www.pcet.org.uk

Cumbria

Lancashire

Gtr Manchester

Merseyside

Cheshire

LANCASTER UNIVERSITY

UNIVERSITY OF CENTRAL LANCASHIRE

boltoninstitute

University of Salford
A Greater Manchester University

Manchester Metropolitan University

JMU

CHESTER

9 780902 896628

Shaping the Future for Primary Care Education & Training Project

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

A Systematic Review of the Literature

VISIONS FOR THE FUTURE

Authors: Michelle Howarth
            Maria J Grant
            Karen Holland

VOLUME: ONE

2004

nwUa
North West Universities Association

Primary Care Education & Training Project

Contents

Executive Summary

Introduction

This literature review is one of series of outputs from *Shaping the Future in Primary Care Education and Training project (www.pcet.org.uk)* which is 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.

Methodology

An iterative search process was adopted for the review. A total of 80 documents were identified as background, context or policy papers and 24 research studies have been appraised in terms of their rigour, trustworthiness and relevance. The review took account of and included an appraisal of contemporary literature, key policies and research evidence. In particular it took account of the importance and inter-connectedness of policy, practice, population and workforce needs within an integrated health and social care service.

Evidenced based implications for health and social care services and education

Six key themes emerged from the policy documents and wider research evidence base. These are:

- team working
- professional and personal development
- practice development and leadership
- role awareness
- partnership working
- communication

The themes have been mapped against the NHS Knowledge and Skills Framework, National Primary and Care Trust Development Programme

Competency Framework (NatPaCT) and the National Occupational Standards for Health and Social Work. The combined themes are considered essential requirements of effective integrated health and social care services.

The key implications for health and social care services and education are:

Team working

- Develop teams, with the appropriate skills and knowledge, that are able to liaise and work collaboratively across organisations and agencies
- Ensure that any team has the required awareness of all the member role functions and professional background as appropriate
- Education and training programmes need to take cognisance of team working in integrated health and social care services, and not simply working in a team
- Education and training for team working needs to be planned to take account of both inter-professional working and inter-agency working
- Service planning and service provision need to take account of the education and training required for a whole team when creating new roles
- Pre-registration/access to health work programmes need to place greater emphasis on team working in integrated health and social care as a core skill
- Co-location of teams needs to take into account education and training for new ways of working

Communication

- Ensure staff working in integrated teams have well developed communication skills to enable

them to work within and across inter-professional and inter-agency boundaries

- Pre-registration/access to health work programmes need to ensure that effective communication skills for integrated working, including use of technology, are core skills
- Ensure a common language is used between health and social care organisations to aid effective team work
- Ensure service users of integrated services are integral to developing communication networks and language
- Ensure that the workforce has the knowledge and skills to manage changing communication channels e.g. information technology

Role awareness

- Role awareness should become an essential element of all programmes relating to preparing the workforce to deliver integrated health and social care
- When developing new roles ensure that there has been organisational preparation for their introduction into the workforce
- Shared learning initiatives between health and social care workforce students in practice should be encouraged to develop awareness and understanding of team roles
- A variety of innovative learning opportunities need to be considered, including role shadowing, secondments to work with multi-professional team and inter-professional education
- Role awareness education for service users/carers should be considered essential to ensure effective communication and appropriate use of services

Practice development and leadership

■ Leaders need to be identified and educated to lead integrated health and social care services

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

■ Leadership education and training for integrated health and social care services needs to be built into educational programmes for all professions

■ Practice development in integrated health and social care requires collaboration between education and training organisations and departments to ensure skills and knowledge base meets requirements for service and user outcomes

Personal and professional development

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

■ Supportive environments need to exist to enable personal and professional development in integrated working

■ Flexible learning opportunities need to exist to enable the workforce to be able to access inter-professional/inter-agency working programmes

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

■ Personal and professional

development education and training programmes need to include essential competencies in team working, role understanding and effective communication as well as leadership development for working in integrated health and social care

Partnership working

■ Partnership and collaboration between health and social care should be essential in the development of curricula for integrated health and social care working

■ Education and training standards from professional bodies should include core requirements for partnership working to deliver integrated health and social care

■ Education and training providers (HE/FE) need to consider including compulsory elements for integrated working, taking account of team working, effective communication and role awareness as essential elements of the programme

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

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

The evidence from this review has been integrated into the development of other project outputs. Full recommendations for future policy and practice in relation to education and training of the workforce to delivery integrated health and social care services will be provided in the final overarching project report.

The Project Context

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* 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, i.e. Health
- The North West Universities Association
- Three North West Strategic Health Authorities
- Primary Care Trusts
- Social Services
- Higher Education Institutions and Further Education Colleges

The project has a project management and development team and a participative Steering Group, which it is anticipated will be the precursor to a close 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.

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, international and national 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 delivery of 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.

Conclusion

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 1:
Methodology for Systematic Review

This report provides a systematic review of what is known about the current and future education and training needs of the primary care trust workforce to achieve and deliver integrated health and social care services. Whilst the broader project aim is concerned with the primary care trust workforce in the North West of England, the review is contextualised within the local, national and international perspective of integrated health and social care.

1.1   Methodology

Systematic reviews are thought to have emerged relatively recently (Cullum 1999). Technological advances over the past decade have resulted in the publication of a vast array of literature. Research evidence has become more accessible as a result and systematic reviews were developed because they have the ability to reduce large amounts of research into key findings (Droogan & Cullum 1998). Systematic reviews have been defined as being:

"A review of a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant research and to collect and analyse data from the studies that are included in the review" (Mulrow & Oxman 1997:Section 6.7.2).

The goal of any systematic review is to produce an analytical evaluation of the topic area (Hart 1998). Correspondingly, the aim of this systematic review was to draw together research evidence which related to integrated health and social care services in order to enable the overall project aim to be met.

The overarching project aim was:

'To identify the evidence of current and future education and training needs of the North West of England
primary care trust workforces to achieve and deliver Integrated Health and Social Care services and the NHS modernisation agenda, taking into account the needs of the independent sector as it interfaces with primary care'

This aim influenced all stages of the review process. Key terms identified through the review were used to develop a working definition of integrated health and social care. Glendinning (2002) argued that there is a need to allow agencies to adopt an entirely flexible approach which can reflect local needs and which should be reactive to the expertise and levels of trusts and partners. The project team was keen to reflect this notion by ensuring that the definition encompassed the community both in the local and individual context. (See Box 1)

To ensure an accurate, transparent account of the review, validated critical appraisal techniques were used to identify the strengths and limitations of research located. Validated appraisal tools, such as the Health Care Practice Research and Development Unit (University of Salford) tools for qualitative, quantitative and mixed method research designs were used (Health Care Practice Research and Development Unit 2001), together with critical appraisal tools developed by Critical Skills Appraisal Programme ((CASP), Public Health Resource Unit 2003). The appraisal also took account of Avis's (1994) three key principles: consideration of the relevance, evaluation of the evidence and the validity of any conclusions. As a result, all the retrieved documents were appraised in terms of their rigour, trustworthiness and relevance. The iterative nature of the appraisal process resulted in the inclusion of research articles which were of direct

relevance to the project and whose methodologies were appropriate and robust.

Prior to the appraisal, the first step was to identify and map all the key words and terms associated with integrated health and social care. To accomplish this, an iterative search process was adopted which facilitated a fluid interaction between all activities in the review lifecycle (Grant & Brettle 2000). This included the scoping of, searching for and appraising of the evidence base, reviewing the process in light of emerging findings, revisiting stages and defining the next steps.

1.2   Sources of Evidence

The breadth of the topic area covered a range of perspectives and crossed professional boundaries necessitating a comprehensive approach to searching.

Background documentation was identified from organizational and governmental web sites, whilst the broader evidence base including research studies was identified by searching a range of bibliographic databases (see Table 1).

Table 1: Source of Evidence

Web sites	Bibliographic databases
● English Department of Health	● Caredata (Grey/unpublished)
● European Observatory on Health Care Systems	● CINAHL (Allied health professionals)
● Health and Community Care Research Unit (HaCCRU)	● ERIC (Educational)
● King's Fund	● MEDLINE (Biomedical)
● National Assembly of Wales	● Sociological Abstracts (Sociological)
● Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS)	*The Department of Health report 'Liberating the Talents' (2002a) was also used to identify and initiate approaches with key personnel involved with the Modernisation Agency 'Changing Workforce Programme', NHS Modernisation Agency, National Primary and Care Trust Development Programme (1994).*
● Scottish Parliament	
● UK Centre for the Advancement of Interprofessional Education (CAIPE)	

1.3   Review Structure

An audit trail of all documents identified during the lifetime of the review was created using Endnote reference management software. Documents were categorized as either being included in the review, excluded from the review, or requiring further assessment. A checklist was developed to assist with this process (see Appendix 1).

During the initial scoping exercise it became apparent that ambiguities existed concerning the terms primary care and integrated health and social care. Clarity was sought via key policy documents and discussions with the project management team. A set of working definitions to inform the overall project was agreed. (See Box 1).

From project management team discussions, emerging evidence from search results, and insights into the 'reality' of integrated health and social care initiatives from key personnel identified via *'Liberating the Talents'* (Department of Health 2002a), the inclusion and exclusion criteria were continual reviewed and

Box 1: Agreed working definitions

Integrated Health and Social Care:
Care that is determined by partnerships between health and social care agencies and users and carers for the health and well-being of the (local) community.

Primary Care:
Primary Care encompasses social, community and primary care. We recognise that currently these three areas remain distinct rather than being encompassed in a generic term.

refined (see Appendix 2). Working collaboratively resulted in the development of tightly defined search strategies which were then utilised within bibliographic databases. Searches were then revisited and further enhancements made. A combination of free-text and thesaurus terms were utilised to maximise recall. To accommodate the indexing policies of the databases, unique search strategies were developed for each resource (see Appendix 3). Citation tracking

identified additional relevant studies, and quality checks were made against the search strategies to identify why they had not been retrieved.

A total of 602 database records were retrieved, including duplications, of which 297 were selected for relevance checks. From these checks, 80 documents were identified as background, context or policy papers, with 24 research studies identified for in-depth critical appraisal. The number of research studies meeting

the review inclusion criteria varied for each database; from 3 studies (MEDLINE) to 11 studies (CINAHL - see Table 2). Each database contributed a substantial percentage of unique studies (13%-48% - see Table 3). (Unfortunately, one of the search strategy databases (Sociological Abstracts) was 'lost' due to serious network failure and is unable to be recorded within the review).

Table 2: Origins of research studies included in the review

	Caredata	CINAHL	Hand-searching/ citation tracking	ERIC	MEDLINE	Sociological Abstracts
All studies	4	12	6	0	3	0
Unique studies	3	11	6	0	3	0

Table 3: Percentage contribution of research studies from each database

	Caredata	CINAHL	Hand-searching/ citation tracking	ERIC	MEDLINE	Sociological Abstracts
Unique studies	3	11	6	0	3	0
%contribution to the overall review	13%	48%	26%	0%	13%	0%

The iterative process was adopted to ensure that integration of all the individual project Work Packages 'contributed to the development of the review'. In turn these were dependent on the review evidence for development of their methodologies and project outputs.

Although the research base is limited due to limited transparency, it has illuminated ways of working at both a strategic and operational level. Reviewing the evidence revealed that much of the work to promote integrated services has been undertaken but the findings have as yet, not been combined through a comprehensive review.

Chapter 2:
Integrated Health & Social Care

Collaboration and partnership are inherent components which warrant the expediency of integrated services. By its very nature, integrated health and social care relies upon the successful collaboration and partnerships between service providers, agencies and professional groups. However, integrated health and social care is a fluid concept, which many have tried to define. On the most part, the evidence has demonstrated that achieving collaboration between organisations, agencies and institutions has proved problematic. This may be due to the fact that to date, collaboration, integration and partnership have remained ambiguous concepts within the literature.

As the main aim of this systematic review was to search for and appraise relevant research articles, it was felt that the concept of integrated services required some clarification. In an attempt to decipher these meanings, a variety of literature was located in the first stage of the review. Surprisingly, although it was widely agreed that successful collaboration is pivotal in partnership working, its concept and application has received limited formal exploration. Henneman, Lee & Cohen (1995) argued that this lack of exploration consequently led to the concept of collaboration being primarily theoretical. This resulted in ambiguity regarding the meaning of partnership, which has been described as "a vague concept, capable of many interpretations, and its evaluation is therefore problematic" (Glendinning, Abbott & Coleman 2001). Credible authors such as Øvereit, Mathias & Thompson (1997), Glendinning *et al* (2001) and Loxley (1997) were used to inform this chapter to try and decipher the concept of collaborative care and how this was considered to be

integral to the notion of integrated care. Attempting to define integrated health and social care has also been challenging due to the plethora and range of theories and opinion which litter contemporary debate.

2.1 The Meaning of Collaboration

In their concept analysis, Henneman *et al* (1995) selected a dictionary definition to define the term 'collaborate' as opposed to providing any analytical framework or new definition. It is interesting to note that the tenth edition of the Oxford English dictionary (2001) defines collaboration as "working jointly on an activity or project". However, to 'collaborate' may also be defined as "co-operating traitorously with an enemy". This may explain why some avoid the use of the term collaboration. Alternatively, Warren, Rose & Bergunder (1974) offered a definition of collaboration as being:

"a structure or process of concerted decision making wherein the decisions or actions of two or more organisations are made simultaneously in part or in whole with some deliberate adjustment to each other"

When discussing the definition of attributes required for collaboration Henneman *et al* (1995) conferred with other authors (for example, Glendinning, Rummery & Clarke 1998:104) that "collaboration requires that individuals view themselves as members of a team, and contribute to produce a common product or goal". Henneman's paper provided model cases that outlined contrary and related cases to exemplify the concept of collaboration. In addition, Henneman *et al* (1995:106) stressed the importance of the individual having a "clear understanding and acceptance

of their own role and level of expertise", together with the recognition of their own role boundaries.

As a result of an extensive concept analysis of collaboration Sullivan (1998) offers a definition which encompasses 'partnership':

"Collaboration is defined as a dynamic transforming process of creating a power sharing partnership for pervasive application in health care practice, education, research and organizational settings for the purposeful attention to needs and problems in order to achieve likely successful outcomes". (Sullivan 1998:6)

2.2 Achieving Collaboration

The introduction of an internal market in health coupled with economic pressures in the 70's and 80's, created a strong culture of competition within and between services which led to marketisation and division in service provision. To reverse this dominant culture and negate the effects of the internal market, the New Labour government (1997) challenged the existing status in an attempt to ameliorate services through the publication of a white paper entitled *'The New NHS: Modern, Dependable'* (Department of Health 1997). This paper introduced a ten-year strategy aimed at promoting a collaborative culture through which health and social care could fashion successful partnerships.

With the implementation of these White Paper recommendations for modernisation (Department of Health 1997), a new direction has been introduced to health and social care providers. The move from expensive acute care settings to one based in the community may have reflected a cost-cutting strategy, which aimed to

improve costs and reduce resources. The resultant shift from the internal market to one that takes account of the services user and promotes the concept of co-operation not competition and actively encourages inter-agency collaboration has been at the forefront of strategic service planning. However, Hudson, Hardy, Henwood & Wistow (1999) pursued the notion that an inter-agency collaboration remains "conceptually elusive and perennially difficult" (Hudson *et al* 1999:236). They attempted to explore the concept of collaboration and argued that key elements of rationality and altruism are naïve assumptions made about organisations in the pursuit of collaborative practice. Whilst reticent about elements of collaboration, Hudson *et al* (1999) proposed an iterative and cumulative 'framework' to collaboration which ranged from the context in which it could flourish, the recognition of the need to collaborate, assessment of collaborative capability, nurturing fragile relationships to the more pragmatic guidance for ensuring organisational ownership and implementation. These components are to some extent echoed in the findings of research that has explored both barriers and supporting influences in relation to the integration of services.

2.3 Defining Primary Care within the context of integration

Recent aspirations of the modernisation agenda and new primary care policy initiatives have endeavoured to define integrated health and social care within a strategic primary care context. Paradoxically, a parallel can be drawn between the concept of collaboration and primary care. Not dissimilar to the problems associated with defining

the parameters of collaboration, very few have considered the ideology of primary care. For example, when considering the definition of collaboration, Ling (2000) suggested that the variety of academic and non-academic commentaries about partnership and collaboration amounted to "methodological anarchy and definitional chaos". It is not surprising therefore that generally, (to date) no single, all-inclusive definition has been offered for primary care. Titles to describe primary care have often been underpinned by a medical model and the notion of 'first point of contact'. Given the lack of formal and acceptable definition, it could be argued that partnership and other terms might be indicative of a range of services dependant upon the organisational context. Glendinning *et al* (2001) contends that this is a beneficial arrangement because it allows for agencies to adopt an entirely flexible approach which can reflect local needs and which is reactive to the expertise and levels of trusts and partners (Glendinning *et al* 2001).

In an attempt to draw parameters to refine this systematic review, concepts of integration were also explored within the context of primary care. Primary care is often defined according to the services involved, so, for example primary care in relation to 'Sure Start' initiatives (programmes designed to empower disadvantaged young people to provide the best opportunities for growth and development) involves a range of professionals, but not all. Services within primary care may not be integrated; one person may simply need to see the pharmacist or chiropodist without the need to seek help or advice from other professionals. Therefore, it may be surmised that integrated health and

social care occurs *as a result of* primary care and may involve a number of services or professionals to meet the needs of the client. Integrated health and social care could be considered as potentially central to service delivery but not essential.

If it is accepted that integrated health and social care is as a result of and not the focus of primary care, questions then may arise as to the relationship between integrated health and social care with primary care. Similarly, is it possible and or realistic to suggest or advocate a single definition for integrated health and social care that also encompasses primary care? To answer this question, a range of primary care definitions was utilised in the review in an attempt to situate integrated services within the context of primary care. The breadth of definitions encompassed Pringle's (1998) description of primary care being "a system for providing first contact rather than a value system" to Kendrick & Hilton's (1997) view that primary care is "health care delivered outside the acute hospital sector". Both of these definitions were located in the British Medical Journal but whilst obvious undertones of a medical model are evident, there is little attention paid to the 'well-being' of the individual or community. Similarly, the social care context is rarely reflected in any definition of primary care or integrated health and social care. This has highlighted a noticeable gap in terms of practitioners' perceived understanding of the concept of primary care.

Although transparent at a strategic level, the existing operational issues and barriers have so far reported a health rather than a social status for organisations and services with the use of performance indicators to

provide measurable variables for health. On the surface, these have excluded the social influence on care and wellbeing and have advocated the NHS as the political driver more willingly than social services. Perhaps the most notable author to consider this polarisation was Bywaters & McLeod (2001) whose analysis of the current political agenda suggested that social services were still considered to be 'second class' despite the modernisation agenda. In an attempt to single out the key concepts of primary care, Elwyn & Smail (1999) concurred with Bywaters & McLeod (2001) and argued for the case that social care had been excluded from the 'primary care equation'. They suggested that the rhetoric of primary care-led NHS is predicated upon an interesting conceptual sleight of hand that suggested that primary healthcare was in fact synonymous with primary medical care. Whilst they recognised that general practice provided a service to meet health care rather than health needs, Elwyn & Smail (1999) suggested that general practice could never be the whole of the primary healthcare – but is one dimension of it.

Stanhope (1995) considered the social care context and noted that there was a difference between primary care and primary health care. She suggested that primary health care embodies "both primary care and public health as the nuclei for a country's or community's health care system". Stanhope (1995) subsequently incorporated social, cultural and economic developmental issues within the context of primary health care arguing these were an integral part of enhancing the health of a community.

The evidence would suggest that whilst the current Government's

relentless aims to secure an equitable health and social care system places a great emphasis on primary care to integrate services and promote seamless care; initial clarity about the principles of primary care at an operational level has been neglected. With a wide range of philosophical values, primary care appears on the surface, to empower the patient and community and reduce health and social inequalities. As such, primary care is viewed as a panacea for all service development since the introduction of the modernisation agenda, yet its definition is elusive.

2.4 The Nature and Purpose of Primary Care

So far, the evidence has revealed a range of conflicting opinions about the nature and purpose of primary care. There are some authors who argue that health care needs are driven by a limited resource and should be based on population needs assessment in order to secure effective health care service and delivery (Jordan, Wright, Wilkinson & Williams 1998). Conversely, when considering the attributes of primary care, Flocke (1997) suggested that there are several components. She attempted to measure the attributes of primary care from the perspectives of the patient by developing an instrument which took into consideration key primary care traits as dictated by the service user. To facilitate this, she relied heavily on the Institute of Medicines (IOM) definition of primary care, which stated that primary care, is:

"the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing sustained partnership with

patients, and practising in the context of family and community". (Flocke 1997:64)

This medicalised perspective exemplifies the role of the physician rather than the 'integrated' team. Alternatively, Farrell, Schmitt & Heinemann's (2001) description of an interdisciplinary team, appears to be more congruent with the principles of primary care. They described the integrated team as being "a group of colleagues from two or more disciplines who co-ordinate their expertise in providing care to patients".

Similarly, Gross (1997) offered a definition that had at its nucleus the notion of co-ordination and co-operation when describing integrated delivery systems (IDS). They purported that an integrated delivery system was:

"a network of organisations that provides or arranges a co-ordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served".(Gross 1997:23)

Reflected in this definition is the assumption that the population is defined, which as Jordan *et al* (1998) argued, is a central consideration when developing primary care services to meet the needs of the community. Stanhope (1995) argued and provided a simplistic discussion, which indicated that, the most common definition of primary care was "initial contact with the client with the 'system' for the purpose of receiving treatment for common, episodic acute and chronic illness". The plethora of evidence could leave the reader confused as to the meaning of primary care, but put simply, it appears to be defined by

the population it serves and as a consequence, the professionals who provide such care.

Whether the care is integrated is entirely dependent upon the needs of the client and the community at large. Øvretveit (1993) explored the notion of community care and created a distinction between primary health care and community care. To accentuate the difference, he used the Department of Health's (1989) definition of community care in which it proposed that community care "means providing the right level of intervention and support to enable people to achieve maximum independence and control over their lives". He supported this by stating that care in the community is:

"about helping clients and their carers in or near their homes, rather than in hospitals away from the community in which they live" (Øvretveit 1993:7).

Øvretveit (1993) advocated that primary health care teams were an integral component of one type of community care. Whilst he agreed that many reports referred to the primary health care team, none provided a usable definition. This lack of definition, he argued was due to the need to consider the different ways in which primary health care practitioners and sometimes social workers operated and co-ordinated their services within an area.

This, for example, could involve a variety of services and professional groups, including social care and the independent sector to sustain a healthy, independent community. It is evident that in the majority of literature reviewed to date, definitions identified have paid limited attention to the principles of 'integrated care' which invariably encompasses the social wellbeing of the community and the individual. However, the

literature has revealed that the social care context has, to a large extent been excluded and it would appear that primary care has focussed on the health of the population as opposed to their overall well-being.

Chapter 3:
Integrated Health and Social Care Policy

3.1 Introduction

The introduction of recent reforms through the modernisation agenda emphasised increased partnership working between health and social care (Department of Health 2000a; Department of Health 2001a). The move toward integrated services resulted in front line services working with newly developed practice strategies and frameworks aimed at removing organisational boundaries to promote the successful integration of services. This chapter focuses on the key strategic policies which have had an impact on integrated services.

The publication of the White Paper outlining the modernisation of the NHS (Department of Health 1997) has empowered a range of services to promote collaborative working arrangements through the creation of Primary Care Trusts, joint investment and workforce planning, together with a shift towards inter-professional education. The subsequent redefinition of the internal market introduced by the previous Government has enabled the development of a 'seamless' service for patients based on a commitment to reduce health and social inequalities and protection and support of vulnerable people in society. In essence, the impetus behind the Department of Health's White Paper - *The New NHS: Modern and Dependable* (Department of Health 1997) sought to promote collaboration between organisations and agencies. To achieve this, an approach to health and social care was proposed which combined efficiency and quality with a belief in fairness and partnership and introduced the concept that the National Health Service (NHS) does not or should not work in isolation from social care or other agencies.

