other partnership organisations published plans reflect your organisations strategic plans	S/D	D	A	S/A
Strategic management of the organisation fully involves service users & carers	S/D	D	A	S/A
Regular planning meetings are held with partner organisations	S/D	D	A	S/A
Regular monitoring and evaluation meetings are held with partner organisations	S/D	D	A	S/A

Q6   Tactical Working

All the different groups in the organisation participate in the definition of problems and/or issues that need to be addressed	S/D	D	A	S/A
All individuals use a common approach for addressing problems/issues	S/D	D	A	S/A
The organisation creates new value - something that individuals and groups could not achieve on their own	S/D	D	A	S/A
Inter-professional training for integrated working is actively promoted	S/D	D	A	S/A
Individuals believe that each members contribution is essential for the realisation of the organisations goals	S/D	D	A	S/A
Individuals within the organisation have the skills necessary to achieve the overall organisational objectives	S/D	D	A	S/A
Use is made of other partnership organisations to ensure a comprehensive skill base is available	S/D	D	A	S/A
Individuals share a sense of responsibility for organisational outcomes, not just the outcomes for which they are individually responsible for	S/D	D	A	S/A

Q7   Operational Working

Meetings are held across the organisation with the frequency required to ensure:·	S/D	D	A	S/A
■ full communication	S/D	D	A	S/A
■ adequate problem solving	S/D	D	A	S/A
■ efficient progress towards organisation goals	S/D	D	A	S/A
The different roles of all those working in the organisation is clearly understood	S/D	D	A	S/A
Multi-professional training is the norm not the exception	S/D	D	A	S/A
Individuals and groups give appropriate, timely and specific feedback to each other	S/D	D	A	S/A
Individuals respond to critical feedback without getting defensive	S/D	D	A	S/A
The organisation has written agreements for how it will work together:				
■ there is consistency of use	S/D	D	A	S/A
■ periodically checked for consistency of use	S/D	D	A	S/A
In meetings, individuals emphasise the open, inclusive and respectful sharing of thoughts and ideas	S/D	D	A	S/A
Individuals deal openly and constructively with problems and conflicts, not allowing these to hinder the organisations performance	S/D	D	A	S/A
Individuals keep their professional bodies, and/or organisations informed about the organisations activities, challenges and progress	S/D	D	A	S/A
Decision making process are clear and transparent to all individuals	S/D	D	A	S/A
Individuals have equal opportunity to influence the direction of the organisation	S/D	D	A	S/A
Resource allocation within the organisation is transparent and in-line with the principles agreed upon by the organisation	S/D	D	A	S/A

Q8 Interpersonal Relationships

Leadership is facilitative involving all the organisations staff in:·				
■ decision making	S/D	D	A	S/A
■ problems solving	S/D	D	A	S/A
■ planning	S/D	D	A	S/A
Individuals share and act according to agreed values regarding the expected outcome of the organisation	S/D	D	A	S/A
Individuals consistently deliver on promises and commitments made	S/D	D	A	S/A
Individuals actively seek to learn from:				
■ the experience and knowledge of others working within the organisation	S/D	D	A	S/
■ and/or in partner organisations	S/D	D	A	S/A
Individuals are open about organisational interests and expectations: keeping covert or hidden agendas to a minimum	S/D	D	A	S/A
Individuals are willing to compromise or make organisational sacrifices of self-interest so that the needs of others' in the organisation are met	S/D	D	A	S/A
Individuals can articulate others' concerns and/or interests when problems and issues are being addressed	S/D	D	A	S/A
Individuals across the organisation keep others' appropriately informed about:				
■ their work	S/D	D	A	S/A
■ their problems	S/D	D	A	S/A
■ their accomplishments and progress	S/D	D	A	S/A
There are agreed norms and processes for holding each other responsible	S/D	D	A	S/A

Q9 Cultural Integration

The organisation uses the diverse skills, knowledge and backgrounds of its staff	S/D	D	A	S/A
Individuals express ideas openly and honestly without irritating others	S/D	D	A	S/A
Leaders ensure that all voices are heard before decisions are made	S/D	D	A	S/A
Individuals use successes and mistakes as learning opportunities to increase skills for future decision making	S/D	D	A	S/A
The organisation has explicit agreements on how to handle the public visibility, and achievements of individual members	S/D	D	A	S/A
The organisation uses other partner organisations to bench mark best practice	S/D	D	A	S/A
Individuals share a responsibility to ensure that other organisations demonstrate a commitment to the organisations goals	S/D	D	A	S/A
Individuals are watchful for opportunities to acknowledge the contribution of others'	S/D	D	A	S/A
Primary care services should become more specialist and less generic in terms of the services provided	S/D	D	A	S/A
Individuals and groups pitch in and help others who are experiencing problems or needing assistance to meet deadlines or outputs	S/D	D	A	S/A

Q10 Educational Integration

All requests for training and personal development opportunities are discussed by the organisations Education and Training Manager	S/D	D	A	S/A
The organisation has good links with local educational providers	S/D	D	A	S/A
The Workforce Development Confederation helps the organisation meet its educational and training needs	S/D	D	A	S/A
My manager has a good understanding of my competence and skills base	S/D	D	A	S/A
My organisation encourages individuals to pursue their own personal development	S/D	D	A	S/A
Current-training courses offered by universities and colleges are effective in meeting current service needs	S/D	D	A	S/A
Current-training courses offered by universities and colleges are effective in preparing practitioners for meeting future service needs	S/D	D	A	S/A
All training and personal development provided by the organisation includes the participation of service users	S/D	D	A	S/A
I think that 'integrated working' is better 'caught than taught'	S/D	D	A	S/A
The development of a generic health and social care worker will enhance the role of current health and social care professionals	S/D	D	A	S/A
There should be a common core pathway for all health related professionals at the basic training level	S/D	D	A	S/A
Future educational approaches should be based upon national practice competence standards	S/D	D	A	S/A
Wherever practical, learning should be shared by different staff groups and professions	S/D	D	A	S/A
Lifelong learning should central to organisational development and service improvement	S/D	D	A	S/A
Each professional group should be allowed to decide the best way to teach, learn and assess professional practice	S/D	D	A	S/A
Access to education, training and development should be as open and flexible as possible	S/D	D	A	S/A

Q11 Which one of the following definitions of 'integrated health and social care' would you most closely agree with?