Previous attempts by organisations to

move away from the competitive market towards a more unified and collaborative approach proved problematic. Due to the reluctance of organisations to share best practice and the restrictive nature of the funding systems in place to support development, the notion of integrated care struggled from the outset. In response, and through the influence of the modernisation agenda, the subsequent Health Act (Department of Health 1999a) together with the Health and Social Care Act (Department of Health 2001b) eased the process by emphasising the need for collaborative work and recommended that all agencies work together in treating people who are ill and reducing health inequality (Department of Health 1997, 1:2). The publication of *'Preparing Older People's Strategies: Linking Housing to Health, social care and other local strategies'* by the Department of Health (Department of Health 2003a) was a recent example which illustrated work in progress to develop an integrated service between the following agencies and organisations i.e. Health, Housing, Transport and Health Authorities. The central aims of this report were to:

"Ease the process of preparing strategies; ensure that all relevant strategies include appropriate housing components in a consistent way and within a unified vision and strategic direction; enable an easy 'read across' from one strategy to another; and assist 'joined up' planning, commissioning and service delivery."

This strategy complemented the Department of Health 2003-2006 guidance on producing effective housing strategies and targets one of the vulnerable groups in an attempt to reduce health and social care inequalities and promote integrated

services for older people (Department of Health 2002b).

3.2 Promoting a seamless service through policy change

The move to end the internal market and replace it with 'integrated care' was seen by many as a positive step forward to improving services both within health and social care. Aptly named the 'Third Way', Labour offered an alternative solution to managing the NHS, based on partnership and performance. This was to ensure that "individual patients, who too often have been passed from pillar to post between competing agencies, will get access to an integrated system of care" (Department of Health 1997 1:4) therefore promoting a 'seamless' service for all. There is now a greater emphasis placed on local health and social needs and the subsequent push to develop integrated services to meet the needs of the local population. The Third Way has encouraged the NHS to work in partnership by breaking down organisational barriers, developing stronger links with Local Authorities which also ensured that the needs of the patient being central to this process.

To ensure the successful implementation of the modernisation agenda (Department of Health 1997), a range of strategies to support the development of integrated health and social care were proposed. These included National Service Frameworks, which "set national standards and define service models for a defined service or care group" (Department of Health 1998a), and common goals to demonstrate service development and integration with social services, especially areas of social deprivation. Services, it was

suggested, would be enhanced through greater public involvement and transparency that would strengthen the need for accountability to the public.

Some authors, for example, Bywaters & McLeod (2001) were disillusioned with the Governments newfound commitment to integrated services and argued that the rhetoric rather than the reality of a seamless service would prevail. For example, in their review of the introduction of the new central role of social services within health policy, Bywaters & McLeod (2001) discussed the impact of New Labour health policy on social services. Based on their exploration of the four years since the introduction of Labours Third Way, they argued that, despite the well meaning intention to promote a seamless service through integration, ideas outlined within the NHS Plan (Department of Health 2000b) place social services staff within NHS locations, but not vice versa. The disparate relationship between health and social care emphasised the NHS as a dominant partner, reluctant to relinquish control and therefore by implication disregarding Social Services. This convincing argument revealed a rather less than rosy picture that the Government may have wished for, and illustrated existing tensions between services despite strategic efforts to promote a seamless service.

Bywaters & McLeod's (2001) analysis was reciprocated by Glendinning (2003) who reported that despite social service representation on primary care trust boards, they still felt underrepresented. The main thrust of these problems centred on the marginalisation of social service input with decision making and commissioning of services. Evidence of Primary Care Trusts/Primary Care

Groups success in collaborating was limited and the extent to which non-health partners are involved in decision making was unclear. Glendinning (2003) was however, cautious not to over emphasise the apparent success of joint commissioning and pooled budgets and suggested that:

"major reconfigurations of services carried the risk of de-stabilising provider organisations, including major disruptions to the professional staff who worked in them" (Glendinning 2003:147)

which led to staff reluctance to change. It is the influence of the wider policy agenda which Glendinning (2003) suggested may have influenced barriers to integration witnessed today.

The notion that the wider policy agenda has negatively influenced collaboration was further expounded by The King's Fund (2002) based on the progress in partnership working between the NHS and local Government argued that current NHS shortfalls within acute care have driven government policy.

A 'push – pull' scenario between government and the NHS is also described, together with the suggestion that the political agenda is in a flux, with funding driven by waiting list initiative and performance indicators instead of being directed by the needs of organisations to provide integrated services.

3.3 Funding strategies to support integrated working

Shaw (1993) once argued that:

"budgetary devolution and fund holding has altered the power between professions. Internal markets have introduced competition within

which collaboration is somehow expected to co-exist"(Shaw 1993:255)

To combat funding inequality between services and in an attempt to align funding streams, a number of changes to central funding systems were made. Following the introduction of the plan for the modernisation agenda (Department of Health 1997), the Department of Health published its discussion document *'Partnerships in Action: New Opportunities for Joint Working Between Health and Social Services'* (Department of Health 1998b) which outlined the governments strategy for delivering integrated health and social care through the introduction of Health Action Zones (HAZ), Health Improvement Programmes (HiMPS) and Joint Investment Planning (JIP).

As a result, numerous strategies for working at different levels within organisations were established. These included; strategic planning between agencies to plan jointly for medium term goals, share information and use of resources and have common goals. Health Improvement Programmes were to be led by Local Authorities working in partnership with NHS & Social services and service commissioning to secure services needs through the joint meetings to develop a common understanding and encourage effective provision. *The Modernising Health and Social Services National Priorities Guidance:1999/2000–2001/02* (Department of Health 1998c) considered National Service Frameworks as vehicles for developing shared statements of the local response to national priories and targets and emphasised working with the National frameworks within the remit of the HiMPs. Although this will be led by the Health Authority, the guidance advocated that this should be an inclusive process between

organisations to promote ownership and that Social Services authorities area also expected to reflect HiMP objectives in their local plans.

Given the problems associated with funding and training, the consultation document: *'Funding Learning & Development for the Healthcare Workforce. Review of NHS Education and Training Funding'* (Department of Health 2002c) reviewed the current funding streams for future learning and presented recommendations for future provision. The Government believed that as one of the key values, integration should be promoted through different disciplines learning together. In an attempt to promote sharing of resources and move towards multi-disciplinary education and the alignment of the education system with the modernisation agenda, the levies for medical and non– medical teaching contracts i.e. were abolished. It was claimed that these separate budgets perpetuated historical distinctions in professional education (Department of Health 2002c). The paper recommended that funding should be re-organised and also advocated an inter-disciplinary framework suggesting that this would mark the end of the demarcation and differences in support offered to professionals.

Combining budgets which were once based solely on the provision of organisational needs had the potential to be problematic. The transition process from independent to pooled budget arrangements was smoothed by the Health Act (Department of Health 1999a).

The Act identified roles and responsibilities for funding and partnership arrangements and provided flexibility for organisations to work across boundaries by pooled funding and joint commissioning. This was further supported by the Health

and Social Care Act (Department of Health 2001b) which was introduced as:

*"An act to amend the law about the NHS; to provide for the exercise of functions by Care Trusts under partnership arrangement of the Health Act 1999 and to make further provision in relation to such agreements; to make further provision in relation to Social Services…."*Chapter 15 (11th May, 2001).

This was another step towards the transition between agencies to ensure pooled budget arrangements and subsequent integration of services through joint commissioning and equity between organisations.

The increased investment in the NHS and the introduction of pooled budgets to support integrated services aimed to increase equality between agencies and bring about real benefits (Bywaters & McLeod 2001). To warrant such benefits, the consultation document of the review of workforce planning: *'A Health Service of All the Talents: Developing the NHS Workforce'* (Department of Health 2000a) was published. It suggested that the workforce should be planned in collaboration with Health Action Zones (HAZ) and focus on the workforce needed to deliver the HAZ across primary, secondary and tertiary care. A greater emphasis was therefore placed on team working across organisational boundaries and the need to integrate with service and financial planning to support multi-disciplinary training and education.

Early reforms which resulted with the internal market enhanced the divide between services and highlighted the budgetary management of service provision. However, monetary reconfiguration alone does not

promote collaboration and partnership working. Other important considerations have been levelled at environmental factors and organisational values such as good support systems; participation, autonomy and interdependence. The importance of environmental factors and their influence on integration were explored by Callaghan, Exworthy, Hudson & Peckham (2000) who offered insight into localisation and collaboration in Primary Care Groups and uncovered major factors which influenced the creation of collaborative relationships. This strategic perspective involved four sites which reflected a range of socio-economic environments all of which advocated the importance of being 'in touch' with the population. Integrated services would therefore invariably reflect the needs of the population they serve.

3.4 Professional and Educational Response to the Modernisation Agenda

Whilst the concept of integrated care was politically problematic, more issues arose when considering the needs of the workforce and how best to prepare them to deliver a quality service.

The integration of services and development of the workforce to deliver these was promoted through the Department of Health's publication: *'Modernising Health and Social Services Developing the Workforce'* (Department of Health 1999b). This document suggested that staff needed to be "supported through the process of building systems of integrated care". Highlighting the need for effective leadership, commitment of organisations, authorities and staff across all boundaries and agencies, it

proposed that National Service Frameworks provide a basis for local employers and the Workforce Development Confederations to review the skill mix of current workforce to enable planning of future workforce development. To ensure such a seamless, quality service, the *NHS Plan* (Department of Health 2000b) advocated partnership and co-operation at all levels, workforce planning needed to generate strong links with organisational development plans. This would entail the development of a 'core curriculum' accessible to all which could respond effectively to the needs of the service and the individual patient. The *NHS Plan* (Department of Health 2000b) espoused the need for joint training across professions and proposed a new "common foundation programme" which incorporated communication skills and the principles of the NHS to enable staff to switch career paths more easily.

Professional bodies were keen to respond to this and took steps towards promoting professionals who were prepared to deliver and advance integrated services. To facilitate this endeavour, The Department of Health in consultation with the United Kingdom Central Council and Royal College of Nursing published the White Paper *'Making A Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Health Care'* (Department of Health 1999c). It was envisaged that nursing, health visiting and midwifery would be strengthened by the development of an integrated programme of measures to tackle the root causes of illness. It was emphasised that such programmes should bring together government, the public sector and business, local communities and individuals to plan and share responsibilities with regards

to the health and well–being of the community.

With objectives central to delivering the NHS Plan, the publication of *'Liberating the Talents: Helping Primary Care Trusts and nurses to deliver the NHS Plan'* (Department of Health 2002a) focused on 'liberating' the talent and skills of the workforce in primary care to ensure that all patients receive the right care in the right place at the right time. A key message within the publication suggested that 'primary care needed to change if patients and communities were to benefit from the NHS reforms and extra investment' (Department of Health 2002a:3). It also envisaged that staff, once trained in interprofessional skills would be better equipped to empower the patient and deliver patient centred care.

Using patient and carer comment, the document highlighted the *'Priorities and Planning Framework for 2003–2006'* (Department of Health 2003b) and recommended improvement of access to services, specifically for: Coronary Heart Disease, Mental Health, Older People and life chances for children. It supported a 'flexible team approach', new clinical roles, advanced and specialist roles, including closer cross practice and primary care trusts joint working. In relation to nurses, examples of how roles are encouraged to develop are included, such as: extending the role of the nurse (particularly that currently performed by General Practitioners), developing key roles within 24-hour first contact services and offering the chance for greater skills mix and leadership opportunities.

Greater freedom for professionals was recommended as a way forward to securing better care. In terms of delivering this ambitious agenda, the

Liberating the Talents report outlined the next steps and recommended health needs assessments, team-working to identify local needs and plan work, strong links with national priorities and adopting a public health approach. (Department of Health 2002a) Key concepts within this agenda was the drive to assure team skills reflected priority needs and to develop creative thinking about working across traditional boundaries. This involved assessing the skills and knowledge needed to provide new services and helping staff to identify what they are going to stop doing when planning for new work roles. Other key initiatives included setting up innovative practice based learning programmes to support cross-boundary working with education and preceptorship programmes to support new generalist roles.

A whole systems approach to care and care pathways were considered to be pivotal in developing new role within partnerships. Joint multi-agency teams were emphasised to support integrated care at different levels and weaken the tension between professional and organisational boundaries. Numerous examples of good practice were provided and include: family health plans which identifies client views in relation to health and social care needs, family health profiling, the introduction of 'changing workforce' programmes, shared training and shared information technology schemes. This ambitious plan, took the *NHS Plan* (Department of Health 2000b) one step further away from rhetoric and closer to reality.

Key priorities (outlined in *Liberating the Talents*) were built upon in the Priorities and Planning Framework 2003 - 2006 (Department of Health 2003b). Heavily linked to the NHS Plan, the strategy aimed to transform

service by "raising standards, tacking inequality, becoming more accessible and flexible and designing our services around the needs and choices of the people we serve" (Department of Health 2000a). The plan advised that organisations should challenge old perceptions and build new systems. To achieve this, it suggested that 'cultural change' was required and that this was "an essential part of the transformation". Such cultural change may only be achieved through increased involvement of the public plus staff, partnerships and service users. Amongst other recommendations, the plan implied that there was a need to modernise service delivery and develop learning which reflected and recognised good practice. Continuing training is highlighted with the development of individuals and re-training where required.

The clear message of professional development in line with the changing health and social care agenda was reflected in a letter sent by the Deputy Director of Human Resources to senior management in NHS, Social Services, NHS and Higher Education (Department of Health 2002) entitled *'Developing a shared framework for health professional learning beyond registration'*. The letter outlined the Department of Health's plans for taking forward post-registration education and continuing personal and professional development. It highlighted the major influences, such as National Service Frameworks and the NHS Plan (Department of Health 2000b), on education and training and discussed the need to "introduce a recognised, shared development framework for all professional staff across healthcare services". A project to develop this shared framework is being undertaken by the University of Salford in partnership with local NHS

Trusts, two Strategic Health Authorities and a postgraduate medical deanery (www.hplbr.org.uk).

Influenced by the radical changes in health and social care policy, the NHS Executive (NHSE) and Committee of Vice-Chancellors and Principles produced a Partnership Statement for the National Health Service Executive (NHSE 2000). Based on the premise that the NHS and Higher Education have to work in partnership to deliver the workforce of the future, principles considered to reflect this and influence future agendas were prepared in the shape of a partnership statement. The principles within the statement were developed by representatives from the NHS and Higher Education and arose from common aims shared between the two organisations. Firstly, the statement outlined a commitment to ensure that professionals received a high quality of education, both academic and practice based and secondly, that they would be able, as a consequence, to meet the present and future health and healthcare needs of the population.

The principles included staff development and succession planning coupled with flexible career pathways and staff exchange as methods for achieving this. (NHSE 2000:20). The statement suggested that both parties support wider access to health professional education through for example, flexible pathways and joint career initiatives (NHSE 2000:15). Tied in with this is the promotion of new programme development, joint curriculum design and the proposed collaborative commitment to the development and expansion of inter-professional approaches to nursing and Allied Health Professionals education and training (NHSE 2000:13). Health care teams in Primary Care Trusts have a pivotal role

in the realisation of this aim and were encouraged to take on the central management of patient care. Recommendations in the *Primary Care Workforce Planning Framework* (Department of Health 2002d) suggested that there was a need to map out the existing workforce to obtain "a good picture" which was considered to be a "prerequisite for understanding what the development needs of the workforce". In terms of integrated planning, the document advocated that "whole systems planning bring together services, capital/estate and workforce planning across a range of primary care services". Amongst some of the recommendations and plans, the framework suggested that workforce numbers, skills and roles needed to be identified at a number of levels.

Following other data collection activities related to the NHS workforce generally, the government proposed far reaching recommendations to shape and develop the workforce of the future. These included widening access to health professional programmes, through for example the Modern Apprenticeship Initiative (Skills for Health 2003). The introduction of the Lifelong Learning strategy for the NHS (Department of Health 2001a) included the Skills Escalator linked to career progression and offers a strategy which encourages all staff to develop their skills and knowledge. It also promoted inter-professional education and team working.

3.5 Inter-professional education to promote integrated working

The NHS modernisation agenda and the development of primary care trusts had in some way inspired and prolonged the interest in interprofessional education (IPE) (Barr 2001). There is, however, pensive

apprehension fueling the debate about inter-professional education and its actual effectiveness. Tensions concerning the impetus for inter-professional education and its relationship to service needs existed. Whilst some such as Hayward & Porter (2001) maintained that the needs of the health service should drive education, as opposed to the needs of traditional professional roles, others such as, Barr (2001) suggested that "team working, integration and workforce flexibility can only be achieved if there is widespread recognition and respect for the specialist base of each profession" (Barr 2001:7).

Inter-professional education is promoted as a method of developing a workforce capable of "looking at healthcare mainly from the patients' perspective and in which professional skills are combined to support patient centred care" (Department of Health 2002d). Similarly, the Primary Care Workforce Planning Framework (Department of Health 2002d) strongly advocated interprofessional education as a method to support the "ethos of team working". Teaching and learning strategies include using a problem solving model which facilitates flexible learning and promotes better team working (Department of Health 2002d). The use of inter-professional education to promote collaborative working is also championed by Papa, Rector & Stone (1998) who endorsed the notion that "health care providers need new skills" and that "they must learn to speak the language of other disciplines to function in a collaborative model" (Papa *et al* 1998:415).

A major contributor to the inter-professional education debate is the Centre for the Advancement of Interprofessional Education (CAIPE).

This Centre promotes inter-professional education as a method to test out the process of collaboration and encourage effective integrated care through the development of interprofessional education initiatives. Barr (2001) suggested that by putting service users first, inter-professional education will reconcile competing objectives, reinforce collaborative practice, relate collaboration in learning to practice to a coherent rationale and incorporate interprofessional values. Rhetorically, Barr's (2001) views could be perceived as being idealistic.

The belief that inter-professional education could improve collaborative working has been explored by many authors. For example, Jones, Packard & Nahrstedt (2002) attempted to test the impact of interdisciplinary training using a quasi-experimental design with pre and post test measures following an interdisciplinary training programme. Specifically, Jones *et al* (2002) aimed to identify whether such training would impact on the acquisition of knowledge, attitudinal change and use of collaborative skills. The training included team building sessions, subject specific topics relating to mental health and aspects of collaboration, diversity and role clarification, conflict management and effective meetings. One hundred and nineteen trainees were sampled and data analysis revealed gains in trainee knowledge, positive attitudes to collaboration and increased levels of collaboration in practice between pre and post-test.

Whilst this example illustrates a positive impact on service through inter-professional education, the evidence itself is limited and the dearth of research evidence available has raised concerns. Despite the practice of inter-professional

education being promoted at both strategic and operational levels, the actual reality of its application remains controversial. Although it has been promised and thought of as a means to improve collaboration, authors such as Lacey (1998) are unconvinced and consider that far from promoting collaboration, they suggest that inter-professional education may have a negative effect on professional socialization. A plethora of literature exists which debates the idea of collaboration itself (Glendinning 2002, Huxman 1993) and whilst its concept remains elusive, Lacey (1998) contends that the evidence base was weak in terms of education and training to facilitate collaboration. Coupled with the distinct lack of reliable evidence, Lacey (1998) put forward a case for exploring further the multi-professional training and education programme and the impact on practice in order to strengthen the evidence base.

This observation was reinforced in a review by Pittilo & Ross (1998) in which they considered the state of multi-professional education and policies which have effected a radical change in the health care education system. Concerns expressed in their review focused on the lack of robust evidence to support the notion that shared multi-professional education actually has any positive impact on service and quality of care delivery. Other concerns directed at inter-professional education in Pittilo & Ross's (1998) review included the belief that multi-professional education is a "slippery slope to reduced quality of care, cost reductions and multi-skilling of the less powerful professions" (Pittilo & Ross 1998:292). The notion of 'generic profession specific competencies' were highlighted as necessary to evoke a training and

education programme to address effective multi-professional team working. Similar to Lacey's (1998) view, the need for longitudinal, robust studies which evaluate the impact of multi-professional education on practice is re-iterated.

Zwarenstein, Atkins, Barr, Hammick, Koppel & Reeves (1999) undertook a systematic review in an attempt to identify the evidence base of the effectiveness of interprofessional education. The review, conducted using guidelines based on the Cochrane Effective Practice and Organisation Care Group (EPOC), included evaluations of evidence which used quasi-experimental design to ascertain the effectiveness of inter-professional education as an intervention. In total, 510 articles from MEDLINE and 552 from CINAHL were located and further refined to 44

MEDLINE abstracts (72% agreement rate) and 45 CINAHL abstracts (44% agreement rate). The inclusion of quasi-experimental evidence restricted the inclusion criteria and as a result, no rigorous studies were identified. Despite this, the team argued that whilst the evidence base for the effectiveness of inter-professional education was weak it did not suggest that it was ineffective, merely that there currently were no robust studies which demonstrated its effectiveness. Essentially, the systematic review of the evidence added weight to the claims made by Lacey (1998) and Pittilo & Ross (1998) and has further fuelled the inter-professional education debate in terms of its potential to enhance service improvement.

This chapter has highlighted research that has explored inter-professional education as a method to promote integrated working. However, apart from Lacey (1998), the research evidence base remains weak

(Zwarenstein *et al* 1999).

Despite this, inter-professional education is being advocated as the way forward and a number of initiatives are being funded by the Department of Health, for example, the New Generation Project led by the University of Southampton (www.commonlearning.net/project/index.asp).

Chapter 4:
The Impact of Integrated Health and Social Care Policy on future Education & Training Needs

4.1   Introduction

The Modernisation Agenda (Department of Health 1997) has attempted to promote collaboration through the implementation of National Service Frameworks, Health Improvement Programmes, Health Action Zones, common funding streams and the promotion of primary care as the main provider of care. This has resulted in a major change to the type of client now cared for within the primary, social and community care setting, which has, in turn led to new professional role development to meet the needs of the service.

To ascertain the future education and training needs of the primary care workforce, literature specifically related to integrated health and social care has been reviewed. The fluid nature of integrated health and social care resulted in a substantial number of research papers, which used evaluation, qualitative, quantitative or mixed method approaches to explore services and subsequent development of new ideas and concepts.

In total six key themes emerged from the literature. These were:

1. Team working
2. Communication
3. Role Awareness
4. Personal and Professional Development
5. Practice Development and Leadership
6. Partnership Working

These key themes have been divided into operational and strategic indicators to reflect a whole systems approach as advocated within the modernisation agenda (see figure 1).