'Care that is determined by partnerships between health agencies, social care agencies and users and carers for the health and well being of the local community'	
'An organisation that is made up of different health and social care agencies able to plan and deliver a range of services to meet the needs of a local community'	
'Service provided by a multi-professional team working towards meeting the needs of a local community, although sometimes, having different bosses makes life difficult'	
'Realistically, there is no such thing as integrated health and social care services'	
Other (Please add your own if those above do not reflect your definition):	

Q12 How many of the following examples of integrated health and social care have your organisation been involved in? (tick as many as you like)

	Not at all	As a partner	Led the project
Health and leisure services	☐	☐	☐
Joint (shared) health and social care records	☐	☐	☐
Joint (shared) health and social care information systems	☐	☐	☐
Multi-agency services for older people	☐	☐	☐
Multi-agency services for children and young people	☐	☐	☐
Ethnically sensitive service responses	☐	☐	☐
Multi-agency health and social needs assessment for asylum seekers and refugees	☐	☐	☐
Support of a service users groups	☐	☐	☐
Sure Start initiatives	☐	☐	☐
Joint (shared) appointments of all staff	☐	☐	☐
Service user/led services for people with mental health problems	☐	☐	☐
Service user/carer led services for people with learning disabilities	☐	☐	☐
Joint (shared) training for all staff	☐	☐	☐
Development of a 'one stop' health/social care service	☐	☐	☐

Other: _____

_____

Q13 In your opinion who drove this initiative?

Individual GP	Individual Nurse Worker	Individual Social	PCT Board Community Worker	Individual
Strategic Health Authority	Health Manager	Social Care Manager	Voluntary Sector Org.	Other/don't know

Q14 What were the reason(s) given for introducing this form of working?

	Secondary driver	Secondary driver
Response to local health needs assessment		
Response to NSF target		
Response to research outcomes		
Economic (cost savings)		
Service Development Plan		
Service user consultation		
Stake holder consultation		
No reason given – just told to do it		
Availability of funds		
Other:		

Q15 How prepared were you (as an individual) for this initiative?

Not involved   Completely unprepared   Partially prepared   Mainly prepared   Fully prepared

☐   ☐   ☐   ☐   ☐

Q16 What form did any preparation for your participation in this initiative take?

☐ 'Away-day' training session(s) – your organisation

☐ 'Away-day' training session(s) – multi-agency

☐ Other in-house training – your organisation (please state)_____

☐ Other in-house training – multi-agency (please state)_____

☐ Modernisation Agency led training sessions

☐ Self study

☐ Uni-professional training and development

☐ Course at University/College

☐ Other:

_____

Q17 How would you (as an individual practitioner) like to be prepared for any future initiatives? (tick as many as you like)

☐ Team briefing meetings

☐ 'Away-day' training session(s) – your organisation

☐ 'Away-day' training session(s) – multi-agency

☐ Other in-house training – your organisation (please state)_____

☐ Other in-house training – multi-agency (please state)_____

☐ Modernisation Agency led training sessions

☐ Self study

☐ Uni-professional training and development

☐ Course at University/College

Other:_____

_____

Q18 How often have you been offered interdisciplinary training and education?

Never	Only in basic training	Occasional in-house course	Regular offers received	Routinely offered
☐	☐	☐	☐	☐

Q19 What was the purpose of the training?

_____

Q20 How often have you participated (as a learner) in interdisciplinary training and education?

Never	On a ad-hoc basis	Through clinical supervision	Regularly participate	Routinely participate
☐	☐	☐	☐	☐

Q21 How are your training needs assessed?

They are not	Only in basic training	Occasional in-house course	Annual personal development review
☐	☐	☐	☐

☐ Other: (please state) _____

Q22 How would you like your training needs to be assessed?

Own assessment	On a ad-hoc basis	Through clinical supervision	Annual personal development review
☐	☐	☐	☐

☐ Other: (please state) _____

Q23 Which aspects of interdisciplinary training worked well (or not) in your experience?

	Worked well	Did not work
Sharing different professional experiences	☐	☐
Collaborative decision making	☐	☐
Multi-professional problem solving	☐	☐
Sharing and agreeing best practice evidence	☐	☐
Ensuring a user led focus is maintained	☐	☐
Organisational boundary crossing	☐	☐

☐ Other: _____

_____

_____

Q24 How were service users involved?

Planning the training	Delivering the training	Evaluating the training	As a participant learner	Representing a special interest
☐	☐	☐	☐	☐

Q25 How often have you been able to participate in the training provided by other health and social care organisations?

(Health)

Never	Sometimes for special projects	Occasional in-house course	Regularly participate	Routinely participate
☐	☐	☐	☐	☐

Details _____

_____

(Social)

Never	Sometimes for special projects	Occasional in-house course	Regularly participate	Routinely participate
☐	☐	☐	☐	☐

Details

_____

_____

Is there anything else you would like to tell us about how you and/or your organisation have experienced the provision and delivery of integrated health and social care services

Thank you for taking the time to help the Shaping The Future Project better understand the workforce views.