Figure 1: Six Key Themes

STRATEGIC

Practice Development & Leadership

Partnership working
■ Culture and relationships

OPERATIONAL

Team working
■ Team characteristics
■ Individual attributes
■ Team process

Communication

OPERATIONAL

Role awareness

Personal & Professional Development (PPD)
■ Significance of PPD to integrated health and social care
■ Perceived PPD needs
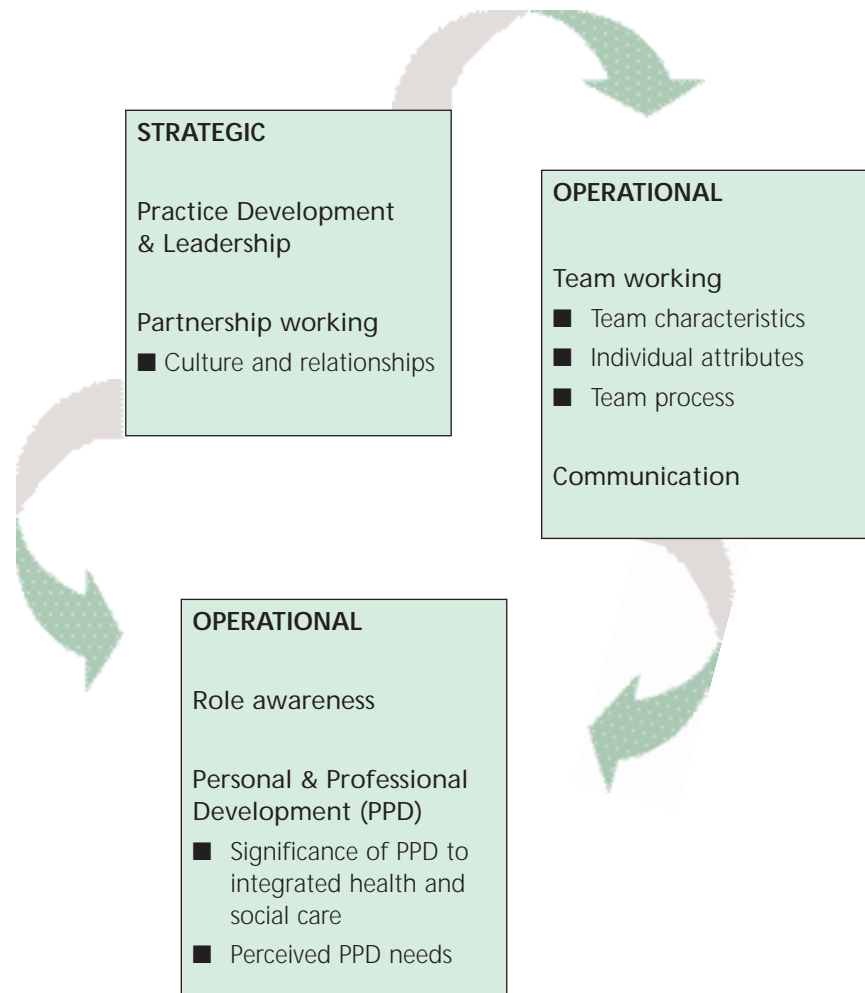
4.2 Operational Indicators

4.2.1   Team working

The importance of effective team working was frequently highlighted within the literature (McNeal, Oster & Alema-Mensah 1999, Nandan 1997, Caan, Streng, Moxon & Machin 2000). A variety of research methods have attempted to explore team working by evaluating team working models, tools and theory development in terms of team effectiveness and individual team member activity and function.

Whilst some have attempted to use a reductionist approach to measure team effectiveness (Millward & Jeffries 2001), others such as Gibb, Morrow, Clarke, Cook, Gertig & Ramprogus (2002) and Higham & Spooner (1998) have explored the meaning and professional perceptions of effective teams through case study design and action research approaches. However, the plethora of parameters available in terms of the concept of teamwork has led to numerous definitions used to support the exploration of team working resulting in limited

generalisability. Whilst most authors used qualitative methodology to evaluate team work, others such as Millward & Jeffries (2001) attempted to validate a psychometric tool which measured team effectiveness, (Millward & Jeffries 2001). Similarly, Caan *et al* (2000) used quantitative methodology to determine team effectiveness.

Essentially, the literature revealed three central attributes in relation to effective team working which are relevant to this project. These were:

■ Team characteristics

■ Individual team members attributes

■ Individual team member philosophy about team working

These three attributes were located within the majority of the papers reviewed and were considered to be worthy of inclusion within the systematic review as they could provide insight into education and training needed to encourage effective team work.

4.2.1.1   Team Characteristics

Using a robust survey design, Millward & Jeffries (2001) distributed validated questionnaires to 10 'teams' which comprised a total of 124 members in different locations. The aim of the study was to validate a team survey tool using factor analysis. The questionnaire was developed through a painstaking review of a variety of theoretical models previously used to measure team effectiveness. The tool focused on cognition as opposed to behavioural aspects and identified cognitive features which influenced the effectiveness of a team. A factor analysis was used to ascertain construct validity; reliability was checked using Alpha *(ã)* Coefficient of reliability. All satisfactory coefficients were combined and an average score

was calculated. Inter-rater reliability was assessed using the split-half method and concurrent validity was established through linear regression analysis which ascertained the degree of covariance across the data. Bivariate correlations were presented. To identify predictive measures of team effectiveness, regression analysis was used with the 'Enter' method. The team measurement tool was found to be reliable (reliability coefficients were 0.70 and 0.93). In terms of content validity, the authors argued that the tool was developed through consultation with experts, an extensive literature review and empirical work which therefore enhanced the content validity of the tool.

Limitations to the study included the use of a small sample size *(n=99)* which may have made correlation difficult and a 'health' focus rather than a combined health and social care focus. Variables such as external influences on team work, not attributed for in their study were identified as potential confounders. Millward & Jeffries (2001) recommended that the effect of such influences would need further exploration.

Despite the apparent limitation identified and discussed by Millward & Jeffries (2001), four key areas emerged from the factors analysis:

■ Shared mental models – the degree to which the team understands each other

■ Team potency – the level of self esteem and team success

■ Team identification – the extent to which the team communicates with each other

■ Team meta-cognitive orientation – a greater understanding about team roles

All four factors, it is suggested could

provide predictive values which relate to the function of an effective team. Shared mental models related to the degree to which the team understands each other. Millward & Jeffries (2001:282) suggested that the ability to predict members within the team will enhance team effectiveness. They recommended that shared mental models could be developed through team meetings and team discussion based on a case scenario. In relation to team meta-cognition orientation, the need for the team to have a greater understanding about shared goals is highlighted as a major influence on team working. The clearer the team are about how each member contributes – the more effective it will be, this essentially "reflects the degree to which the team are cognitively orientated towards effective team working". Considered to be the most effective predictor of team performance, team meta-cognition referred to the level of role awareness within the team. If role ambiguity was reduced, the resultant enhanced role awareness within the team will result in effective organisation and performance. Whilst team orientation reflected the extent to which team members communicate to each other and their perspectives and value of others, team potency referred to the notion that identify was influenced by self-concept and esteem and that potency is expressed through team success (Millward & Purvis 1998).

The need to collaborate is re-iterated throughout modernisation agenda policies. Integrated services dictated the need for effective teamwork to support successful services. Whilst Millward & Jeffries' (2001) tool used a specific health focus; parallels could be drawn between health and social care. The purpose of the tool and its validation was supported through the comprehensive integration of theory

which highlighted the need to focus on cognition rather than behaviour as a predictor of team effectiveness. Such predictors of effective teams identified through Millward & Jeffries' (2001) research are reflected in other studies which have explored team effectiveness functions. One such example is Caan et al (2000) whose work evaluated multi-disciplinary team effectiveness by exploring members perceived strengths and weaknesses of the team. Similar to McDonald, Langford & Boldero (1997) who illustrated the negative effects resulting from multiple policy implementations, the children's disabilities team in Caan *et al's (2000) study* witnessed major structural reorganisation as a result of strategic policy based arising out of the modernisation plan (Department of Health 1997). The changes which ensued led to changes within a small effective team to the development of a larger team. Team effectiveness waned and conflict within the team was clearly evident. To reform the negative impact on team dynamics, and redress the equilibrium, the team was encouraged to use a multi-disciplinary and multi-agency approach to care provision. Caan *et al* (2000) then used a 'soft analysis' coupled with team reflection on events, functional analysis and an anonymous survey questionnaire to identify the perceived strength and weaknesses of the team.

Caan *et al's* (2000) findings illustrated that there was significant agreement amongst the multi-professional group regarding the teams strengths and weaknesses *(p=0.0001)*. In relation to perceived strengths of the team, Caan *et al* (2000) identified that the team had more confidence with parents, and that the provision of information and reported good communication within the team resulted in the ability for joint

working. Interestingly, strategies for resolving conflict within the team included an away day, at which team members discussed problems which helped to resolve some of the conflict.

Similarly, the Millward & Jeffries' (2001) Team Survey illustrated that the process of shared mental models played a pivotal role in the success of the team. For example, these 'shared mental models' related to the degree to which the team understood each other and their ability to 'predict' members within the team. Millward & Jeffries' (2001) proposed that team meetings encouraged shared mental model development; similarly, Caan *et al* (2000) reported that the team used an away day to resolve some of the conflicts within the team. The "high concordance" found in Caan *et al's* (2000) survey showed that team members already shared a common perspective of their work (pg 89) which potentially endorses Millward & Jeffries (2001) notion of 'meta cognitive orientation'. However, caution must be applied to the findings of Caan *et al's* (2000) work. The reporting style lacked transparency and whilst their findings highlighted some important issues, there was insufficient detail provided about the research design in terms of data collection and analysis.

4.2.1.2 Individual attributes to the team

By attempting to measure and evaluate team effectiveness as a whole, Millward & Jeffries (2001) and Caan *et al* (2000) illustrated key attributes of effective team function. However, whilst the need for team effectiveness and team development has been extensively researched, there is a paucity of evidence about individual characteristics and their impact on commitment. The importance of individual dedication to

the team was highlighted in Nandan's (1997) exploration of the commitment of social workers to interdisciplinary care plans. Based on the notion that many teams fail under stress due to lack of individual commitment (Fink 1992), Nandan (1997) used a 'general systems model' to assess the association between individual characteristics of social service workers and their commitment to interdisciplinary care plan teams (ICPT's). Nandan (1997) surveyed social services staff with a bachelor's degree in social work (SW) or related discipline to assess the association between individual traits of social workers in relation to their commitment to interdisciplinary care plan teams.

This was attempted by analysing differences in the commitment levels across the two dependant variables (non social work background degree 'v' social work degree). Using Chi square, *z* tests and Wilcox-Mann-Whitney *U* to identify causal factors in relation to commitment, the analysis revealed that there was some disparity in terms of commitment between the social workers with degrees in social work and those who had degrees in other disciplines. It was suggested that this could be due to the educational background as graduates of social work may be more likely to be committed to the goals, values and members of interdisciplinary care plan teams than graduates of other programmes. These findings were explained by linking the associations to the social work educational programme content through which social work graduates were prepared to work in teams. Although the sample size was small, Nadan (1997) managed to illicit statistical significance through careful application of non-parametric tests and thorough operationalisation (using validated models) of variables –

although to some extent, this limited the study findings in terms of the demographics and lack of statistical significance.

The application of Millward & Jeffries' (2001) Cognitive Motivational Model of Team Effectiveness to this scenario would indicate that the apparent lack of commitment demonstrated by non social work degree students could have a detrimental effect on team meta-cognition orientation. This would result in a negative impact on the effectiveness of a team, which Nandan's (1997) work illustrated. In the discussion, Nandan (1997) purported that 'certain dimensions' of the social work curriculum may have better prepared [these] social workers for teamwork than non-social work disciplines curricula. This was ascertained through positive correlation between the non-social work and social work graduates. Although no inference can be made Nandan (1997) used previous literature to support her analysis and discussed the notion of 'logical inference' and advocated future research to explore this further.

Similar to Millward & Jeffries' (2001) notion of team identification, Nandan (1997) also highlighted that those respondents who were clear about their role, reported higher levels of commitment. Conversely, however, the association between educational background and role clarity was not statistically significant, which could challenge the notion that inter-professional education enhances role awareness of other professional groups (Barr & Waterton 1996, Freeman, Miller & Ross 2000). However, Nandan's (1997) sample was based on a comparison between two graduate groups and as such only measures the association between those groups and does not

necessarily mean that education has no impact on role clarity.

Others have attempted to use qualitative methodological approaches to explore the impact of individuals on team success. Freeman et al's (2000) work provides an example where meanings behind individual behaviour within a team were elicited. Using a grounded theory approach, Freeman et al (2000) explored the impact of individual philosophies on a team. Freeman et al's (2000) finding were analogous to Nandan's work (Nandan 1997) whose research highlighted that the individuals behaviour could determine the success or otherwise of a team.

Freeman et al (2000) purposively selected six multi-professional 'teams' from a number of specialties. The teams were 'studied' for three months using triangulated data collection methods. Data were subjected to constant comparison then coded and categorised. Freeman et al (2000) ascertained that there were three philosophies which influenced team work. These include directive, integrative and elective philosophies. (See Box 2)

> **Box 2: Individual Philosophy (Freeman *et al* 2000)**
>
> - Directive – philosophy *is directed* by professional hierarchy
> - Integrative – individuals *value others* and share work
> - Elective – the individual is reluctant to share notes and operates in an *insular* fashion.

The data revealed that individuals operated in seemingly different ways depending on their philosophy. Those with a directive philosophy tended to demonstrate a hierarchical position; those in 'power' could and would only learn from their peers or superiors. The integrative philosophy suggested that the individual expressed an ability which demonstrated commitment to two aspects of being a team member; i.e. the practice of collaboration and attention to being a team player. This involved recognition of different roles, development of negotiated role boundaries and equal value assigned to each professionals contribution. Conversely, whereas Nandan (1997) highlighted the value of commitment to the success of a team, and Gibb's *et al* (2002) acknowledgement of the importance of sharing within a team, Freeman *et al* (2000) discovered an 'elective' philosophy in which practitioners operated autonomously, and demonstrated no commitment to the team. The elective philosophy was evident amongst some of the team members and resulted in insular practice which inhibited the development of shared understanding.

Freeman *et al* (2000:245) stated that "where different [individual] philosophies clash, team function could be adversely affected". Similarities extrapolated from Freeman's and Nandan's (1997) work provide insight into the ways in which team members behaviour is influenced by professional and educational status. The effect on team working is substantial and further highlighted the need to recognize the individuals' impact on team process, function and effectiveness.

4.2.1.3 Team Process

Whilst it is recognised that the individual plays an important part of the teams' success, Gibb *et al* (2002) believed that 'team process' was equally important in promoting effective team work. Influenced by Hart & Fletcher's (1999) notion that:

"the potential to pool individual learning is important to successful team working and occurs when the team becomes aware of itself as more than the sum total of its individual members". (Hart & Fletcher 1999:341)

Gibb *et al* (2002) used a soft systems methodology to evaluate team process within a community service. Team members and stakeholders were involved and data were collected through uni-professional focus groups, collaborative learning group meetings and individual interviews.

Through thematic analysis of the data, Gibb *et al* (2002) identified subsequent themes which emerged from open coding of transcribed interviews. Credibility, dependability and transferability (Guba 1990) were enhanced through triangulating data and two or more researchers analysing the data. As a result, three key processes involved in teamwork were identified, these were; team practice-team building, role negotiation and trans-disciplinary decision-making. The themes, validated though comparative exploration of the outcomes process and further analysis across data sets identified that although structurally, there was no actual evidence of integration within the service, the team functioned effectively. Influencing factors included strong leadership and a supportive team which enhanced communication and the sharing of knowledge. In relation to role negotiation, analysis of the

verbatim quotes highlighted that the team often identified roles within the context of the team. As a result, external stakeholders viewed the team as being 'a collective' taking responsibility for service users.

The creation of a flexible infrastructure to achieve common goals suggested that the team used a proactive rather than reactive approach to care.

Although verbatim quotes were used to support the analysis, those included were limited, therefore making justification of the findings problematic. However, Gibb *et al's* (2002) findings illustrated that new care processes and structures enabled the team and clients knowledge to be used as a resource. Role negotiation within the team removed the potential for professional tribalism and turf war issues which facilitated joint care planning and fostered flexible support systems for the client. A shared geographical location meant that the team could meet or exchange information quite easily and the demonstrated a commitment to team objectives. This shared goal trust and mutual respect has been referred to elsewhere (Russell & Hymans 2001) and can be related to Millward & Jeffries' (2001) shared mental model factor which highlighted the need for a shared vision and common goals to promote effective team work.

Applied to contemporary findings, Millward & Jeffries' (2001) notion of team identification is evident throughout the literature. Team identification (Millward & Jeffries 2001) enables team success to flourish, however, whilst this cognitive model provided predictive indicators with which to measure a teams attributes, team identification can only succeed where good communication patterns thrive. Without the ability to communicate

to each other, a team will flounder and the integration of services could fall short of the seamless service promised by the Government. Poor communication between agencies and professional groups is considered to be a major causal factor of ineffective team work. As such a number of studies have explored how professional groups communicate which take account of individual attributes, ability and communication processes.

4.3 Communication

Inappropriate or poor referrals within and between professional groups and services together with ambiguous definitions of collaboration are considered causal influences attributed to ineffective teams. Perceptions about what constitutes an effective team are variable (Freeman et al 2000) and some authors, such as Nochajski (2001) have contested that effective communication plays a pivotal role in the activities of effective teams.

Whilst the literature has focussed on all major contributory factors in relation to team work, a large percentage of evidence referred to the detrimental effects of poor communication on team working. McDonald *et al* (1997), Hudson (2002) and Slater (2002) have all attributed this to the swift re-organisation of the NHS from secondary services to primary care services and confusing terminology used in policy documents. Although the interface between acute and primary care settings has received some attention, a plethora of evidence has argued that policy aimed at strategic direction as opposed to operational initiatives has meant that new roles have been developed without careful consideration of the professionals competencies to deliver on policy

demands. Major service redesign has resulted in reduced role awareness which has subsequently led to communication breakdown between professional groups. How the individual communicates with others determines whether a team will succeed. (Millward & Jeffries 2001, Gibb *et al* 2002, Freeman *et al* 2000).

The importance of good communication is reiterated in Nochajski's (2001) paper which explored collaboration between team members in an inclusive educational setting. A convenience sample of 51 educators, special educators and therapists were asked about their perceptions and definitions of collaboration using semi-structured interviews. Using this qualitative approach, Nochajski (2001) gained insight into the perspectives of regular and special educators, occupational, physical and speech and language therapists working with students with disabilities in inclusive educational settings. The findings revealed that communication and co-ordination were thought to be important aspects of collaboration.

Rainforth, York and MacDonald's (1992) definition of collaboration was used to as an indicator of collaboration with which to compare the participants' responses.

Definitions of collaboration were varied; the rhetoric was often reported as being different from the reality. Although the participants used a variety of 'buzz words' to describe the concept of collaboration, none matched the definition proposed by Rainforth *et al* (1992). In addition, Nochajski (2001) also explored the individual's perceived barriers to collaboration and described strategies to promote collaborative working based on the findings. Communication and co-ordination were considered to be important

aspects of collaboration and were terms used to describe collaboration by 92.1% and 74.5% of the participants respectively. Barriers acknowledged included: lack of administrative support and lack of time.

In terms of strategies to promote collaboration 86% of the participants suggested that continuing education and in-service training on collaboration was needed and 78.4% recommended more information about team working, team member roles and responsibilities and the need for improved communication. Whilst the study was based on a qualitative approach, findings appear to have been quantified and offered no verbatim quotes to support the findings or discussion. Despite this, the findings did illuminate some valuable insight into roles, role awareness and the effects of good communication. Nearly half of the participants reported a lack of knowledge about each others roles, the need for role clarification was evident, and this has been frequently commented on in the literature.

Whilst roles and role awareness make vast contributions to effective team working, good communication needed to understand individual roles is considered to be paramount. Nochajski (2001) made good use of existing literature by including a comprehensive range of pertinent, contemporary evidence within the discussion, however, no conclusive recommendations for practice were offered. The findings from this study were consistent with other work Closs (1997) and accentuated the need for effective communication between professionals.

Referrals constitute one method of communication between professional groups and as such are thought to be essential in terms of promoting a

seamless service between hospital and community staff. In a selective review, Closs (1997) assessed the effectiveness of discharge communication. Based on the need to promote effective communication across the hospital and community interface, this selective literature review examined six aspects of communications between nursing and medical staff who were located in the hospital and in the community. Closs (1997) asserted that discharge communications were not only a research priority but they are equally important for audit purposes. Although an outline of the search strategy is provided, databases searched were limited to MEDLINE and CINAHL which may have affected the successful capture of all relevant evidence. Indeed, Closs (1997) conceded that much of the research literature focussed on the satisfaction of health professionals rather than the views of the user. Inclusion and exclusion criteria were presented coupled with some insight into how articles were included or excluded. For example, Closs (1997) reviewed titles and abstracts and included pre-1985 references. Whilst methodological strengths and weaknesses were described, there was insufficient detail as to the method of appraisal. For example, when appraising a systematised review, a description of validated tools used to appraise located evidence should be provided (Critical Skills Appraisal Programme (CASP) 2003). This would help ascertain the trustworthiness, rigour and credibility of the review.

In total, six main 'areas of concern' were identified. Out of these, two reflected communication between professionals, namely who contributed to communication and the direction of communications (uni or multidisciplinary). The other four

findings related to the timing and dispatch of communications, the relevance of such communications, format of communication transmission and mode of communication discharge.

In relation to the format of discharge communications, the review findings suggested that there was considerable variation in the format of nurses discharge communication. Multidisciplinary communication was seen to be repetitive and suggestion was made that "wasteful duplication could be avoided by the use of multi-disciplinary documentation" (Closs 1997:187). Closs (1997) concluded by suggesting that multidisciplinary planning could potentially reduce duplication of effort and achieve effective communications across the interface. A number of recommendations were made which included attention to early receipt of communications to community health care or social services staff.

Fakhoury & Wright's (2000) exploration of community psychiatric nurse's communication came to similar conclusions from which parallels could be drawn with Closs's (1997) concerns about communication between professional groups. Fakhoury & Wright (2000) explored the communication and information needs of Community Psychiatric Nurses, access to other professionals and barriers encountered providing their service using a quantitative cross-sectional survey of a random sample of 200 community psychiatric nurse's attached to a community mental health team (CMHT). However, limitations to the study recognized by Fakhoury & Wright (2000) included their lack of knowledge about the sample characteristics. Although over half (55%) of community psychiatric nurses responded to the questionnaire, there was some

ambiguity as to who completed the questionnaires which led to insufficient detail of the respondents' profiles. Parahoo (1997) suggested that when sample characteristics are unknown, the representativeness of the 'random' sample could be restricted. The randomization strategy used was ambiguous resulting in added uncertainty about the representativeness of the sample and reduction of researcher bias.

Data analysis exploited SPSS version 8.0 coupled with descriptive categorical data for number counts and frequencies. Descriptive numerical data were reported as means and standard errors. Spearman, Rho & Pearsons correlation coefficient were calculated to assess statistical correlation and linearity between rank ordered variables and Chi square was used to assess group differences between categorical variables.

As with other studies, the survey highlighted poor communication between and among professionals which acted as a barrier to inter-professional collaboration and contributed to poor liaison between mental health services. A poor relationship between the General Practitioner and the community psychiatric nurse was an unexpected finding. Given the pivotal role of the community psychiatric nurse in co-ordinating services for the patient, Fakhoury & Wright (2000:878) asserted that this finding was worrying and advised that "increased communication between community psychiatric nurses and General Practitioners s was not only essential to the success of the co-ordination of various health and social services ….but also to the harmonious integration of these services".

Other key findings typified the community psychiatric nurses

concerns about problems they had encountered in accessing the General Practitioner (GP). This significant finding is comparable with other evidence extrapolated from this review which suggests that the more difficult the access to other professionals, the less helpful that professional will be. Fakhoury & Wright (2000) concluded that:

"increasing access to professionals was a way of increasing satisfaction with the help provided by these professionals. Increased satisfaction may lead to increased collaboration amongst professionals, which in turn, may lead to better co-ordination of services" Fakhoury & Wright (2000:878).

Other recommendations put forward by Fakhoury & Wright (2000) stressed the need for ongoing training to help community psychiatric nurses cope with their changing role. This concern is echoed throughout the literature particularly since the introduction of the modernisation agenda. Notable changes that have occurred include the development of new roles through the increase in new health and social care strategies and the introduction of new services. There is now a pressing need for new and emerging roles within the health and social care arena to be recognised and identified by all professionals involved in the same context of care.

It is evident that communication plays a pivotal role in the success of team working. Whilst this is recognised as an important attribute to communication, the needs of the workforce faced with a changing demographics and population must be taken into consideration. As new roles have emerged to meet service needs, communication, now more than ever needs to given a greater priority.

4.4   Role awareness

Whilst some have suggested the need for improved communication to promote team working, others such as Dalley & Sim (2001) and Stanley, Reed & Brown (1999) have argued that the key to effective team working is an acute awareness of individual roles, responsibilities and their contributions to care. Although this is well documented in the literature, the recent case of Victoria Climbié (Department of Health 2003c) highlighted what can go wrong when teams do not function due to amongst other things – role ambiguity. It could be argued that the apparent breakdown of communication between professionals coupled with a distinct lack of understanding about roles led to Victoria's needs being neglected with fateful consequences.

The importance of role awareness as a determinant of team effectiveness was particularly pertinent in Higham & Spooner's (1998) case study of collaborative research within community practice. Published five years before the case of Victoria Climbié, the case study findings highlighted role confusion and demarcation, feelings of being undervalued, role overlap and uncertainty which resulted in professional rivalry. In addition, Higham & Spooner (1998) reported on tensions between health and social services and that the failure to place the patient central to the collaborative process was evident.

Higham & Spooner (1998) attempted to evaluate collaborative practice by eliciting different perspectives from semi-structured interviews. The case study was based on Alice Johnson, a pseudonym for an elderly African Caribbean lady with complex and misunderstood problems, but which then analysed the real life outcomes

of the case. The appropriateness of the case study approach facilitated a realistic insight into the care of one person. An opportunistic sample of those involved in the clients care management was used which included; the care manager/social worker, district nurses, assistant domiciliary care manager, the warden, private home care agency, and clients themselves. Data were analysed through two variations of cognitive mapping used to code each interview. According to some (Robson 1993), validity is an alien concept in a qualitative context. Despite this, Higham & Spooner (1998) enhanced validity by diagrammatically mapping participant stories. The subsequent use of words rather than inferences enabled the findings to be presented in a table format which described correlation's between perceptions and as a map/flow chart of events.

This case study highlighted the effects of poor collaborative work and cited common cause for poor collaboration. Apart from the issues of ageism which arose, the hypothetical patient (Alice Johnson) played no role in the decision making or in the collaborative process. However, limitations to the research design included an incomplete description of researchers role in the study and their relationship with the participants. Insight into this relationship would have proved beneficial when considering the intense nature of the interviews and the poor practice highlighted.

The findings, however, are validated through the recurrent themes and concerns about role ambiguity. Higham & Spooner's (1998) study revealed similar concerns about role ambiguity to that of Fakhoury & Wright (2000). Whilst Fakhoury & Wright (2000) identified a poor relationship and reduced role lucidity

between community psychiatric nurses and General Practitioners.

Higham & Spooner's (1998) findings argued that agencies still tended to operate in very insular ways as a result of practitioners own uncertainties about their new flexible roles. Even though verbatim quotes were limited, they did exemplify the lack of regard for collaborative working. Four interconnected issues were identified in Higham & Spooner's (1998) study, which included the need for better attitudinal understanding, improved communication, enhanced skills and knowledge, and greater screening and eligibility criteria. The relationships between the professionals involved in Alice's care were explored:

"each agency practitioner worked within personal, cultural, professional and organisational constraints, which shaped their contribution. The relationships between different health care workers had not settled into comfortable patterns, nor had the relationships across health and social care" (Higham & Spooner 1998:123).

Although Higham & Spooner (1998) stated that this could be problematic to generalise, the findings from this study could be transferable to other similar settings. The inhibited role awareness is frequently referred to in the literature as one of the major causal factors to poor collaborative practice and subsequent team work.

Higham & Spooner's (1998) case study typified poor practice due to role demarcation and ambiguity. Whilst the findings from this differed from that of Gibb *et al* 2002, Higham & Spooner's (1998) findings were similar to Dalley & Sim's (2001) in terms of reduced role awareness and the potential negative impact on collaboration and patient services.

Role ambiguity can lead to failure in services and a limited awareness of statutory bodies involved in the provision of a seamless service.

This supports the notion that:

"conflict and confusion between, and within, occupations can compromise service users' endeavours to exercise choice as they try to negotiate their way through different organisations and staff in the context of tradition of deference and professional 'expert' opinion" (Stanley *et al* 1999:230).

As a result, patients are at risk of falling into the cracks between services, negating the aim of whole systems approaches which are promoted by the Department of Health (2000a).

The potential for patient care to be adversely influenced by role ambiguity was characterised through the work of Dalley & Sim (2001) who used a qualitative exploratory study to investigate the nurses perceptions of physiotherapists as members of the rehabilitation team. Dalley & Sim (2001) allude to the fact that no one health care professional can be skilled in all aspects of rehabilitation. The need for co-operation within a rehabilitation team is of vital importance, requiring an understanding by all the team members of each others roles and responsibilities. They argued that whilst evidence existed about the nature of roles and role ambiguity, very few studies had focused specifically on nurse-physiotherapist relationships. They interviewed eight experienced rehabilitation qualified nurses working for more than one year in a recognised rehabilitation setting in the acute care sector of the NHS. Experienced staff, it was suggested, would have more formed opinions about the role of the physiotherapists, so nursing staff in

grades C to E were included. Interestingly, night staff members were excluded due to their infrequent contact with physiotherapists and other professional groups. It could be argued however, that some night staff may have been rotated to days on a regular basis. This was not discussed by Dalley & Sim (2001), which may have resulted in the night staff being disadvantaged by the research allowing for the potential of a biased sample selection.

Content analysis of the tape-recorded interviews uncovered themes which were then categorised. Cutcliffe & McKenna (1999) advised that the credibility of qualitative research may benefit by enhancing the involvement of the participants. Dalley & Sim (2001) attempted to enhance validity and provided copies of the analysis to the participants and external review for comments as to the accuracy of the analysis.

Four themes were identified with 'subsidiary' themes. This included role image of the physiotherapist, specificity of physiotherapy, physiotherapist interaction with nurses and patients and physiotherapists understanding of the nurses role. Stronger themes illustrated that nurses believed the main function of the physiotherapist was to improve the patients mobility and that physiotherapy was a well defined job. The notion that the physiotherapist role could be measured as opposed to nursing, which was considered to be less defined and more ambiguous, was interesting and provided some insight into the lack of the nurses awareness about the role of the physiotherapist. Although nurses had some understanding of the role of the physiotherapist in a rehabilitation setting, this was mainly restricted to the physiotherapist involvement in

physical abilities and the nurses viewed themselves as largely distinct from the physiotherapists. Dalley & Sim (2001) suggested that this could act as a barrier to organisational structures within the rehabilitation setting. As with Freeman *et al's* (2000) elective philosophy, the individual perceptions and beliefs held by the two professions had a significant impact on the roles of the multi-disciplinary team as a whole. The perceived subtle differences between the two professions was explored and resulted with an account of professionals acting in an insular manner on different aspects of patients rehabilitation. This resulted in the use of separate approaches to achieve the same goal for the patient.

Lack of role awareness and clarity of role function was highlighted by Stanley *et al* (1999) whose concerns focused on similar issues to that of Higham & Spooner (1998). Stanley *et al* (1999) used a multi method approach to explore the perceptions of the developing role of care management.

To identify perceptions about the role of the care manager, eight qualitative case studies with a total of 45 interviews were undertaken with older people; the social service departments care manager, carers, care home staff and health care staff. Unfortunately, data analysis techniques were not described. Rather than themes emerging from the data, interview data were clustered under the headings linked to the views of the individual as opposed to collective views of the participants.

Similar to Higham & Spooner's (1998) findings, which demonstrated poor collaboration due to role ambiguity, Stanley *et al* (1999:230) discovered that there was conflicting views between the people involved in each

case about the role of the care manager. Given the nature of the care manager as a coordinator of care and support services for the benefit of the patient, there was "a substantial degree of confusion about what this role involved". Stanley *et al* (1999) identified that there was no evidence to demonstrate that the patients knew that their care was being 'managed'. However, the relationship between the researcher and participants was not explored which could have influenced the findings. Arguably, the researchers could have used a questionnaire to ascertain whether respondents were aware of the care managers roles and functions.

Data obtained were clearly presented and simple sentences provided to illustrate the responses. As a consequence a description rather than an analysis of the phenomena under study prevailed. The findings did however, offer insight into the problems encountered within a changing service and subsequent role developments.

In the discussion, attention was drawn to the notion of professional rivalry and different interpretations of the multidisciplinary team which had led to:

"a significant difference between the ideas of a multidisciplinary team, one where there is a range of personnel all discharging their own different professional tasks to a common end, and true inter-professional working where people were proactively facilitating each other towards a common goal" (Stanley *et al* 1999:234).

Stanley *et al* (1999) concluded by recommending interdisciplinary training as a strategy to reduce role ambiguity and remove participants perceived threat.

Parallels can be drawn between Stanley *et al's* (1999) research and McNeal *et al's* (1999) survey which revealed that there were significant differences between professionals with regards to the attitudes of students on issues relevant to their ability to work in interdisciplinary health care teams. Driven by proposals in the United States health care system, the move towards service collaboration has played a central role in reducing costs and providing comprehensive care. McNeal *et al* (1999) sought to explore how educational facilities could best prepare students for collaborative working. As with Dalley & Sim (2001) McNeal *et al* (1999) believed that no one single profession could solely posses the skills needed to provide the best health care was highlighted as a concern. Education was seen as one way to enhance team work though inter-disciplinary education between doctors, nurses and social workers. As a result, three educational institutions in the United States merged to develop an inter-disciplinary community based educational programme. One hundred and seventy mixed race multi-professional students who had enrolled for the interdisciplinary team taught course were surveyed. Although social work students elected to undertake the course, attendance was compulsory for doctors and nurses.

Some of the students had previous exposure to other professionals but medical students were only in their first year, which meant that their exposure to other professional groups was limited.

McNeal *et al* (1999) used a questionnaire which incorporated a Likert scale to measure all the students attitudes on the first day of the course. Ordinal data were

analysed using the Epi Info system and SPSS used for inferential statistics. 95% Confidence Intervals used and *p* values of .05 were considered to be significant. Questionnaire design should take into account construct and face validity when considering the trustworthiness of research findings. McNeal *et al* (1999) directed attention to the limitations of the questionnaire which were caused through inadequate face and construct validity. Bias enhanced as a result of reduced validity should be noted with care and balanced against the potential value of the study. On closer inspection of McNeal *et al's* (1999) questionnaire, five out of the eight questions asked, focused on the doctors role. The weak construct validity could have skewed the questionnaire findings and re-enforced negative stereotypes perceived by the other professional groups, therefore, healthy scepticism should be applied to the findings. Conversely, the findings in McNeal *et al's* (1999) paper were congruent with other research findings (Stanley *et al* 1999, Higham & Spooner 1998) results which also demonstrated differences in role interpretation between professional groups.

As with Stanley *et al's* (1998) findings, there was considerable divergence between professionals, with regards to the attitudes of students on issues relevant to their ability to work in interdisciplinary health care teams. Notably, larger differences occurred between the doctors and the nurses on issues related to leadership. Although there was no significant difference noted on issues related to health care, disparity between doctors and other professionals on issues relating to roles and responsibilities and stereotyping were apparent.

A similar picture emerged from Freeman *et al's* (2000) work which identified how team member's individual philosophies shaped the way in which they worked within the team and influenced their communication with others and how they perceived other professional roles. The three philosophies were mapped against professional groups which highlighted differences between groups, namely, doctors, specialist nurses and therapists.

To compensate for this multiplicity in interpretation, McNeal *et al* (1999) advocated "early interdisciplinary experiences". This included "exposure to roles and responsibilities of other members of the health care team" and recommended that:

"interdisciplinary team training can help provide students with the opportunity to learn about roles and responsibilities of team members, the training ground for the development of communication skills and the foundation for the development of trust among professionals from different disciplines". (McNeal *et al* 1999:20)

This opinion is shared by others, notably Barr (2001) and Freeman *et al* (2000) who advised that early introduction of inter-professional education can help reduce pre-conceived negative stereotyping thought to occur through early professional socialisation.

Conflicting opinion about the timing and nature of any inter-professional learning is prevalent throughout educational research. Whilst tensions still exist between the two schools of thought, projects such as the 'New Generation Project' led by University of Southampton (www.commonlearning.net/project/index.asp) and the Combined Universities Inter-professional Learning

Unit led by Sheffield Hallam University (www.shef.ac.uk/cuilu/projstruc.htm), have since emerged as innovative educational developments aimed at enhancing collaborative practice. For example, the 'New Generation' project will provide students studying nursing, medicine, midwifery, occupational therapy, pharmacy, physiotherapy, radiography and social work with the opportunity to work and learn together. Humphris & Clark (2002) note that:

"The combination of inter-professional and profession-specific learning experiences will cross traditional boundaries. Approaches to learning will give depth and breadth to each student's knowledge (theoretical and clinical) through the application and integration of profession-specific knowledge to shared inter-professional learning. The resultant diversity of problem-solving opportunities used by students will develop their ability to work within the changing health and social care environment and give them the key transferable skills necessary to the management of both clients and carers and their own career progression." (Humphris & Clark 2002:6)

The recent paradigm shifts in health and social care pedagogy from uni-professional to multi-professional programmes of learning have been evaluated. However, the evidence base has yet to convince some of the potential influences on collaborative practice (Zwarenstein *et al* 1999). Potentially, multi-professional education could have a positive influence on personal and professional development within the context of team work. There is now a pressing requirement for professionals involved in integrated care to be empowered to identify their own individual training needs in relation to

new roles and services developed as a result of the modernisation agenda.

4.5 Personal and professional development

The personal and professional development of the individual team member is considered to be a potential skill needed to deliver and promote integrated health and social care (Nochajski 2001; Freeman *et al* 2000). A number of examples from the literature which illustrated training and education requirements of staff working within integrated services have facilitated an understanding of professionals' needs to deliver integrated health and social care. Consistent reference to some aspects of training within the findings has helped to identify two themes within the literature.

For example:

■ The significance of personal and professional planning
■ Perceived personal and professional development needs

The significance of personal development planning is integral to the identification of education and training needed to deliver and promote integrated services within primary care. Moreover, explicit needs frequently referred to included joint training between professional groups. As highlighted by Werrett, Helm & Carnwell (2001) and Gibb *et al* (2002), the move towards joint training initiatives was considered as important by practitioners themselves. Specific needs in terms of individual roles are, not surprisingly, context bound and driven by the client or populations needs. For example, dealing with alcohol abuse in mental health and awareness of the medical model as viewed by counsellors in primary care. Generic needs such as

information technology, communication, role awareness and awareness of voluntary and statutory agencies are reflected in nearly all of the papers reviewed and re-enforce the need to ensure that practitioners in health and social care are better equipped to identify their own learning and professional needs through robust personal and professional development (PPD) planning.

4.5.1 Significance of personal and professional development to Integrated Health and Social Care

Carlisle, Elwyn & Smail's (2000) study attempted to evaluate Personal and Professional Development Plans (PPDP's) within primary care led NHS services. They supported the notion that these could facilitate planning and integration within primary care. Using a participatory research design and evaluative methods, Carlisle *et al* (2000), evaluated a model and process used to develop PPDP's as a method of facilitating change towards Continuous Professional Development (CPD) and collaborative working. Whilst the methodology was described as being akin to an action research design, the description of the research process was limited. In addition, there was inadequate disclosure of the data analysis method and data collection, this essentially rendered the paper as a descriptive account of the problems the project team encountered and the dilemmas faced which reduces the credibility of the paper.

Although Carlisle *et al's* (2000) sample population and data analysis were ambiguous, the findings highlighted problems which they encountered when attempting to implement a model to facilitate the introduction of personal and professional development plans. This was attributed to a variety of factors which included the current changing political healthcare environment, misunderstanding about the project and relevance of the project to individual practices. Whilst it was accepted that training and education should be directed by personal and professional development needs and plans of staff, actual implementation of these into clinical practice proved problematic due to a perceived low priority assigned to them. The need for clear leadership to take forward such initiatives was evident. The need for CPD and clear clinical leadership has been endorsed by others, such as Slater (2002) who clearly advocated that practitioners personal and professional development needs should be considered if effective integrated services are to be implemented and sustained.

The significance of personal and professional development planning was confirmed by Werrett *et al* (2001) in their triangulated study which explored nurses' perceived gaps in knowledge and skills required for seamless care provision. Werrett *et al* (2001) argued that current Hospital at Home schemes highlighted the need for specialist and advanced practitioners to be able to practice across boundaries. This quantitative study illustrated that regular consultation about the individuals training and education needs should take place between hospital and community staff. Subsequent development of an educational model could provide clarity of how roles should coalesce with other health care professionals.

4.5.1.1 Perceived Professional Development Needs

Werrett *et al* (2001) used triangulated methods incorporating homogenous focus groups to generate questions for a questionnaire to explore nurses' perceived gaps in knowledge and skills required for seamless care provision. A stratified random sample of nursing staff from acute care staff working in surgery and medicine and all primary care staff (grades from D - I) were included. Given that the sample characteristics were not described and external validity was weakened as a result of a poor response rate of 23.8% (n=722), results from this study may be problematic to apply to other professional groups. However, key findings demonstrated that role awareness within hospital and community staff was seen as important and respondents suggested that role boundaries presented an area for training. Congruent with other research (Fakhoury & Wright 2000) teamwork and team building skills, together with communication training between health professionals and other agencies were viewed as essential. Although information technology was found to be most important area for training, Werrett *et al* (2001) discovered a low knowledge about multi-agency meetings (despite high use in practice). Other perceived training needs included the development and maintenance of research based knowledge. In terms of practice related issues, use of multi-disciplinary documentation was felt to be important and is an area which the *National Service Framework for Older People* (Department of Health 2001c) included through the introduction of the single assessment process.

Paradoxically, unlike other studies which illustrated some confusion about the skills needed as a result of service development, Werrett *et al* (2001) revealed most of the nursing staff had some idea about their training requirements for the provision of seamless care.

Recommendations based on the findings included clarification of professional skills and competencies together with increased role awareness and elucidation of responsibilities. It was believed that teambuilding skills could help overcome some of the concerns and foster positive attitudes in relation to inter-professional communication between acute and community services.

A specific focus was placed on information technology and teambuilding methods, out of which it was suggested that 'role shadowing' could be used as a method to improve role awareness. Both McNeal *et al* (1999) and Werrett *et al* (2001) advocated the introduction of ' cross-training' to help develop new skills for extended roles.

Prior to Werrett *et al's* (2001) study, Einzig, Curtis-Jenkins & Basharan (1995) undertook a quantitative survey and telephone interviews to identify whether prior training had prepared the counsellors for working within a primary care setting. Although this paper is outside of the inclusion criteria for this review, problems encountered and concerns raised by the counsellors in 1995, are similar to that of contemporary research findings. In Einzig *et al's* (1995) study, trained counsellors were "chosen" to reflect a national spread. The response rate was good (24 out of 25 responded to the questionnaire) and 11 counsellors volunteered for telephone interview. Data analysis methods were not described, however, descriptive statistics were presented which provides some indication of how the data were analysed.

The findings revealed that 18 counsellors felt unprepared by their training. Key elements which were thought to be missing included the use of a medical model in care and information about the structure of the NHS especially primary care.

Team collaboration and the range of problems seen and how to manage these - specific mental health disorders and coping with the isolation of being a counsellor were also felt to be lacking. Some of the findings were similar to that of Fakhoury & Wright (2000) which highlighted a poor relationship with the General Practitioner. Einzig *et al* (1995) also uncovered role misunderstanding and feelings of marginalisation by the General Practitioner's. Conversely, the General Practitioners lack of awareness about the counsellor's role influenced some of the counsellors to teach General Practitioner's about their role. Some of the respondents suggested that a joint General Practitioner/counsellor training day should be offered. A gap between training and recognition of its usefulness for primary care was recognized. Subsequent recommendations focused on the need for on-going in-service training which promoted collaboration between counsellors and other members of the primary care team. Einzig *et al* (1995) concluded by stating that:

"for counseling to take its place as a valued and integrated part of primary health care it is clearly just as important for counsellors to learn to interact with the medical model and the practice team, and to understand their place within it as it is for GP's to learn more about counseling" (Einzig *et al* 1995:208)

This statement illustrates the importance of professionals being able to identify their own learning needs as advocated by Werrett *et al* (2001) and Carlisle *et al* (2000). In addition, it re-enforces the need for role awareness within primary care as reported by others (McNeal *et al* 1999, Stanley *et al* 1999, Higham & Spooner 1998, Dalley & Sim 2001).

The repeated message of role development resonates throughout the evidence base and is implied in Simpson's (1999) paper which used a qualitative approach to identify the training and education needs of Community Psychiatric Nurses. Whilst Fakhoury & Wright's (2000) research highlighted a poor relationship between the community psychiatric nurse and General Practitioner, Simpson's (1999) findings identified the training needs of the community psychiatric nurse's from the perspective of 283 participants.

This included community psychiatric nurse's and service users, carers, lecturers, representatives from voluntary organisations and care support workers. Focus groups were undertaken with 125 participants and interviews included 158 participants. As a qualitative approach, this sample size is very large which may have increased the probability of achieving data saturation.

A thematic analysis was used to identify emergent themes. Whilst member checking of the analysis enhanced the credibility of the findings, the description of the research process itself was limited and no information was provided concerning data collection in terms of how the interviews and focus groups were structured. Although analyses were returned to the participants via a conference, it was unclear as to whether the interpretations of the transcripts were amended following the conference. This information would have improved the trustworthiness of this paper, which offered some insight into both the professionals and users thoughts about training and education needs.

The findings established that service users were very positive about community psychiatric nurses but believed that they should help users explore their concerns and provide more information. Alternatively, carers wanted more involvement in care planning. These findings were consistent with Glendinning's (2003) research which identified the older person was rarely included in any planning and wanted more involvement in their care. The community psychiatric nurses identified some training needs which included training in psychosocial interventions. Similar to Fakhoury & Wright's (2000) findings, there was a perceived need for them to develop a greater awareness of other voluntary organisations and self-help groups. There were some difficulties voiced by the community psychiatric nurses about their involvement with a care programme approach which were associated with working in a multi-disciplinary team. Congruent with Werrett *et al's* (2001) findings, Simpson (1999) re-enforced the need for training within teams and team-focused training to "help staff work effectively as a team".

Similar to Millward & Jeffries (2001), Simpson (1999) also suggested that regular team-focused training and team building programmes were required coupled with improved communication between educationalists and mental health teams.

The importance of role and team awareness was one of the findings uncovered in Secker, Pidd & Parham's (1999) exploration of mental health training needs for primary health care nurses. The mixed method research design attempted to identify the training needs in relation to mental health of health care professionals working in a London Health Authority

area. Geographically based in two districts, district nurse, health visitors, school nurses and practice nurses were surveyed. From this a sample of 30 volunteered to take part in interviews and focus groups. Amongst other training needs identified, the need for a "multi-disciplinary approach to mental health training that could facilitate a common awareness of the varied roles" was suggested. Although there was a poor response from the survey, the interviews and focus groups elicited rich data which revealed concerns and training needs. Surprisingly, interviews were not audio taped, Secker *et al* (1999) took notes instead and then taped their descriptions of the key points raised in the interviews. This was then transcribed and combined with the notes taken in interview. No verbatim extracts offered to support findings leaving the validity and reliability of the study questionable.

When collated, the findings were similar in each group in relation to training needs and included the need for defining and maintaining roles - particularly with other services and training with other professionals. In relation to the potential content of future training, the participants discussed the need for more training on a variety of issues which ranged from alcohol abuse, problem with refugees, violence and social isolation, cultural differences to the need for joint training "particularly with social workers and community psychiatric nurse's".

A structured relevant learning programme was needed which offered counselling skills (especially for children with mental health problems), greater awareness of other services, use of a cascade model, practical issues, use of specific case studies and basic skills such as

listening, communication and on-going training. Similar to that of Simpson (1999), there was a clear need for a multidisciplinary approach to mental health training amongst the nurses in particular. Given Secker *et al's* (1999) methodological flaws, the paper provided insight into the content and structure of training needed to help integrate services in primary care, although social worker input is minimal here, aspects and key themes have the potential to be transferred to similar settings.

Encouraging and supporting practitioners to identify their own development needs in relation to the integration of services is one method used to enhance practice and service delivery. Actual practice development, management and leadership are other essential requirements which have been highlighted in the literature (Farmakopoulou 2002). This may relate to the introduction of innovative service delivery through changes in referral routes (Taylor, Blue & Misan 2001) or the development of new leadership roles to manage integrated service provision. Whereas personal and professional development issues are considered to be operational matters, the expansion of practice to deliver integrated services is strategically directed.

4.6 Strategic Indicators:

4.6.1 Practice Development and Leadership

One of the strategic indicators relates to the need to help develop practice and the leadership skills needed to achieve this. Service provision and swift demographic changes introduced by the modernisation agenda led to swift changes which resulted in many staff feeling threatened and disenfranchised (McDonald *et al* 1997). New structures in place to support

integrated working need effective leadership to ensure a successful service.

Freeman *et al* (2000) suggested that whilst government initiatives were aimed at promoting collaborative practice, the reality was different, in that "working collaboratively may not be readily achieved". Equally Watson (1994) argued that co-operative working does not occur as a result of legislation alone, and has rarely been realised in practice. A number of studies have reported dissatisfaction with policy implementation. As a consequence, researchers have attempted to draw on current practice to illustrate the resultant tensions. The shift from secondary care services to primary care was especially pertinent in McDonald et al's (1997) study. The research was undertaken at the start of the modernisation agenda and reflected some of the problems faced by practice staff.

In particular, McDonald *et al* (1997) reported on changes in tasks and workforce practices, which primarily affected the district nursing services. Strategic changes made in response to the modernisation agenda resulted in an increased number of dependant patients with complex needs.

Some practices had developed a care manager role to manage new demands and requirements from the increased dependant patients and co-ordinate services between health, social care and the independent sector. For example, Hudson (2002) evaluated a project which aimed to develop joint working in primary care services through the introduction of a 'care manager'. The notion that the development of practice and integrated services could be managed effectively by a 'care manager' is a concept which is echoed by others (Stanley *et al* 1999) and is seen as a

method to promote a seamless service in a changing health and social care programme.

The introduction of new reforms however, which preceded the frameworks, were a concern highlighted in McDonald *et al's* (1997) survey which explored the future of community nursing in the United Kingdom i.e. district nursing, health visiting and school nursing. One finding indicated that district nurses were concerned with the swift change in care direction from secondary to primary care. Due to demands within the mmodernisation agenda, staff felt there was no 'slack' for training initiatives. This rapid change led to poor communication between acute services and district nursing teams.

McDonald *et al* (1997) commissioned by the Community Performance Review Network in England and Wales (CPRN) explored the future of community nursing within the context of a changing NHS and intended to use the findings to help individual trusts develop strategies for the future of community nurses. To achieve this, a survey was distributed to all 24 members of the Community Performance Review Network and 22 responded. The questionnaires were completed by a variety of respondents in each of the member trust sites. Discussions based on the questionnaire findings were held at a Community Performance Review Network theme day, through which a number of issues were highlighted.

Whilst analysis of the questionnaires was described as using Excel 5 and Minitab 10 to provide descriptive statistics, analysis of discussions which took place on the theme day are not explained. Data obtained during the theme day have been used within the paper, but no verbatim quotes have been used to support the analysis and

discussion.

The questionnaire highlighted key issues which included concerns about the changes in tasks and working practices as a result of increased caseloads due to faster turn-around in hospitals and the subsequent complexity of increased medical and clinical needs. In relation to training needs, the expansion of technical skills in the community were thought to be necessary to deal with the demands of the new patient intake. However, due to rapid changes introduced as a result of the mmodernisation agenda, poor communication between acute services and district nurses prevailed. However, the increased interaction between General Practitioners (GP's) and District Nurses led to a reduction in the duplication of services and signaled the need for re-organisation of service-delivery issues. Generally it was noticed that since the introduction of the mmodernisation agenda there had been a move from an illness-based to a health promotion model.

Findings from McDonald's *et al* (1997) 'theme' day included an expressed mistrust between community trust managers and primary care workers and relationships with acute services were not considered to be cordial. There were some concerns about the move from secondary to primary care and changes in skill mix required to deliver services. In terms of links with Social Services, a recurring topic was identified. 'How the role of community nursing was defined in relation to needs being met by social service' was perceived to be an ill-defined area, which had not been addressed and could lead to confusion and misunderstanding. Changing demands of client population had led to anxiety regarding communication between

other agencies.

McDonald *et al* (1997) identified their own limitations i.e., some skeptics might view the use of a non-random sample of trusts as providing an opportunity for those trusts who were interested in furthering common aims. As a result, the reliability of the responses could be questioned. Despite the sampling errors, the findings illustrated some useful evidence which point toward potential training needs. Similar to other research (Taylor *et al* 2001) an emphasis was placed on the need for good communication between agencies, role development and 'population' led services. McDonald *et al* (1997) concluded by stating that the "grey areas between health and social services" remained a 'major' concern. They suggested that health visitors had been 'disempowered' with regards to providing preventative health care, as a consequence of social services only taking action on definite referrals.

This paper highlighted the change in practice since the introduction of the modernisation plan and illuminated some of the concerns held by community staff. Although this paper was written at the cusp of change in the NHS, its findings in relation to communication needs of professionals working in and between services have not been fully addressed to date. A clear message from this paper is the need for practices to develop clear and coherent strategies with which to underpin a changing workforce and changing role descriptions. In relation to collaboration between health and social care in the community, a number of issues arose from the paper which suggested that some professional health groups felt marginalized or disempowered due to ambiguity about social services. Conversely, Bywaters & McLeod

(2001) commented on social care staff becoming disenfranchised through feelings of marginalisation and an unequal relationship between the NHS and social services. This appears on the surface to be a common concern echoed by numerous authors since the introduction of the modernisation agenda (Hudson 2002, Glendinning 2003, McDonald *et al* 1997). A variety of projects have been developed with the main aim of improving working relationships between health and social care and thus provide a seamless services for the patient.

One such project, the 'Shipley Project' was evaluated by Hudson (2002). This project was developed in response to the implementation of a practice 'care manager' who was responsible for the co-ordination of care across agencies and organisations. Aptly named 'Interprofessionality in health and social care: The Achilles' Heel of Partnership?' Hudson used an 'optimistic hypothesis' to challenge pessimistic, sceptical views about the feasibility of joint working between professional groups.

Based on the belief that older people see the doctor as an access route to health and social care services, the Shipley Project was developed which placed a care manager in General Practitioner practices to promote joint working between social workers, healthcare professionals and the community health trust. Care managers were responsible for assessing the needs of the individual client and designing packages of care with joint commissioning. It was suggested that this care manager model could be transferable to other practices and could promote better co-ordination of services.

Hudson's (2002) work supported findings from other studies

(Farmakopoulou 2002) and recommended ways of improving inter-professional working. Hudson suggested that the array of policy initiatives which had come out of the modernisation agenda in an attempt to encourage health and social care to collaborate had resulted in confusion at operational levels of organizations. Whilst the Agenda placed a focus on strategic organisational relationships and working, interprofessional working needed to secure strategic initiative received little attention. Hudson (2002) stated that there was an assumption that operationalising innovative strategies would simply fall into place once policies were introduced.

In total, Hudson (2002:11) conducted 81 interviews and nine focus group interviews. The findings highlighted some serious concerns about the relationship between the social workers and nurses which were noted to be "far from comfortable". Professionals felt threatened and 'turf wars' existed instead of co-operation. The social worker participants believed that they had been brushed aside by the introduction of the care manager.

Hudson (2002) concluded that the main differences between the social workers and the nurses were as a result of 'ideological issues' largely caused by the ways in which services were funded. Healthcare was free at the point of contact whereas social care was means tested resulted in nursing staff reluctant to engage with social care staff. Whilst Hudson described his work as qualitative, the process of data collection and analysis was ambiguous. No description was offered as to whether any steps were taken to assure dependability of data interpretation. Moreover, the sample had not been adequately described or

the type of services the participants were involved with and whilst the use of the pessimistic model is an innovative approach to analysis, subsequent interpretation was not supported by participant's quotes. However, Hudson's (2002) findings were in keeping with other studies who have highlighted differences between health and social care in terms of ideology and funding. For example, Bywaters & McLeod (2001) stated that the relationship between the NHS and social services may never be equal due to the size and dominant culture of the NHS. Social services often feel marginalized, a concern also raised by Glendinning (2003). Hudson (2002) advocated the development of trust and an awareness of others roles, coupled with the demise of professional hierarchies to promote skills and attributes needed to deliver an integrated agenda.

Strategic policies aimed at integrating services around a defined population have been common place since the introduction of the modernisation agenda. Many policies, as Hudson suggested, assumed that strategic direction would invariably lead to the operationalisation of a seamless service.

For example, in March 2000, *'No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse'* was launched (Department of Health 2000c). The introduction of this document caused some concern for Slater (2002), who argued that "agencies would, however, be well advised to pause and consider a number of critical issues in relation to the local implementation of the *'No Secrets'* policy". Slater (2002) highlighted the ambiguity of language used on Department of Health policy

documents and attempted to use professionals themselves in directing future policy development. Policy terminology used within *'No Secrets'* was at best misleading and did not take into consideration previous concerns highlighted by the social work profession and subsequent recommendations. To implement the policy successfully, Slater (2002) contended that staff needed to become familiar with the basic concepts of No Secrets in order to effect a successful implementation. To address this, a single day course aimed a frontline managerial staff from health and social care was designed to raise understanding of the No Secrets policy, appraise existing practice and feedback participant's views about future policy developments to the lead for No Secrets. Slater (2002) suggested that the use of staff development initiatives could contribute to the strategic direction within broader organisational aims. He also evaluated the training day to identify what policy professionals think should be developed to support them in protecting vulnerable adults.

Frontline and managerial staff from health and social care involved in care of the older person participated in the study day. However, there was no full description of the sample strategy which Slater (2002) later described as being "the mundane-sounding collection of post-it statements which were accorded with the status of 'recording units". Data were collected via a 'specially designed evaluation form' and the collection of 'post-it' notes. A content analysis was undertaken; initial categories were 'culled' from the diffuse policy headings from No Secrets and then 'reduced' to four 'emerging themes' which were then coded with a numbering scheme.

The use of post-it notes neatly presented some of the participants' views, these may well have been taken out of context through the reductionalist approach used. A more qualitative methodology may have elicited a more comprehensive and accurate interpretation of the participants' views. Findings specific to integration included; explicit commitment to joint working across agencies, coherent statements of competency roles and responsibilities, named contacts for advice, liaison and support and integrated range of training facilities related to roles, responsibilities and tasks.

These themes are echoed in other work Farmakopoulou (2002), Hardy, Hudson & Waddington (2000) and are viewed as essential components of successful service delivery services have witnessed major re-organisation over the past eight years which has impacted both negatively and positively on practice. Negative impacts have been borne out through research (Slater 2002, Hudson 2002) which evaluated the introduction of new policies and roles aimed at co-coordinating services. Whilst Slater (2002) identified the need for clear lines of responsibility, leadership and commitment, Hudson illustrated differences between professional and service ideology as a potential negative influence on the integration of services. Evidence drawn from such literature outlined the need for collective respect and co-ordination from the individuals and partners involved in service development at policy level. In many instances, limited guidance provided by policy makers has been demonstrated to impair implementation processes (Farmakopoulou 2002). A high level of mutual dependence, equality of power, clear local guidelines with clear aims and objectives are promoted as essential needs when

introducing new policy aimed at integrating services (Farmakopoulou 2002).

Effective partnerships at strategic and operational levels within organisations resulted in integrated service provision. Hardy *et al* (2000) advocated that clearly defined joint aims and objectives, commitment and ownership, appropriate seniority of commitment and sufficient consistency of commitment are, amongst others, elements required to enable a partnership to flourish.

Securing widespread ownership within and outside partner organisations leads to policies which are accepted and adopted by individuals working within the service. The principles of good partnership working need to be used a framework to support initiatives at an operational level to ensure collaboration, co-operation and a seamless services provision for the patient.

4.7   Partnership Working

The diversity of research design pertaining to partnership working was clearly evident in the literature. Evaluations of partnership working (Peck, Towell & Gulliver 2001), development of partnership assessment tools (Hardy *et al* 2000), inter-organisational analysis (Farmakopoulou 2002) and experiential research designs (Secker & Hill 2001) have been used to explore the notion and effectiveness of partnership working. The evidence related to the notion of action and collaboration between agencies which illustrated problems encountered with subsequent partnership working and the gap between health and social care. Equality must be addressed if integration is to occur at all levels within and across organisations and whilst some literature has alluded to

both health and social care, health has retained a predominant position which could re-enforce negative stereotypes and further promote un-equal relationships between health and social care. Differing funding priorities (Hudson 2002) and agendas between agencies have compounded ineffective working and limited the chances of successful integration.

Through an organisational analysis, Farmakopoulou (2002) concluded that there should be an acknowledgement and resolution of the conflicts between relationships, a high level of mutual dependence, equality of power, local guidelines with clear aims and objectives and the promotion of joint training.

Using a case study design, Farmakopoulou (2002) adopted an integrated theoretical approach through a mixed method design and examined inter-professional and inter-agency collaboration in special needs assessments. Similar to that of Slater (2002) Farmakopoulou (2002) argued that despite the abundance of government policies to enhance interagency collaboration, actual collaborative activities remained limited.

The sample population consisted of social work staff, parents of case study children and a 'limited number of health and voluntary organisational representatives'. Six children were used in each of the three 'case study' authorities. The majority of the educational staff interviewed was educational psychologists and social worker staff consisted of day-care staff. Due to confidentiality, a brief description only is provided of the case sites. Data were collected through a 'mapping exercise' using a survey approach and questionnaires and semi-structured interviews with an additional 'checklist' as a supplementary technique to collect

data although the checklist is not fully described. Data were interpreted using an 'inter-organisational analysis' model.

Farmakopoulou (2002) then used Goacher, Evans, Welton & Wedell's (1998) theoretical framework to underpin her analysis of the environmental factors which were thought to influence inter-agency collaboration. As a result of the 1995 Scottish Children's Act (Department of Health 1995) there was some increased frequency in the rate of collaboration although education and social work departments were still in a transitional phase in terms of implementation. Whilst the education and social work departments were given a list of tasks needed to be implemented as part of the Children's Act (Department of Health 1995), no guidance was provided. As a consequence, the implementation process was impaired.

In relation to inter-organisational factors which were thought to influence inter-agency collaboration, Farmakopoulou (2002) identified delays due to lack of and/or shortage of staff which led to late notifications of referrals and sometimes inhibited collaboration. Similar to Hudson's (2002) findings in relation to the negative impact of professional ideologies, Farmakopoulou (2002) discovered different priorities between agencies and differences in time scales which could lead to ineffective collaboration between services.

In her recommendations, Farmakopoulou (2002) suggested that there should be an acknowledgement and resolution of the conflicts between relationships, a high level of mutual dependence, equality of power, clear local guidelines with clear aims and objectives and the promotion of joint training.

Whilst Farmakopoulou (2002) provided evidence which sustained the notion that role ambiguity promotes ineffective integrated health and social care, the reporting of the project, was based on a theoretical framework which influenced the study as opposed to the research process in terms of how data were collected and analysed. There was limited use of quotes to support the interpretations and relationships between the researcher and the participants were not fully explored. Whereas Farmakopoulou (2002) highlighted that joint training would be useful to promote integrated health and social care, conversely, Zwarenstein *et al's* (1999) systematic review highlighted a dearth of evidence regarding the effectiveness of joint training. As a result of limited evidence, introducing joint training initiatives could actually compound ineffective partnerships rather than promote the process.

Barriers to partnership working were also explored by Secker & Hill (2001). This qualitative study explored the extent of interagency working, identified barriers and examined the potential impact on service users. A purposive sample of 30 agencies (128 participants) working across five practices (local housing agencies, criminal justice services, community learning disability, drug, alcohol and child care teams and local community mental health teams were involved in focus group interviews. The focus group interviews were not tape-recorded. Secker & Hill (2001) used in-depth notes that were taken and 'written up' within one week.

The absence of a tape recorder to capture the data was not explained and may have allowed for a significantly high chance of bias in the recording and subsequent interpretation of the findings.

Nonetheless, data was analysed appropriately using a 'staged content analysis' to draw together the data and identify themes. Main themes were identified and developed and the sub themes which emerged were then compared across the agencies.

The findings illustrated problems in partnership working across agency boundaries. Four themes which included involvement with mental health issues, inter-agency working, the extent of joint working and barriers to joint working were identified. The ability of the organisation and individuals to cope with increased demand as a result of policy change was discovered. Similar to the concerns about population expansion and increase in demands raised in McDonald *et al's* (1997), Secker & Hill's (2001) findings raised concerns which reflected the range and extent of mental ill-health encountered. This ranged from the increased rates in depression to diagnosis of ADS (attention deficit disorder). Mental health illness combined with substance misuse and personality disorders were singled out as significant problems. Barriers to effective working were thought to be the result of ambiguous role boundaries, the inability to share information and tensions between agencies. Similar to that of Farmakopoulou (2002), Secker & Hill (2001) recommended joint training and multi agency protocols to try to overcome some of the identified problems.

Partnership assessment tools have been suggested as one method to promote collaborative working and successful partnerships. Hardy *et al* (2000) developed a Partnership Assessment Tool (PAT) in conjunction with members of the Community Care Division at the Nuffield Institute for Health. The team argue that the

tool addresses generic concepts and therefore has the ability to be applied at a variety of different levels and within different organisations.

Whilst the tool was developed with Trent National Health Service Executive, the potential use to promote partnership working between agencies and across organisational boundaries is clearly evident. The purpose and use of Partnership Assessment Tool is described as being a developmental tool. It was suggested that this may be done prospectively or retrospectively to address and help anticipate barriers.

There are six stages in total which lead the organisation (and partnership) through a developmental process (See Box 3 overleaf).

Box 3: Example of Partnership Assessment Tool Stages (Hardy *et al* 2000)

Stage one: Was designed to help partners assess their perceived strengths and weaknesses in relation to partnership working. This, it is suggested, may be realised through comparing partner responses to six principles in which they are asked to agree or disagree with a statement.

Stage two: Encourages participants to draw a rapid profile based on six principles and co-existing elements and stage three involves the discussion of findings.

Stage four: Is split into parts 'a' and 'b' which indicates where agreements and disagreements are located.

Stage five: Involves designing the in-depth partnership assessment and finally, stage six relates to action planning. Each principle has a series of elements which are described within the context of the principles. Members complete a 'Rapid Partnership Profile' using a Likert scale to score against each of the elements and principles.

Hardy B, Hudson B, Waddington E (2000) *What Makes a Good Partnership? A Partnership Assessment Tool.* Nuffield Institute for Health. Community Care Division. Leeds.

The principles outlined in the Partnership Assessment Tool reflect much of the literature in relation to collaboration, co-operation and trust. The first principle related to the need for organisations to recognise and accept the need for partnership. As a result of the internal market, many organisations have been reticent about sharing and the need for partnership to develop services has been de-sensitised. To facilitate an effective partnership, Hardy *et al* (2000) advocated the need for the development of clarity and realism of purpose.

As with Farmakopoulou (2002) recommendations for joint working and goals, Hardy *et al* (2000) outlined their second principle, which emphasised the need to ensure that partnership is built on shared vision, shared values and agreed service principles and define clear joint aims and objectives, with objectives expressed as outcomes for users.

Through this, partners need to recognise the extent to which any separate aims and objectives of individual partners are enhanced or compromised by the pursuit of joint aims and objectives. The third principle, commitment and ownership, relates closely to Slater's (2002) findings which highlighted commitment as a pre-requisite to guarantee the successful implementation of policy initiatives. Hardy *et al's* (2000) Partnership Assessment Tool provided a series of elements to support this process which included appropriate seniority of commitment, sufficient consistency of commitment and widespread ownership within and outside partner organisations. Equality and trust between partners is echoed within the literature (Peck *et al* 2001) and also served as the fourth principle in the Partnership Assessment Tool. Hardy *et al* (2000) recommended that all partners are accorded equal status

and that trust built up with partnerships needs to be protected from any mistrust that develops in parent organisations.

Congruent with Hudson's (2002) view is Hardy et al's (2000) fifth principle, which referred to the need to create robust and clear partnership working arrangements with transparent financial resources and an awareness of the non-financial resources each partner brings to the relationship. Single responsibilities should be distinguished from joint responsibilities and structures should be developed which are time limited and task orientated. Finally, the Hardy *et al's* (2000) last principle encouraged organisations to monitor, measure and learn. To achieve this, members must agree a range of success criteria including the feedback of progress to and from parent organisations.

Feedback as a result of good communication channels was highlighted in Taylor *et al's* (2001) study which attributed good communication and collaboration between organisations as a major causal factor in the success of sustainable primary services in rural and remote Australia. Many of Hardy *et al's* (2000) principles reflected the needs of organisations through out the literature (Farmakopoulou 2002, Slater 2002, Hudson 2002) and addressed concerns raised in relation to problems encountered when attempting to meet the needs of the modernisation agenda and the integration of services.

An example where collaboration had flourished as a result of effective partnership working was typified by Taylor *et al* (2001) whose case study described the structure and operation of a particular model of service delivery which actively promoted integrated care in rural communities.

Four University teaching practices and the Adelaide University Department of General Practice were established as a response to poor recruitment in rural South Australia. The practices were co-located within a hospital or Accident and Emergency department and accommodated community based nurses and allied health professionals. This model encouraged the integration of services and also provided an opportunity for students to experience an integrated rural health care service. Taylor *et al* (2001) evaluated the model by distributing a questionnaire to 80 consumers, and 29 health care students from four different sites and interviewing 73 staff. They identified that the model promoted effective communication, collaboration and sharing of case notes to support integrated care at each of the sites. However, whilst Taylor *et al* (2001) provided insight into a model which has provoked a positive impact on integrated care, much of the discussion is taken up with the potential sustainability without providing more information about the actual project and teaching sites involved.

Conversely, unlike other studies which identified poor referral techniques (Closs 1997) Taylor *et al's* (2001) findings illustrated that the University Teaching Practices, hospital and allied health professionals shared patients/clients involved referral to each other when appropriate.

Taylor *et al* (2001:306) suggested that the referrals among professionals were "a strong indicator of the existence of an integrated practice". Some problems were discovered which related to the funding sources of the individual professional involved in the model. However, whilst Australia is culturally similar to the United Kingdom, the health care system is not centrally funded, and

therefore, similar problems should not occur. Analogous with Hudson's (2002) disclosure in relation to problems associated professional ideologies and funding, Taylor et al (2001) also uncovered problems associated with different professionals funding sources and the process of common goals.

4.7.1 Culture and relationship in relation to partnership working

Peck & Crawford (2004) in a recently published report for the Integrated Care Network conclude that:

"it is clear that culture plays a major role in the success or failure of merged organisations. The process of creating and sustaining new partnership forms between health and local government thus needs to pay significant attention to culture."
(Peck & Crawford 2004:20)

This conclusion was also predominant within the literature reviewed. For example, in their case study of a new combined mental health trust in Somerset, Peck *et al* (2001) observed that the notion of culture within an integrated service heavily influenced the success of integrated services and joint working. They discovered that the meanings of 'culture' differed between and within professional groups. Moreover, Peck *et al* (2001) also highlighted that some staff viewed culture as "primarily an enactment of professional training and socialisation".

The main aim of Peck *et al's* (2001) study was to evaluate the impact of the changes on service users and carers and assess the impact of changes on professional staff involved and to explore changes and aspirations and beliefs of the senior officers and members of the agencies involved. Using a mixed method design, the project sampled senior

managers; all trust staff, self-selected trust staff, elected members/non-executive directors of the Local Authority, health authority including all members of the joint commissioning board. Response rate for the annual survey was 44% in 1999 and 34% in 2000. Data were collected using a postal survey incorporating a Likert scale to measure role clarity, satisfaction and level of burnout experienced by the staff. Open ended questions permitted further exploration of respondent's satisfaction with and expectations of the newly integrated trust and semi-structured interviews were used to elicit further data. Annual exploratory groups provided data which was fed back to the participants for verification. The use of SPSS and Winmax Pro identified a common concern amongst the respondents. It transpired that whilst some staff members were troubled by a perceived lack of identity, others felt threatened through potential changed relationships with relationships. There was some concern voiced about professional development with supporting statements such as "it can be a struggle to keep a hold of social work values in a strong health culture".

These findings illustrated that the meanings of 'culture' differed between and within groups. Peck *et al* (2001) continued to analyse the differences through use of the literature, semantics and discourse. On a local level, they identified that a shared culture was described as a tool for integration and that the creation of common values and language could be seen as a potential move towards integration. Similar to Farmakopoulou (2000), the notion of co-location is promoted as a method to enhance effective collaboration between agencies. Peck et al (2001) also highlighted that some staff

viewed culture as "primarily an enactment of professional training and socialisation".

Although pertinent to the debate around culture and its influences on practice, Peck et al's (2001) work provided little insight into the research design. Commentary was based on the identified concerns about culture rather than the original aims of the study. Visualising data origin proved problematic as a result and limits insight into the researcher role, bias reduction and data interpretation.

As with other research findings, ambiguity existed about relationships with other staff in the newly formed trust. Peck *et al* (2001) purported that this study has many messages for the use of culture in the creation and maintenance of multi-agency working. They contested that there is danger when mutual misunderstanding of culture is explicit and that this is obvious. The reality that the findings fitted 'too easily' with the conceptual framework were recognised as a limitation to the study. Given more time and future data collection, new themes may have emerged. However, other studies have reported problems associated with culture and professional divide. Glendinning's (2003) study explored barriers in integrating services for older people identified limited evidence of primary care trusts/ primary care group's success in collaborating. Glendinning (2003) reported that despite social service representation on primary care trust boards, they still felt marginalised.

Concerns about the marginalization and un-reciprocal relationship between the NHS and social care is corroborated by Bywaters & McLeod (2001) in their discussion paper on Labour's 'Third Way'. The main thrust

of both these papers focuses on identified problems with integrated services and the marginalisation of social service input within the decision making process and commissioning of care services. Based on research undertaken following the introduction of the Health Act (Department of Health 1999a) and dissolution of the Primary Care Group's, Glendinning (2003) offered insight into the effects of reorganisation of older people's services at strategic and operational levels. Survey and longitudinal in-depth case studies of a representative sample with 15% of the 481 English Primary Care Trust's revealed limited evidence of Primary Care Trusts/Primary Care Groups success in collaborating.

The extent to which non-health partners are involved in decision making was unclear. Glendinning (2003) reported that despite social service representation on primary care trusts boards, they still feel marginalised.

Other accusations leveled at strategic planning and organisation of the primary care trusts' suggested that the older person is rarely included in any planning and none of the needs highlighted in the Hope Report (2000) are mentioned in the Governments primary care trusts planning. Glendinning (2003) suggested that 'integrated care' is "capable of many different meanings, depending on who is using the term and in what circumstances". She purported that terms like this, and partnership, are politically attractive when considering alternatives terms such as fragmented. Similar to that of Farmakopoulou's (2002) inter-organisational analysis, Glendinning (2003) proposed that this can only be achieved by organisations who exhibit several characteristics.

She lists the characteristics as being:

- *Joint goals*
- *Close knit highly connected communities*
- *Little concern about reciprocation*
- *High degrees of mutual respect and trust, joint arrangements which are mainstream core business*
- *Joint planning which encompasses strategic and operational issues*
- *Shared or single management arrangements*
- *Joint commissioning at micro and macro level.*

Many of these characteristics constitute repeated themes throughout the literature on partnership working and have direct relevance for the *Shaping the Future for Primary Care Education and Training Project* (www.pcet.org.uk) and subsequent thematic analysis of the review.

4.8 Summary of Appraised Evidence

Utilising a spiral search strategy (Grant & Brettle 2000), relevant evidence has been located and evaluated using validated screening tools. Evidence appraised has focussed on the education and training needs of the primary care workforce to deliver integrated services. The range of evidence included has paid specific attention to the concept of collaboration, the influences of the modernisation agenda and research evidence. This collective evidence base has revealed skills and competencies needed at both operational and strategic levels within organisations to promote integrated working. A plethora of research has pointed towards the need for basic core competencies

such as team working, communication and role awareness to be re-addressed and emphasised by providers of future education and training within Further and Higher Education Institutions and health and social care organisations.

The evidence located was of variable quality. The diversity in research designs identified is reflected in the literature which indicates a need for more robust research to evaluate aspects of Integrated Health and Social Care service delivery. Surprisingly, much of the literature failed to demonstrate a transparent research process which made appraisal of these papers problematic. This resulted in the inclusion of less rigorous, available evidence, that might normally have been excluded but which has provided a rich and comprehensive insight into the six themes pertinent to the successful delivery of integrated services. Successful partnership working is viewed as the cornerstone of integrated services. It is an essential requirement to empower the workforce and create responsive, reflective practitioners who are able to appraise the needs of the individual and partner organisations.

Chapter 5:
Developing the Workforce:
Validating the Emergent Themes

To ensure the success of the modernisation agenda the Department of Health commissioned the development of three frameworks aimed at helping health and social care organisations and practitioners to develop skills and competencies needed to deliver services. They were the National Occupational Standards for Care and Social Care (www.skillsforhealth.uk), the NHS Knowledge and Skills Framework (KSF) (Department of Health 2003d) and the NatPaCT Competency Framework (NHS Modernisation Agency 2004). In addition, the National Training Organisation for Social Care (Topss) in England (Topss UK Partnership 2002) have developed National Occupational Standards for Social Work.

5.1 The Skills and Competency Frameworks

A brief overview of each Framework offers a degree of clarity regarding their function and inter-connectedness in relation to the emerging review themes.

5.1.1 NHS Knowledge and Skills Framework (Department of Health 2003d)

This is a developmental tool aimed at providing the basis for pay progression within bands. The six *core dimensions* which make up the framework are considered to be core to the NHS as they occur in everyone's job. A further 16 specific dimensions are also defined – but these are not generic and may relate to some jobs but not all. The dimensions will link to the Occupational National Standards, QAA benchmarks and other nationally developed competencies. The core dimensions are communication, personal and people

development, health, safety and security, service development, quality and equality, diversity and rights. Specific dimensions linked to this review are: Partnership (18) and Leadership (19).

Each of these dimensions are further divided into a series of *level descriptors* which 'show successively more advanced levels of knowledge and skill and/or the increasing complexity of application of knowledge and skills to the demands of work. Each level builds on the preceding level(s)' (Department of Health 2003d:4). Each of the level descriptors includes a number of indicators and examples of how all the dimensions, descriptors and indicators can be applied across a range of jobs in the NHS.

5.1.2 National Occupational Standards for Care and Social Care (Skills for Health 2003)

'National Occupational Standards describe performance – what people are expected to do in employment' and are linked to professional standards, codes of conduct and professional guidelines (Skills for Health 2003). They have been developed by representatives of each occupational area and form the basis for the National and Scottish Vocational Qualifications (NVQ/SVQ). The Standards are set out as a series of Units, underpinned by Elements of Competency which include performance criteria and expected knowledge and skills to be achieved. (See Box 4):

Box 4: National Occupational Standards. Example of Elements of Competency inc. Performance Criteria and Expected Knowledge and Skills to be achieved *(Skills for Health 2003)*

Care Unit 10 (CU10) Contribute to the Effectiveness of work teams

Elements of Competence

1. CU10.1 Contribute to effective team working
2. CU10.2 Develop oneself in own work role
1. *Element CU10.1*

    The worker must be able to: Contribute to effective team working

Example Performance Criteria:

2. The worker's behaviour to others in the team supports effective functioning of the team

Knowledge specification for Care Unit 10

Example statement:

(knowledge of)

1. What effective communication is
6. Barriers to developing relationships and how these can be overcome

---

National Occupational Standards are closely linked to other national initiatives such as the NHS Plan (Department of Health 2000b), Working Together, Learning Together (Department of Health 2001a), Knowledge Skills Framework (Department of Health 2003d) and the Skills Escalator (Skills for Health 2003). This latter development:

"provides a dynamic approach to supporting career potential and development. Staff are encouraged

through lifelong learning to renew and extend their skills and knowledge so they can move up the escalator. At the same time, roles and workload pass down where appropriate, giving greater job satisfaction, and generating efficiency plans." (Skills for Health 2003)

5.1.3. NatPaCT PCT Competency Framework (NHS Modernisation Agency 2004)

The National Primary and Care Trust Development Programme has produced a Competency Framework, which is a self-assessment and support tool designed to help Primary Care Trusts deliver services. The Framework is based on a number of Competency Domains, each of these being further sub-divided into key competencies, competency statements and examples of required evidence to support these.

There are nine main Competency Domains with a further eight Specialist Competency Domains:

- 1 Organisational Maturity
- 2 Primary care contracting
- 3 Service provision
- 4 Commissioning: Initial Competencies
- 5 Partnership
- 6 Public Health
- 7 Community, Patient and Public Involvement
- 8 Clinical quality
- 9 Workforce

Specialist Competency Domains

- A Allied Health Professions (AHP}
- D Dentistry
- E Emergency Care
- I Information Management and Technology
- M Medicines Management, Pharmacy and Prescribing

- N Nursing, Midwifery and Health Visiting (NMHV)
- O Optometry
- T Teaching PCTS - Supplementary Competencies

The Competency Framework can be accessed via the NHS Modernisation Agency NatPaCT web-site: www.natpact.nhs.uk. A number of these have been used in the Mapping of the Review Themes (see Appendix 4 & 5).

5.1.4. The National Occupational Standards for Social Work (Topss UK Partnership 2002)

The National Occupational Standards for Social Work set out a statement of expectations from individuals, families, carers, groups and communities who use services and those who care for them (Topss UK Partnership 2002). The statements summarise their expectations of social workers in six key areas: communication skills and information sharing, good social work practice, advocacy, working with other professionals, knowledge and values. The Standards took into account the General Social Care Council Code of Practice for Employers of Social Care Workers and Social Care Workers (2002) which sets down responsibilities of the employers in the regulation of social care workers. Competencies are assessed in six key Role Areas (sub-divided into Units and Elements).

Given the influence of these four policy documents on health, social care and social work, it was anticipated that these frameworks would provide an indication of the skills, knowledge and competencies needed to deliver integrated health and social care. In addition, they would provide a way of validating the themes identified within the review.

A cursory analysis mapping of all four documents was undertaken using the six themes identified, taking into account that the frameworks were not specifically designed for integrated health and social care. However, combining all the evidence concerning integrated health and social care from the four different frameworks highlighted the potential purpose of each one within the context of integrated health and social care.

Given the influence of these four policy documents on health and social care, it was anticipated that these frameworks could provide an indication of the skills, knowledge and competencies needed to deliver integrated health and social care. In addition, they would provide a way of validating the themes identified within the review.

A provisional analysis mapping of all four documents was undertaken using the six themes identified, taking into account that the frameworks were not specifically designed for integrated health and social care. However, combining all the evidence concerning integrated health and social care from the four different frameworks highlighted the potential purpose of each one within the context of integrated health and social care.

5.2 Mapping of Themes

The four frameworks were mapped using colour coding for the review themes. The resultant mapping tables are found in Appendix 4 & 5.

5.2.1 Team working

Team working was the most common skill/competency identified and was implicit in all four frameworks. One of the strategic aims which related to teamwork in the NatPaCT

Competency Framework (NHS Modernisation Agency 2004) suggested that:

"the vision and values are translated into the objectives of individuals, teams and services."(Organisational Maturity:1.5.2). The process of team development is outlined in section 1.13 which offers a range of outcomes to support team development within organisations. (see Box 5)

In terms of the process of integrating services, specifically with social care, there was one indicator which related to the need for innovation and joint direction of services, *"Innovative development activities e.g. joint developments activities between health/social services."* (Workforce: 9.8.1.2)

The NHS Knowledge Skills Framework (Department of Health 2003d) predictably advocated a series of objectives for individuals to promote effective team working. Many of the stated skills disclose ways in which to promote team working amongst colleagues which requires some comprehension by the individual of the importance of team work. Despite research highlighting the need for team working to be included in future training and education, the NHS Knowledge and Skills Framework assumes that individuals will already be familiar with the concept of team working, which, as demonstrated by the literature (Millward & Jeffries 2001) may not necessarily be the case. Many, including Millward & Jeffries (2001) advocate the need to develop team work skills within professional groups.

The NHS Knowledge and Skills Framework also emphasises the promotion of quality through evaluation of the individuals own practice and identification of poor practice, maintaining and improving quality in all areas of work and practice. This includes supporting and empowering others by acting as an enabler and role model. (see Box 6)

Box 5: NatPaCT Competency Framework outcomes
(NHS Modernisation Agency 2004)

1.13.4 *Each team within the Primary Care Trusts is encouraged to undertake teambuilding activities, to improve team performance and facilitate interaction.*

1.13.4.1 *Activities include regular team meetings, (that include as part of the agenda internal working arrangements, training and development needs).Away days, workshops on particular issues affecting the team.*

1.13.4.2 *Where teams are made up of staff from more than one organisation all the team members are involved in team building activities.*

1.13.4.3 *There is a mechanism whereby teams can share developments.*

1.13.5 *There are effective systems to facilitate team communication and clear decision making processes.*

Box 6: NHS Knowledge and Skills Framework Levels
(Department of Health 2003d)

1. *(Level 2) D] alerts the team to developments in quality and recommends how own and others work should change as a result.*

2. *(Level 3) D] evaluates the quality of own and others work and make necessary improvements – this includes poor team practice.*

3. *(Level 4) A] acts as a role model in quality improvement offering advice and support to others who need it*

4. *(Level 4) C] enables others to (others include those from other agencies)*

The NHS Knowledge and Skills Framework (Department of Health 2003d) contains six core dimensions and sixteen specific dimensions. In relation to the specific dimensions, six were selected (8, 9, 10, 13, 18, 19) which were felt to reflect skills and knowledge to promote team working. These six dimensions narrated the need to address health and well-being needs, protect health and well-being needs and leadership issues (see Box 7).

**Box 7: Specific dimensions in the Knowledge Skills Framework
*(Department of Health 2003d)***

8. *Addressing individuals health and well being needs*
9. *Improvement of health and well being*
10. *Protection of health and well being*
13. *Production and communication of information and knowledge*
18. *Partnership*
19. *Leadership*

**Box 8: National Occupational Standards Care Units
*(Skills for Health 2003)***

Care Unit (CU) 1:
Work effectively as team members

CU9: Contribute to the development and effectiveness of work teams.

CU9.1 Contribute to effective team practice

CU9.2 Contribute to the development of others in the work team

CU10: Contribute to the effectiveness of work teams.

CU101 Contribute to effective team working

**Box 9: National Occupational Standards Social Care Units
*(Skills for Health 2003)***

Social Care Unit (SC) 15: Develop and sustain arrangements for joint working between workers and agencies

SC15.1 Evaluate potential for joint working with other workers and agencies

SC15.2 Establish and sustain working relationships with other workers and agencies

SC15.3 Contribute to joint working with other workers and agencies.

The National Occupational Standards for Care Units (Skills for Health 2003) also outlined ways in which individuals can contribute to effective team working. These standards reflected the NHS Knowledge and Skills framework and promote the development of others in the team and individual contribution.

The National Occupational Standards for Care Units (Skills for Health 2003) refer to skills such as co-operation, understanding of others roles, clear and unambiguous leadership coupled with a shared common goal needed to promote effective team working in other units. This would suggest that practitioners are already capable of making links between the units and synthesising the units (see Box 8).

As suggested by Millward & Jeffries (2001), Freeman *et al* (2000) and others, team working is influenced by the individuals ability to communicate and their awareness of their and others role within the team. These attributes are considered in separate domains in the National Occupational Standards. They are therefore reliant on the mentor in practice to assist the student to identify these requirements and link the standards.

In terms of joint working and the promotion of integrated services, the National Occupational Standards have also developed the Social Care (SC) Units which focus on the development of potential working between agencies (see Box 9).

This is similar to the National Occupational Standards for Social Work in Key Role 5: 'Manage and be accountable with supervision and support, for your own social work practice within your organisation'. The emphasis in this standard has been placed on developing skills to work within teams, for example, Unit 17: includes performance criteria which describes the need for role awareness within the team, accountability and expectations of others (See Box 10).

Box 10: National Occupational Standards for Social Work (Key Role 5)

a. *Identify; your responsibilities and the expectations of your organisation*

b. *Negotiate and establish; your responsibilities within the relationship; your expectations of the relationship; the expectations others have of you within the relationship*

c. *Ensure that differences in power and authority are addressed*

d. *Seek advice, supervision and support in areas of confusion and conflict. (Key Role 5: Element 17.1)*

Key Role 5 (Element 17.2) also encourages the social worker to " Contribute to identifying and agreeing the goals and objectives, and lifespan of the team, network or system". This includes developing the ability to contribute to the team, agree team leadership and setting measurable objectives to monitor the team's success. Team effectiveness and development is reiterated in Key Role 5: Element 17.3 which encompasses a range of performance criteria to meet the standard:

a) *"contribute to; evaluating the work of the team, network or system in achieving its goals"*

b *"making changes and improvements that will enhance the quality of the team, network or system and the working relationship of its members"* (Key Role 5: Element 17.3, Performance Criteria)

In all four frameworks, the importance of effective team working is instilled within the standards. Each

framework refers to working with and alongside other agencies, despite a clear definition and description of the term agencies.

5.2.2 Communication

Within the NatPaCT Competency Framework, the need for effective communication was mentioned within Section 1.4: Clear Clinical Leadership (Organisational Maturity Competencies). To achieve this it states that there should be clear communication channels in place, which include and engage all professional staff (Competency Evidence: 1.4.2.2). Communication also appears in Section 6.7: Intersectoral action on protecting public health (Public Health Competencies), examples of evidence being 'there are clear lines of communication with all relevant agencies, including out of hours' (6.7.2.1).

Conversely, the NHS Knowledge and Skills Framework allocated communication as a core domain and states that there is a need to " establish and maintain communication with various individuals and groups on complex potentially stressful topics in a range of situations" (Level 4). This included; identifying potential communication difficulties, identifying relevant contextual factors, communicating with people in an appropriate manner, recognising and reflecting on barriers to effective communication and how to improve communication and use a range of skills to improve communication between everyone involved.

Communication is also represented within the NHS Knowledge and Skills Framework Leadership Dimension as a Level 5 descriptor. This states that

clear benefits, goals and processes for developing knowledge, ideas and work practice should be identified and that this is communicated effectively to other agencies and communities. To achieve this, the domain also encourages the practitioner to " enable people to communicate their views about improvements and listens to what they are saying."

In relation to the draft core review in the National Occupational Standards for Social Care, communication was classified as *a core standard (A1)* which advocates that effective relationships to maximise and promote peoples well-being are developed. The specific competencies linked to this domain are not yet published so it is difficult to ascertain the full promotional extent of this standard.

Similar attention is drawn to communication in the National Occupational Standards for Social Work (Topss 2002). For example, in Key Role 1 social workers are encouraged to: Prepare for, and work with individuals, families, carers, groups and communities to assess their needs and circumstances.

In addition, the importance of good communication between all agencies, families, carers groups and communities is reflected throughout most of the occupational standards for social work.

This is most noticeable under Key Role 5 which states that the social worker should manage and be accountable with supervision and support, for your own social work practice within your organisation. The sharing and maintenance of records between those involved encourages the social worker to:"

A) identify: legal and organisational requirements for sharing information,

including the need to maintain privacy, confidentiality and security of information. The criteria for sharing information including: how the information will be accessed and shared; the frequency with which the information will be shared" and "B) Share records with individuals, families, carers, groups, communities and professional colleagues according to legal and organisational requirements and the criteria set." (Key Role 5: Unit 16: Manage, present and share records and reports, element 16.4).

5.2.3 Role awareness

It has been suggested that the key to effective team working is an acute awareness of individual roles, responsibilities and their contributions to care (Freeman *et al* 2000, Stanley *et al* 1999, Hudson 2002, Millward & Jeffries 2001). Whilst this was well documented in the literature, the recent case of Victoria Climbié (Department of Health 2003c) highlighted what could go wrong when communication and role clarity breaks down. Given that role awareness is identified as essential in the delivery of integrated health and social care, it was surprising to note that whilst communication and teamwork were referred to extensively, role awareness had received limited attention within the four frameworks. Roles and responsibilities are alluded to, but not made explicit.

At a strategic level, the NatPaCT competency framework *(Organisational Maturity:* 1.13) outlines the need for role awareness. Under team development, the section states that "A definition of roles, responsibilities and relationships within each staff team and between

the staff teams that make up the primary care trusts" (1.13.2) is needed. This is coupled with the recommendation that:

"roles and responsibilities are outlined in job descriptions, it is important that team members have access to the other job descriptions within the team, so that overlaps and adjoining responsibilities are understood" (NatPaCT Competency Framework: 1.13.2.1, NHS Modernisation Agency 2004).

The NHS Knowledge and Skills Framework integrates roles and role awareness through the specific dimensions in a variety of levels. These sections relate to the need to address health and well-being needs, improve health and well being and protect health and well being. Level five indicators suggest that the individual should be able to discuss and agree with colleagues, who could contribute to different aspects of care and subsequent care plans, might involve different professional groups and different agencies.

In relation to own role awareness and the need for clarity, it was suggested that the individual be able to explain clearly to people their own and others roles and responsibilities and how they inter-relate. Importantly, at level 1 in the framework also promoted the individual to develop an ability to identify with others in the team his/her own role in relation to awareness raining and how this role can best be met. At level three, this is enhanced to ensure that the individual will be able to "agree with the team their role and the groups and individuals whom they should be contacting". Similarly, the National Occupational Standards for Social Work reinforces the importance of roles and responsibilities. Agreement and mutual understanding between organisations, agencies, families,

carers, groups and communities is advocated in Unit 17: Key Role 5: (see Box 11).

> **Box 11: Unit 17: Key Role 5 National Occupational Standards for Social Work *(Topss UK Partnership 2002)***
>
> *Unit 17: work within multi-disciplinary and multi-organisational teams, networks and systems.*
>
> *17.1 Element: develop and maintain effective working relationships:*
>
> *Performance criteria:*
>
> ■ *A) identify: your responsibilities and the expectations of your organisation;*
>
> ■ *B) Negotiate and establish; your responsibilities within the relationship; your expectations of the relationship; the expectations others have of you within the relationship*

Likewise, under the domain of 'Partnership' in the NHS Knowledge and Skills framework, (Specific Dimension 18) Level 3 and 4 descriptors guide the individual and promote the need to "understand and value others' roles and contributions, acknowledge the nature and context of others' roles and work with others to develop agreed arrangements and action plans that contain communication and channels, roles and responsibilities, who is responsible for undertaking different actions".

The four documents clearly highlight the need for effective team working which is supported by an awareness of roles and responsibilities. Role awareness was a clear theme within the evidence base which illustrates problems associated with limited role

awareness such as 'turf wars' and 'professional tribalism'. Clearly, the four frameworks have attempted to re-dress some of the problems associated with team building by focusing on the need for mutual understanding of roles to support effective integrated working.

5.2.4 Personal and professional development

Personal and professional development is viewed as a skill, needed to promote integrated health and social care. Within this theme, training and education requirements are alluded to and in some instances, suggests that the individual should be able to access all training opportunities, develop oneself and others and be aware of own roles and responsibilities.

Not surprisingly, personal and professional development received most support within the NHS Knowledge and Skills Framework. Whilst the NatPaCT and National Occupational Standards for Care and Social Care and National Occupational Standards for Social work alluded to the need for personal and professional development, this was limited in comparison with the NHS Knowledge Skills Framework. Most of the personal and professional development indicators in the NatPaCT Framework are located in the organisational maturity and workforce sections. These combined sections describe the need for clear clinical leadership (1.4) including professional development arrangements, and a Continuing Professional Development (CPD) strategy which supports a positive culture that promotes all staff equal access to all training and development initiatives (9.7.1).

The NHS Knowledge and Skills Framework is linked to the skills within the United Kingdom Central Council (now the Nursing and Midwifery Council) standards and promotes the development of knowledge that should span across organisational and professional boundaries (United Kingdom Central Council 1999). The framework clearly advocates the need for shared opportunities and actively encourages practitioners to work across established boundaries to facilitate individuals learning from each other.

The Personal & People Development (Knowledge Skills Framework Core Dimension Level 5) suggests that the individual should be able to develop their own and others knowledge and practice across professional and organisational boundaries. This includes:

a] *evaluates the currency and sufficiency of his/her own knowledge and practice, develops PDP, generates and uses appropriate learning opportunities and applies own learning to the future development of work.*

b] *works with others to develop, identify and implement learning opportunities within and outside the workplace appropriate for peoples learning needs.*

c] *supports the development of a learning and development culture which encourages everyone to learn from each other and from external good practice.*

Similarly, Skills for Health (2003) recently produced new standards. Of these, the 'Care Units' (CU) relate to the need to developing one's own knowledge and practice (CU7) by " Reflecting on & evaluating ones own values, priorities, interests and effectiveness. (CU7.1). This entails the synthesis of new knowledge into

one's own practice (CU7.2), and the development of the individual in their own role. (CU10.2). A comparable direction is echoed in the National Occupational Standards for Social Work. Key Role 6 directs the social worker to be able to demonstrate professional competence in social work practice. In Care Unit 19, the social worker is also encouraged to " work within agreed standards of social work practice and ensure own professional development".

As Carlisle *et al* (2000) suggested the importance of personal and professional development planning should not be overlooked when promoting the delivery of integrated services. This is especially pertinent when considering the changing workforce and role developments since the implementation of the Modernisation Agenda (Department of Health 1997). It is evident that professional development has been adopted within all four frameworks. This has facilitated a strategic and operational approach to ensure that the individual's professional development needs are catered for.

5.2.5 Practice development and leadership

Practice development and leadership has been highlighted in the literature as essential requirements to ensure effective integration of services (McDonald *et al* 1997, Hudson 2002, Stanley *et al* 1999). The three areas of practice development, leadership and management are threaded throughout the NatPaCT Framework and through different levels within the service development section of the NHS Knowledge and Skills Framework. Both of these frameworks provide organisations and individuals with clear objectives for service development. The NatPaCT Competency Framework

advocates a 'shared vision' coupled with "clear links to the vision in the stated objectives of individuals, teams and services" *(Organisational Maturity:* 1.5.2.1), and the development of primary care through practice management and workforce planning. The framework advocates that human resource strategies should include "planning for an integrated workforce" *(Workforce:* 9.1.7) and "the development of new ways of working across organisational boundaries" *(Workforce:* 9.1.8).

The NHS Knowledge and Skills Framework places a greater emphasis on service development in terms of multi-professional working and recommends that services are offered as a multi-professional service, leadership skills and empowering individuals are used to contribute to service development through varying levels.

Leadership and service development are also highlighted in the National Occupational Standards for Social Work. Within Key Role 2, the requirement to "plan, carry out, review and evaluate social work practice, with individuals, families, carers, groups, communities and other professionals" is promoted. Unit 7 describes this in more detail as the ability of the social worker to "support the development of networks to meet assessed needs and planned outcomes". Specifically, element 7.2 promotes sustainable networks through which the performance indicators relate to supporting leadership of networks and the involvement of other (see Appendix 4 & 5). Professional development is also implied through the National Occupational Standards for social work through the repeated messages of encouragement to seek supervision and support.

5.2.6 Partnership Working

On a broader level, partnership working is reflected throughout the four frameworks but is most explicit within the section of the NatPaCT Framework specifically directed to the Allied Health professions. (see Appendix 6). This section significantly promotes the development of practitioners to work in partnership, in particular as it relates to integrated health and social care. Practitioners are encouraged to take part in multi-professional education and joint working initiatives. The need for primary care trusts to address the implications for allied health professionals in relation to lifelong learning, working together and learning together *(Workforce:* A2.4) is clearly evident. The performance management section encourages active involvement in multi-agency and inter-disciplinary teams and initiatives to deliver National Service Framework's, plus other local and national strategic initiatives and targets *(Performance Management:* A.6.2). The framework also advocates that allied health professionals work as part of a multi-agency and use a whole systems approach across health, education and social care. Specific attention is also paid to patient pathways and the needs of the local community *(Access and Choice:* A.7.4).

Likewise, a healthy approach is adopted to promote integrated health and social care within the allied health professional NatPaCT framework. Organisations are advised to empower practitioners to work across agency and organisational boundaries and ensure a seamless service for patients *(Partnership:* A.8.2). In addition, the framework recommends that previous professional experience in working across boundaries should be used to further the development of integrated health and social care *(Partnership:* A.8.3). The strategy endorses multi-professional education and makes explicit the need for participation in the delivery of multi-agency and inter-professional education and training and research and development opportunities *(Partnership:* A.8.6).

The NatPaCT Competency Framework is, however, health rather than care focused. Despite discussing 'joint development' *(Partnership:* 5:1), there is no specific reference made to social care, and the term 'agencies' is frequently used although not defined. Social care is first alluded to within the joint planning section, which suggests that "there should be evidence of improved use of resources to meet joint objectives for health and social care *(Partnership:* 5.2.1.3) and that "there is evidence of reduced social exclusion" *(Partnership:* 5.2.1.4).

The 'Verona Benchmark' is promoted as a partnership assessment tool, although this benchmark is not described within the document. It was developed as a result of the *'World Health Organisation's Investment for Health Initiative at Verona* in 1998 and tested in a number of pilot sites across Europe' (Health Development Agency 2003).

Following extensive testing and review 'the tool was revised and restructured to support capacity development and to offer greater flexibility in its use. It was then re-titled and re-launched as *'The Working Partnership'* (Health Development Agency 2003). It includes both an assessment and continuous improvement tool and is based on 'six key elements of good practice in partnership working, each of which is crucial to effective, sustainable and satisfying partnership

working: leadership, organisation, strategy, learning, resources and programmes' (Health Development Agency 2003).

The NatPaCT framework advocates that "primary care trusts should have an established framework to develop integrated care pathways on a multi-agency basis" *(Partnership:* 5.3.4). In relation to partnerships with Local Authorities, sections 5.7 and 5.8 covers a range of objectives including the requirement for the primary care trusts to develop local strategic plans and "work with communities and groups to develop and deliver local plans for neighbourhood renewal" *(Partnership:* 5.8.4). This should involve active multi-disciplinary and multi-agency work with commonalties *(Partnership:* 5.8.4.1). A similar message is presented in the National Occupational Standards for Social work which involves families, carers, individuals, groups and communities throughout the core text. Assessment Unit 7 relates to the need for the social worker to "support the development of networks to meet assessed needs and planned outcomes".

The performance criteria linked to this unit suggests that the social worker should:

"Identify and collate information on: possible networks that could be accessed locally, regionally and nationally that will enable networks to be developed to meet assessed needs and planned outcomes" (Assessment Unit 7.1 (a)).

Social care and education and training initiates are mentioned within the NatPaCT competency framework human resource strategy which stated that organisations should ensure that "pooled budgets for social services and joint posts with social services" *(Workforce:* 9.1.8.1) are developed.

This objective leads to the promotion of a co-ordinated approach to training and education across the health economy, including joint initiatives across health and social care *(Workforce:* 9.7.3) and that education and training plans are shared with other agencies *(Workforce:* 9.7.3.1). Similar to the allied health professional strategy, the NatPaCT framework promotes the sharing of education across organisational boundaries through training sessions run by the primary care trusts which should be publicised and accessible, where applicable to staff from local authority, voluntary organisations and other partner organisations *(Workforce:* 9.7.3.2). This notion of shared education is not however, promoted within the National Occupational Standards for Social Work.

Surprisingly, the NHS Knowledge and Skills Framework pays limited attention to partnership issues. This may be because the framework is aimed at the individual on an operational level, rather than the organisation and partnership at a strategic level. The main focus of this framework in terms of partnership working has centred mainly on level four descriptors. These descriptors state that the individual must be able to identify and promote the advantages and disadvantages of partnership working, and that the purpose of partnership working appropriately supports and encourages people to understand their contribution to partnership working, that they work effectively together and share achievements. At Level five, this also includes the ability to identify and select methods that facilitate partnership working.

5.3   Conclusion

Collectively, the four frameworks have provided guidance for core skills needed to deliver a seamless service at operational level. It appears that the frameworks, specifically in relation to the review themes, are explicit in encouraging the individual to develop skills in communication and team working but there is only an implied reference to that in relation to role awareness. At a strategic level, practice development and leadership and partnership working are noted, including specific levels and indicators and elements needed to achieve competencies in these areas.

Although there are significant differences in the inter-relationship of both operational and strategic level across the four frameworks, there are also similarities. Whilst these are generic in nature, they do present a strategic direction for individuals working within health and social care.

To ensure that the future workforce can deliver integrated health and social care services at all levels of Primary Care services there will be a need to consider integrated education and training plans which bring together all these different frameworks into one overarching workforce development programme.

Chapter 6:
The Evidence and Implications for Future Education and Training Provision

6.1 Introduction

The evidence base exposed much about the nature of integrated services and problems encountered by different professional groups in their attempts to comply with the modernisation agenda. Whilst the review provides a comprehensive assessment of evidence, the conclusions may not be exhaustive. This is in part due to the fluid nature of integrated services and the diversity of the population, which limits any generalisation of the findings. The six key themes represent central concepts pivotal to the success of integrated care services. However, the demands of the changing population necessitate that geographical variables are considered. It is therefore recommended that these key themes be contextualised within individualised primary care settings. It is also important to note that although these six themes have been deemed essential requirements for the delivery of effective integrated health and social care, there is still the need to ensure that all the mandatory education and training is in place. Examples include equality and diversity, risk management and clinical governance.

The introduction of the *NHS Modern & Dependable report* (Department of Health 1997) meant that the NHS was committed to developing services which actively promoted collaboration. As a result, education and training were brought to the forefront of policy. Based on the modernisation agenda the strategy for life-long learning, *'Working together, learning together: a framework for lifelong learning for the NHS'* (Department of Health 2001a) aimed:

*"to promote improved patient care and services by building a competent workforce for the future through life-long learning". The framework relates specifically to the NHS Plan (Department of Health 2000b), through which it was claimed that a 'new and radical agenda for education and training' was promoted.* (Department of Health 2001a)

Other frameworks published since this have attempted to direct organizations and services to meet the needs of the Agenda. *A Health Service of All the Talents: Developing the NHS Workforce* (Department of Health 2000a) proposed that the workforce should be planned in collaboration with Health Action Zones (HAZ) and focus on the workforce needed to deliver the HAZ and subsequent HiMP agendas. Similar to other policies emerging out of the modernisation agenda, an emphasis was placed on team working across organisational boundaries.

6.2 Implications for Future Education and Training

Population relative evidence, together with the political insight and research base has been instrumental in the development of a Thematic Framework of Evidence for this project (Figure 2). Key themes located as a result of the review, indicated the need to incorporate internal and external forces when determining the education and training needs of the primary care workforce. The subsequent Thematic Framework of Evidence takes account of the importance and inter-connectedness of policy, practice, population and workforce needs within integrated health and social care services. Each aspect of the framework is seen as inter-dependant on the other.

Figure 2:
Thematic Framework of Evidence.
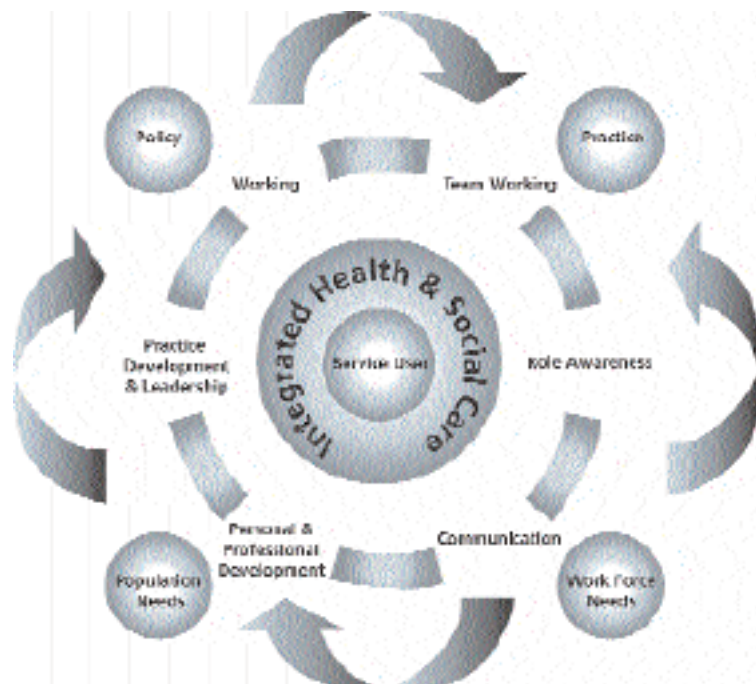
The six key areas have been demonstrated as having the potential to shape services or create barriers. Fundamental to the framework are the needs of the patient and the move to ensure that disparity between service provision is not experienced in the patients journey. Concerns raised about clients with multiple needs becoming susceptible to falling down the gap between services (Calloway, Morrissey, Topping and Fried 2001) have resulted in past Government attempts to close the divide between health and social care. However, the modernisation agenda (Department of Health 1997) brought changes that were thought to be too swift resulting in a plethora of practitioners struggling to adapt to the changing population and service needs (McDonald *et al* 1997, Hudson 2002, Stanley 1999).

The Labour Government's vision of 60% of patients being cared for in primary care (Department of Health 1997) was an innovative strategy aimed at reducing mortality and morbidity rates as well as promoting well being. In the publication *Our Healthier Nation,* (Department of Health 1998a) the Government targeted social exclusion and areas of deprivation with key areas such as mental health, coronary heart disease and cancers among the highest priorities. Changes in primary care population demographics ensued, leading to an increased number of dependant and multi-need patients.

The rapid change in population demographics resulted in practitioners feeling disenfranchised and under confident in dealing with a different client group (McDonald *et al* 1997). Staff are now faced with developing new ways of care management and service delivery to meet the needs of service re-design. However, contemporary literature suggests that

the political divide between health and social care still exist (Bywaters & McLeod 2001) which further emphasises the need to consider all of the key aspects included in the Thematic Framework of Evidence (see Figure 2). Situating the patient at the centre of service design and education and training initiatives as illustrated in the framework is imperative, and should encourage a proactive integrated service which may empower carers and service users with confidence and knowledge about the professionals involved in their care and the service philosophy.

Polarisation from the essential issues such as team working, practice and professional development could lead to fragmented, reactive and insular services. The six key areas highlighted in this review have been the focus of much debate and whilst these issues are not new, there has to date been no comprehensive review of the literature which takes account of all the issues within a collective evidence base.

At an operational level, workplaces have witnessed the introduction of healthy workplace initiatives and schools are being encouraged to promote healthier life styles to children through the *Healthy Schools initiative* (Department of Health 1999e). There are now diagnostic and treatment centres, an increased role in pharmacy and the *New Mental Health Bill* (Department of Health 2002f). All have the potential to integrate services effectively, but as borne out by authors such as Hudson (2002), the need to pay equal attention to implementation at both strategic and operational levels is of vital importance if integrated services are to succeed. The need to incorporate these skills in future education and training strategies suggests some urgency with regards

to revisiting seemingly common core skills, the importance of which appears to have disappeared beneath the veil of policy and change. Organisations now need to audit their workforce abilities in relation to the core skills and outline realistic goals to sustain integrated working at both operational and strategic levels.

Based on the Thematic Framework of Evidence, key issues for consideration by education and training providers for future workforce development have been drawn out. These are represented as evidence–based implications for both health and social care services and education.

6.2.1   Team working

Traditional teams within services have evolved as a result the modernisation agenda. Previously influenced by a non-sharing culture, the 'modern' team is now faced with closing existing gaps between services and developing teams which are responsive to the changing population and which are able to liase and work collaboratively across organisations and agencies. Historically, cultures which were heavily influenced by professional socialisation have led to a disparate service in which threat and competition were rife. Whilst the concept of the multi-disciplinary team is promoted within some education & training initiatives, the need to ensure that inter-agency work is also represented could present a challenge for some. The report, *Education and Training for Inter-agency working: New Standards* (Shardlow, Davis, Johnson, Long, Murphy and Race 2004), specifically aimed at inter-agency working in relation to children, is one such initiative. This offers a model for other groups of health and social care service users.

The development of new services and

changes in primary care demographics has led to increased variation between team function. This variation in team process and function has been singled out in the literature as being a key barrier to successful integration and team working. However, there is no standard team led service which could be generalised to the wider audience. Instead, there exists a range of generic concepts and theories related to team working and team function which need to be incorporated into future team work planning.

As teams expanded, many observed a negative impact on team dynamics leading to ineffective team working and reduced integration. Millward & Purvis's (1998) example of the Team Survey Tool highlighted how cognition affects team work, similarly, Freeman *et al's* (2000) three philosophies, demonstrated how individual attributes could shape how teams worked. Effective team work is related to job satisfaction (West & Poulton 1997), improved health delivery (Wood, Farrow & Elliott 1994) and staff motivation. To develop an effective team requires that the team needs to be aware of its own team members roles and individual team members need to appreciate and understand other people roles within the team.

Attention should be afforded to individual team attributes, team awareness and the impact individual philosophies when introducing team work into future education planning.

Organisations have been aware of the benefits of effective team working on service delivery for about 80 years (West & Poulton 1997), yet a large number of publications which make reference to ineffective team working is still evident today. The existence of such evidence would seem to suggest that some organisations may have become complacent about the

importance of team working and its effects on inter-agency and inter-professional working. A void between service planning and service provision has left a plethora of diverse roles which have created a vacuum in team working. This may be partly due to poor communication between professionals and agencies and partly as a result of limited understanding of new roles within the context of new or existing services.

6.2.1.1 *Implications for education and training to promote team working*

■ Develop teams, with the appropriate skills and knowledge, that are able to liaise and work collaboratively across organisations and agencies

■ Ensure that any team has the required awareness of all team member role functions and professional background as appropriate

■ Education and training programmes need to take cognisance of team working in integrated health and social care services, and not simply working in a team

■ Education and training for team working needs to be planned to take account of both inter-professional working and inter-agency working

■ Service planning and service provision need to take account of the education and training required for a whole team when creating new roles

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

■ Co-location of teams needs to take account education and training for new ways of working

6.2.2 Communication

Communication is a major indicator of whether team processes have been successful. Communication involves the exchange of information and is reliant upon individual interactions. Power, professional attitude and beliefs are communicated through a variety of media and structures. As witnessed by Freeman *et al* (2000) individual philosophies shaped by discourse can influence the success of a team. Communication plays a pivotal role in the success of a team and as such, the need for all practitioners to develop good communication skills is crucial. Heavily influenced by beliefs, the individual practitioner can make a great difference to how the team functions. However, research undertaken by West & Poulton (1997) indicates that less than one in four healthcare teams do not use communication to benefit and enhance teamwork. An array of literature has illustrated problems when communication has been poor and where fragmented services have occurred as a result.

Information can be exchanged formally or informally (Loxley 1997). The way in which information is communicated and the effectiveness of the communication is dependant upon the media used and the individuals involved. Referrals to other agencies have been considered to be problematic and are thought to be partially responsible for the breakdown in communication and care delivery. The jargon which professional groups are familiar with often confuse the 'unfamiliar'. The use of language between professional groups is highlighted as a potential barrier to effective team work. Terminology used between professional groups should be free of jargon and easy to understand. Appropriate referral to other agencies

is instrumental in relation to the success of integrated services. The need to communicate at a level and pace that is acceptable for all involved in the service is paramount.

Whilst some courses offer an insight into communication, there needs to be a greater emphasis placed on the central role of communication in relation to team working, role awareness and the success of a seamless service. With the advent of information technology as a main communication strategy and the development of patient electronic records, there is a pressing need to develop workforce skills to meet the needs of the changing communication systems.

Collaboration at the interface now involves information sharing through written or electronic mode. Information Technology (IT) and the use of electronic resources has witnessed a sharp increase over the past decade. Well designed infrastructures to support the development of staff with IT training and access to information has been envisaged for all organisations. However, evidence has also illustrated the need for skill development in basic IT, use of the internet and searching (Alpay & Russell 2002). In response, many organisations have already developed training initiatives to help practitioners develop IT skills. As part of this, providers need to consider re-auditing education and training strategies for evidence of communication as a core skill inclusion.

6.2.2.1   *Implications for Education & Training to promote Communication*

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

inter-professional and inter-agency boundaries

■ Pre-registration/access to health work programmes need to ensure that effective communication skills, including use of technology, for integrated working are core skills

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

■ Ensure service users of integrated services are integral to developing communication networks and language

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

6.2.3   Role awareness

Historically, constant changes in health and social care systems, has resulted in an increased demand on professional groups who have had to come to terms with re-defined role boundaries (Biggs 1993). Whilst the definition of collaboration remains elusive, the notion of skills and competencies needed to deliver integrated services has received much attention. The NHS Knowledge and Skills Framework (Department of Health 2003d), National Occupational Standards (Skills for Health 2003) and publication of the NatPaCT Competency framework (NHS Modernisation Agency 2004) and National Occupational Standards for Social Work (Topss UK Partnership 2002) highlighted skills needed to deliver integrated services at operational and strategic levels. Whilst these documents have commented on the importance of team working and effective communication, the significance of role awareness has received limited attention. This is in stark contrast to

the evidence appraised which repeatedly echoed concerns about role ambiguity.

A tradition of 'turf wars' and 'professional tribalism' have been proclaimed as cultures which now exist within both health and social care as a result. Ministerial attempts to dissolve the gap between health and social care have to some extent removed some of the old boundaries by encouraging cross fertilisation of roles between organisations and agencies. The move from competition to co-operation was a substantive step in the right direction. However, many have argued that the over abundance and swift effects of the modernisation agenda have left many practitioners feeling threatened and more confused.

Contemporary health and social care has witnessed the evolution of a variety of new roles and services. Without full deliberation regarding the transparency of these new roles, many may experience reluctance from others to accept them into organisations. This is mainly due to the threat perceived by professionals caused by misunderstanding about role objectives and their position within new services. This should be highlighted as a main concern for all managers who are involved with the development of integrated services in primary care.

A large percentage of the evidence, which attempted to pursue team working and evaluate collaborative services, has instead discovered an absence of clear role definitions. Shared training was recommended in 1996 as a method which could contribute to the awareness and understanding of others (Barr 1996). Breaking down negative stereotypes and role confusion could be reduced through developing the practitioners experience with collaborative working

and encouraging familiarity. All these strategies could be realised through the promotion of role awareness and life long learning (Sainsbury Centre for Mental Health 1997).

6.2.3.1 Implications for Education & Training to promote Role Awareness

■ Role awareness should become an essential element of all programmes relating to preparing the workforce to deliver integrated health and social care

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

■ Shared learning initiatives between health and social care workforce students in practice should be encouraged to develop awareness and understanding of team roles

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

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

6.2.4 Practice Development and Leadership

'Modernising Health and Social Services Developing the Workforce' (Department of Health 1999b) advocated the need for staff to be "supported through the process of building systems of integrated care" which would invariably involve effective leadership. Similarly, *'Liberating the Talents, Developing the Workforce'* (Department of Health 2002a) envisaged a workforce that was responsive to change and which

could also ensure that all patients receive the right care in the right place. Once trained in inter-professional skills, the workforce will be better equipped to empower the patient and deliver patient-centred care. It suggested that greater skills mix and leadership opportunities should be provided to accomplish such tasks. The message of change through education and training is strongly advocated for primary care to ensure that patients and communities benefit from NHS reforms and extra investment. Leadership and management are therefore deemed to be pre-requisite skills needed for practice development for the successful integration of services.

Leadership skills are re-enforced through out policy agenda, and are central to the successful implementation of integrated services. The need for clear service development objectives are re-iterated throughout the NatPaCT Competency framework, NHS Knowledge and Skills framework and the National Occupational Standards for Health and Social Work. All the frameworks emphasise the requirement for practice development to be encouraged through both organisational and operational strategies. With any 'shared vision', clear links to the stated objectives of individuals, teams and services need to be made transparent.

This has generated an impetus for organisations and individuals to encompass the notion of practice development and leadership to facilitate the successful delivery of new services. Individuals should be empowered through education and training provided by both Higher Education and health and social care organisations to take on leadership posts and develop new practices and roles.

However, as Freeman *et al* (2000) illustrated despite policy and strategic direction "working collaboratively may not be readily achieved". Policy rhetoric needs to be transparent (Slater 2002) and rapid changes in service made through policy need time to develop. Clear lines of responsibility and accountability coupled with a transparent account of service requirements, led by practitioners who are enthusiastic and willing to collaborate with others is essential. Good leadership skills are therefore a necessary requirement if professionals are to work together in the development of integrated services. This was clearly evident in the case of Victoria Climbié (Department of Health 2003c). Recommendations made by Lord Lamin totalled 128, in which a clear emphasis was placed on the need for clear lines of managerial responsibility, accurate documentation, effective communication and above all, effective leadership.

The literature has revealed that many organisations have grappled with new policy initiatives in isolation from each other. Accusations levelled at policy included amongst others, the terminology used and lack of transparency with policy documents. Nuances within policy have previously been tirelessly unpacked by managers in an attempt to comply with new directions and ways of working. Encouraging local groups to work together through leadership to instil confidence in the implementation process and assist partnership working between organisations would be beneficial and could help to demystify policy terminology.

6.2.4.1 Implication for Education & Training to promote Practice Development and Leadership

■ Leaders need to be identified and

educated to lead integrated health and social care services

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

■ Leadership education and training for integrated health and social care services needs to be built into educational programmes for all professions

■ Practice development in integrated health and social care requires collaboration between education and training organisations and departments to ensure skills and knowledge base meets requirements for service and user outcomes

6.2.5 Personal & Professional Development

Attributes of the individual needed to deliver integrated services are highlighted within the NHS Knowledge and Skills Framework, NatPaCT Competency Framework and National Occupational Standards for Health and Social Work. Whilst social care is not alluded to in the NHS Knowledge and Skills Framework nor the NatPaCT framework, personal and professional development is a generic skill, viewed as important by all professional groups. This is evidenced through the inclusion of personal and professional development within the National Occupational Standards for Social Work where personal and professional development planning is regarded as one method of facilitating integration within primary care.

Supportive environments which foster healthier attitudes to personal and professional development should encourage practitioners to identify their own strengths, limitations and

learning needs in relation to integrated care provision. To facilitate this, practitioners' need to be supported and encouraged to reflect on their skills in relation to team working, communication and role awareness. Through supervised personal and professional development, those staff with an elective philosophy as illustrated by Freeman *et al* (2000) could be identified at an early stage and supported to help develop an awareness of the team and roles. Speculation about the *'Agenda for Change – Modernising the NHS Pay System'* (Department of Health 1999f) has fostered a belief that personal and professional development will receive additional attention as staff attempt to clarify their roles and responsibilities. Future staff development will need to take account of the *'Agenda for Change'* which will relate competencies, experience, education and skills to pay progression. This may encourage practitioners to give greater precedence to the importance of personal and professional development and subsequently provide an opportunity for integrated care to be considered in context with the practitioners personal and professional development needs.

6.2.5.1 *Implications for Education & Training to promote Personal & Professional Development*

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

■ Supportive environments need to exist to enable personal and professional development in integrated working

■ Flexible learning opportunities need to exist to enable the workforce to be able to access inter-professional/inter-agency working programmes

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

■ Personal and professional development education and training programmes need to include essential competencies in team working, role understanding and effective communication as well as leadership development for working in integrated health and social care

6.2.6 Partnership Working

If collaboration is to be successful, all parties involved in delivering integrated services must demonstrate a commitment to each other and service users, and foster openness, honesty and accountability. Divisions between health and social care are not uncommon and have resulted in defensive, insular practices, which expose service users to 'service gaps'. Yet, in almost all examples in the literature, social care has been perceived as an 'add on' or 'extra' to service provision. The work of Bywaters & McLeod (2001) clearly illuminated this concern when they discussed Labours *'Third Way'*, the non-reciprocal arrangements noted between the NHS and social care and the marginalisation of the social care workforce as a consequence. Unresolved conflict between professional groups is well documented and litters contemporary literature. The *'cloak of professionalism'* referred to by Davis (1998) for example, promotes insular practice and re-enforces professional hierarchies. As a result, organisational

paradigms exist which are dominated by a singular professional group, or directed by the organisation rather than the populations needs. Ideological divisions between health and social care may be arbitrary and influenced by monetary roots, but they still exert a heavy influence at both strategic and operational levels.

Robust systems with clear lines of accountability, openness, ownership and an awareness of the organisations own strengths and weaknesses are reported to be beneficial for the organisation partnership planning (Farmakopoulou 2002). The need to assess organisations' abilities has to some extent been addressed by the development of a variety of partnership assessment tools. An example which helps organisations take an emic (insider) perspective was Hardy *et al's* (2000) Partnership Assessment Tool which outlined methods to promote and support harmonious partnership working.

The value of partnership tools have also been recognised by the NatPaCT Competency Framework, which recommended the Verona Benchmark (Health Development Agency 2003) as one tool which could ease the process of partnership working within and between organisations. However, whilst partnership working is viewed generally as a strategic directive, skills needed to operationalise a successful partnership are reliant on team working, communication and role awareness.

It has been suggested that essential attributes of a partnership is the organisations ability to assess its own strengths in terms of partnership working (Hudson 2002). Historically, the notion of co-operation was dissolved by the Conservative Government and replaced with competition. The resultant internal

market laid a path towards entrepreneurialism within organisations, and an unwillingness to share. An awareness of the successful attributes needed to collaborate now needs to be emphasised at both strategic and operational level. Empowering the workforce to develop trusting relationships which offer equality to all partner agencies involved, and one which is transparent and open from the outset, is seen as important step towards removing previous politically driven constraints and promoting a sharing philosophy.

6.2.6.1 *Implications for Education & Training to promote partnership working*

■ Partnership and collaboration between health and social care should be essential in the development of curricula for integrated health and social care working

■ Education and training standards from professional bodies should include core requirements for partnership working to deliver integrated health and social care

■ Education and training providers (HE/FE) need to consider including compulsory elements for integrated working , taking account of team working, effective communication and role awareness as essential elements of the programme

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

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

6.3 Implications for the User/Carer Perspective

User involvement and carer participation in the promotion of successful inter-professional collaboration is seen as being fundamental to the care process (Biggs 1993). The success of service user participation is dependant upon the organisational culture and climate which includes the need for users and professionals to be confident that their opinions will be heard and valued and where objective may be mutually agreed. Population and demographic changes should be taken account of when planning new services. The skills of practitioners within those areas are directed by the needs of the population rather than the organisation. Calloway *et al's* (2001) work illustrated the impact of services re-design and change in population demographics on the clients and staff involved in the care and highlighted the need to ensure that communities are more responsive to the multi-need client. Calloway *et al* (2001) recommended that cross-training and agreements on treatment ideologies could provide more effective integrated services.

The need for inter-professional education has echoed throughout the literature. Consequently, a strong theme supporting inter-professional education emerged, which encourages the use of mixed teaching and learning strategies to prepare the work force to work inter-professionally.

6.4 Conclusion

Ironically, whilst the project was dependant on collaboration and good partnership working, similar designs influenced by the political agenda reflected a polarised perspective of

collaborative working. Whilst collaboration was recognised as an essential component to ensure the success of the project, the concept of collaboration within health and social care has been fraught with difficulties often resulting in partnership working which has been one-sided and driven by ambiguity.

The Labour Government has introduced significant policies and reports concerning new ways of working, and the integration of previously disparate services has attempted to provide a whole systems approach to health and social care. The resultant formation of primary care trusts requires effective inter-professional and inter-agency working supported by education and training which will empower the workforce to meet the demands of future population health and social care needs.

However, it could be argued that the 'newness' of Primary Care Trusts has influenced limited service evaluation, as time needed to undertake research, has been subsumed by resources and events needed to implement new services.

Whilst many have explored problems associated with integrated health and social care, none to date have provided a sound evaluation of an integrated service which would offer any analytical perspective of an effective service. This lack of thorough investigation could result in the development of services which will not be able to base themselves on previously evaluated examples of 'best practice'.

Appendix 1:
Checklist to assess whether to review papers

Review if the answers to <u>all</u> of the following six criteria is yes.

	Yes – Include	No – Exclude
➤ primary care trusts or PCG or community		
➤ Published between 1 January 1997 to present day		
➤ Education and training *(user/service/professional perspectives)*	–	–
o 'Identification of an education and training need' or 'evaluation of education and training provision' or 'evaluation of an integrated health and social care service'		
➤ Predominantly primary care services and/or Integrated Health and Social Care		
➤ Primary research studies, review or policy document		
➤ Describes/evaluates a current service, model of service and/or training/ teamwork with evaluated models.		

Exclude from review at this stage if the answers to <u>any</u> of the following questions is yes.

If no, place in box for possible review at a later date.

	Yes – Exclude
➤ Acute sector *(either purely tertiary sector or not across organisational/sectoral boundaries)*	
➤ Studies from other cultural settings where 1) the client group, 2) the nature of the intervention, and 3) the policy implications, are judged to be substantively different from those in the UK	
➤ Non-English language references	
➤ Nature of reference *(book review, commentary, editorials, letters, thesis, conference report, conference paper or abstract)*	
➤ Uni-professional	
➤ Purely 'health' focused	
➤ Evaluations of specific training methods	

Appendix 2:
Finalised Inclusion and Exclusion Criteria

Inclusion Criteria

➤ Primary Care Trusts (Teaching)

➤ Published literature between 1 January 1997 and present

➤ Workforce

    o Professionally qualified

    o Unqualified nursing staff e.g. health care support workers

    o Unprofessional qualified social care

➤ Education and training

    o Identification *of need in terms of competencies and skills*

        • *Communication skills, team working, role awareness, shared goals, mutual support, trust etc.*

➤ Evaluation of provision

➤ Primary care services

    o *Modernisation Agency, SureStart, Health Improvement Plans (HimPs), Health Action Zones (HAZs) etc.*

➤ Primary research studies

➤ Reviews

    o *Literature or systematic reviews where explicit search strategies have been provided and if the majority of studies included in the review meet the inclusion/exclusion criteria for this review*

➤ Policy documents

➤ Studies included in the following databases: Caredata, CINAHL, Cochrane Library, MEDLINE, Sociofile

Exclusion Criteria

➤ Acute sector

    o *Where care is provided purely in the tertiary sector, not across organisational/sectorial boundaries)*

➤ Studies from other cultural settings where 1) the client group, 2) the nature of the intervention, and 3) the policy implications, are judged to be substantively different from those in the UK *e.g. Canadian, American or Australian health care systems which are financed and provided in a very different way from UK e.g. care received dependent on insurance package)*

➤ Non-English language references

➤ Nature of reference: documents which are a book review, commentary, editorials, letters, thesis, conference report, conference paper or abstract

➤ Uni-professional

➤ Evaluations of specific training methods

Appendix 3:
Search Strategies

Caredata Search Strategies Dates

Title: primary & care & trust*

Keyword: education

Title: primary & care & trust*

Keyword: training

Keyword: training

Abstract: primary & care & trust*

Keyword: education

Abstract: primary & care & trust*

Keyword: primary care trust*

Abstract: education

Keyword: primary care trust*

Abstract: training

Keyword: interagency cooperation

Abstract: training

Keyword: interagency cooperation

Title: training

Keyword: interagency cooperation

Title: education

Keyword: interagency cooperation

Abstract: education

CINAHL Search Strategy 1982-2003

> *Key:*
> / = indexing term0
> $ = truncation symbol
> mp = term appears in either the title, abstract or indexing term
> exp = explode

1. Family Practice/
2. general practi$.mp.
3. Office Nursing/
4. practice nurs$.mp.
5. exp Community Health Nursing/
6. district nurs$.mp.
7. health visit$.mp.
8. community mental health nurs$.mp.
9. community learning disabilit$ nurs$.mp.
10. consultant nurs$.mp.
11. exp Midwives/
12. midwi$.mp.
13. Psychologists/
14. psychologist$.mp.
15. Physical Therapists
16. physical therapist$.mp.
17. physiotherapisttherapist$.mp.
18. Occupational Therapists/
19. occupational therapist$.mp.
20. Continence Advisors/
21. continence advisor$.mp.
22. continence nurs$.mp.
23. Social Workers/
24. social worker$.mp.
25. School Health Nursing/
26. school nurs$.mp.
27. exp Counselors/
28. counsel$.mp.
29. Pharmacists/
30. pharmacist$.mp.
31. community development worker$.mp.
32. citizens advice bureau$.mp.
33. exp Research Personnel/
34. researcher$.mp.
35. lecturer practitioner$.mp.
36. health service manage$.mp.
37. social services manage$.mp.
38. Social Workers/
39. social worker$.mp.
40. housing workers.mp.
41. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40
42. exp Education/
43. education.mp.
44. training.mp.
45. 42 or 43 or 44
46. Health Care Delivery, Integrated/
47. Interprofessional Relations/
48. (Integrated Health and Social Care).mp.
49. 46 or 47 or 48
50. 41 and 45 and 49

ERIC Search Strategy
1992-2003

> *Key:*
> kw = keyword
> ab = abstract
> + = truncation symbol

1. kw: family-practice

2. kw: family-physician

3. kw: family-practitioners

4. ab: general AND ab: practice

5. ab: general AND ab: practitioner

6. ab: general AND ab: practitioners

7. ab: practice AND ab: nurse+

8. ab: district AND ab: nurs+

9. ab: health AND ab: visit+

10. ab: community AND ab: mental AND ab: health AND ab: nurs+

11. ab: advanced AND ab: nurs+

12. kw: midwife

13. kw: midwifery

14. kw: midwifes

15. kw: midwifing

16. ab: midwif+

17. kw: psychologist

18. ab: psychologist+

19. kw: physiotherapisttherapist

20. kw: physiotherapisttherapists

21. kw: physiotherapisttherapy

22. ab: physiotherapisttherapist+

23. kw: occupational-therapy

24. ab: occupational AND ab: therapist+

25. ab: continence AND ab: nurs+

26. kw: social-work

27. kw: social-worker

28. ab: social AND ab: worker+

29. kw: school-nursing

30. ab: school AND ab: nurse+

31. kw: counselinq

32. kw: counselling

33. kw: counsellor

34. kw: counsellor-coach

35. kw: counsellor-consultant

36. kw: counsellor-student

37. kw: counsellor-trainees

38. kw: counsellor-worker

39. kw: counsellors

40. kw: counsellors-in-training

41. ab: counsel+

42. kw: pharmacists

43. ab: pharmacist+

44. kw: community-development

45. ab: community AND ab: development AND ab: worker

46. ab: community AND ab: development AND ab: worker+

47. ab: citizens AND ab: advice AND ab: bureau+

48. kw: researchers

49. kw: lecturer-practitioner

50. ab: lecturer AND ab: practitioner+

51. ab: health AND ab: service AND ab: administration

52. ab: health AND ab: service AND ab: manage+

53. ab: social AND ab: service+ AND ab: manage+

54. ab: support AND ab: worker+

55. ab: housing AND ab: worker+

56. kw: family-practice or kw: family-physician or kw: family-practitioners or (ab: general AND ab: practice) or (ab: general AND ab: practitioner) or (ab: general AND ab: practitioners) or (ab: practice AND ab: nurse+) or (ab: district AND ab: nurs+) or (ab: health AND ab: visit+) or (ab: community AND ab: mental

AND ab: health AND ab: nurs+) or (ab: advanced AND ab: nurs+) or kw: midwife or kw: midwifery or kw: midwifes or kw: midwifing or ab: midwif+ or kw: psychologist or ab: psychologist+ or kw: physiotherapisttherapist or kw: physiotherapisttherapists or kw: physiotherapisttherapy or ab: physiotherapisttherapist+ or kw: occupational-therapy or (ab: occupational AND ab: therapist+) or (ab: continence AND ab: nurs+) or kw: social-work or kw: social-worker or (ab: social AND ab: worker+) or kw: school-nursing or (ab: school AND ab: nurse+) or kw: counselinq or kw: counselling or kw: counsellor or kw: counsellor-coach or kw: counsellor-consultant or kw: counsellor-student or kw: counsellor-trainees or kw: counsellor-worker or kw: counsellors or kw: counsellors-in-training or ab: counsel+ or kw: pharmacists or ab: pharmacist+ or kw: community-development or (ab: community AND ab: development AND ab: worker) or (ab: community AND ab: development AND ab: worker+) or (ab: citizens AND ab: advice AND ab: bureau+) or kw: researchers or kw: lecturer-practitioner or (ab: lecturer AND ab: practitioner+) or (ab: health AND ab: service AND ab: administration) or (ab: health AND ab: service AND ab: manage+) or (ab: social AND ab: service+ AND ab: manage+) or (ab: support AND ab: worker+) or (ab: housing AND ab: worker+)

57. ab: integrated AND ab: health AND ab: social AND ab: care

58. ab: primary AND ab: care AND ab: trust+

59. ab: PRIMARY CARE TRUSTS+

60. ab: PCG+

61. ab: primary AND ab: care AND ab: group+

62. (ab: integrated AND ab: health AND ab: social AND ab: care) or (ab: primary AND ab: care AND ab: trust+) or ab: PRIMARY CARE TRUSTS+ or ab: PCG+ or (ab: primary AND ab: care AND ab: group+)

63. kw: education

64. ab: education

65. kw: inservice-training

66. ab: in-service AND ab: training

67. ab: inservice AND ab: training

68. ab: training

69. kw: training

70. kw: education or ab: education or kw: inservice-training or (ab: in-service AND ab: training) or (ab: inservice AND ab: training) or ab: training or kw: training

71. kw: family-practice or kw: family-physician or kw: family-practitioners or (ab: general AND ab: practice) or (ab: general AND ab: practitioner) or (ab: general AND ab: practitioners) or (ab: practice AND ab: nurse+) or (ab: district AND ab: nurs+) or (ab: health AND ab: visit+) or (ab: community AND ab: mental AND ab: health AND ab: nurs+) or (ab: advanced AND ab: nurs+) or kw: midwife or kw: midwifery or kw: midwifes or kw: midwifing or ab: midwif+ or kw: psychologist or ab: psychologist+ or kw: physiotherapisttherapist or kw: physiotherapisttherapists or kw: physiotherapisttherapy or ab: physiotherapisttherapist+ or kw: occupational-therapy or (ab: occupational AND ab: therapist+) or (ab: continence AND ab: nurs+) or kw: social-work or kw: social-worker or (ab: social AND ab: worker+) or kw: school-nursing or (ab: school AND ab: nurse+) or kw: counselinq or kw: counselling or kw: counsellor or kw: counsellor-coach or kw: counsellor-consultant or kw: counsellor-student or kw: counsellor-trainees or kw: counsellor-worker or kw: counsellors or kw: counsellors-in-training or ab: counsel+ or kw: pharmacists or ab: pharmacist+ or kw: community-development or (ab: community AND ab: development AND ab: worker) or (ab: community AND ab: development AND ab: worker+) or (ab: citizens AND ab: advice AND ab: bureau+) or kw: researchers or kw: lecturer-practitioner or (ab: lecturer AND ab: practitioner+) or (ab: health AND ab: service AND ab: administration) or (ab: health AND ab: service AND ab: manage+) or (ab: social AND ab: service+ AND ab: manage+) or (ab: support AND ab: worker+) or (ab: housing AND ab: worker+)) and ((ab: integrated AND ab: health AND ab: social AND ab: care) or (ab: primary AND ab: care AND ab: trust+) or ab: PRIMARY CARE TRUSTS+ or ab: PCG+ or (ab: primary AND ab: care AND ab: group+)) and (kw: education or ab: education or kw: inservice-training or (ab: in-service AND ab: training) or (ab: inservice AND ab: training) or ab: training or kw: training)

Medline Search Strategy 1966-2003

> *Key:*
> Exp = explode
> / = indexing term
> mp = **term appears in either the title, abstract or indexing term**
> $ = truncation symbol

1. exp Education/
2. INSERVICE TRAINING/
3. education.mp.
4. training.mp.
5. 1 or 2 or 3 or 4
6. Delivery of Health Care, Integrated/
7. (Integrated Health and Social Care).mp.
8. primary care trust$.mp.
9. PRIMARY CARE TRUSTS$.mp.
10. primary care group$.mp.
11. PCG$.mp.
12. 6 or 7 or 8 or 9 or 10 or 11
13. Family Practice/
14. family practitioner$.mp.
15. family physician$.mp.
16. general practitioner$.mp.
17. general physician$.mp.
18. exp NURSES/
19. Community Health Nursing/
20. community health nurse$.mp.
21. health visitor$.mp.
22. visiting nurse$.mp.
23. district nurse$.mp.
24. community mental health nurse$.mp.
25. community learning disabilit$ nurse$.mp.
26. nursing personnel.mp.

27. Nurse Clinicians/
28. clinical nurse specialist$.mp.
29. Nurse Midwives/
30. nurs$ midwife.mp.
31. nurs$ midwive$.mp.
32. nurse practitioner$.mp.
33. consultant nurse$.mp.
34. practice nurse$.mp.
35. Public Health Nursing/
36. public health nurse$.mp.
37. Family Nursing/
38. exp nursing staff/
39. exp allied health personnel/
40. Midwifery/
41. midwife.mp.
42. midwives.mp.
43. "Physical Therapy (Specialty)"/
44. physical therapist$.mp.
45. physiotherapisttherapist$.mp.
46. Occupational Therapy/
47. occupational therapist$.mp.
48. exp social work/
49. social worker$.mp.
50. School Nursing/
51. school nurse$.mp.
52. PHARMACISTS/
53. pharmacist$.mp.
54. Pharmacists' Aides/
55. PSYCHOLOGY/
56. psychologist$.mp.
57. Counseling/
58. counsellor$.mp.
59. counselor$.mp.
60. counseller$.mp.
61. Research Personnel/
62. lecturer practitioner$.mp.
63. continence advisor$.mp.
64. continence adviser$.mp.

65. continence nurse$.mp.
66. community development worker$.mp.
67. health service$ manager$.mp.
68. social service$ manager$.mp.
69. housing worker$.mp.
70. citizens advice bureau$.mp.
71. assistant practitioner$.mp.
72. support worker$.mp.
73. nurs$ auxiliar$.mp.
74. health care assistant$.mp.
75. healthcare assistant$.mp.
76. Psychiatry/
77. psychiatrist$.mp.
78. Nurse Practitioners/
79. nurse practitioner$.mp.
80. workforce.mp.
81. workforce$.mp.
82. work force$.mp.
83. 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82
84. 5 and 12 and 83

Sociological Abstracts Search Strategy

Dates

Key

Search strategy 'lost' due to network failure

Appendix 4:
Policy Framework Mapping Tables
(see Chapter 5)

Mapping of six key review themes for education and training to deliver integrated health and social care within four skills, knowledge and competency frameworks

NatPaCT PCT Competency Framework (in 9 sections) (NHS Modernisation Agency, 2004)	NHS Knowledge & Skills Framework (6 core dimensions and 16 specific dimensions) (Department of Health, 2003d)	The National Occupational Standards for Social Work (Topss UK Partnership, 2002)
IHSC sections (5 selected).	**Core Competencies (4 selected)**	**Key Role 1: Prepare for, and work with individuals, families, carers, groups and communities to assess their needs and circumstances.**

IHSC sections (5 selected).

1: Organisational Maturity
2: Primary Care
5: Partnership
9: Workforce
AHP self assessment

1: Organisational Maturity

1.4: Clear clinical leadership

1.4.2.2 *There are clear communication channels in place, which include and engage all professional staff.*

1.4.3 *Professional development arrangements are in place and agreed.*

1.4.4 *Clinicians actively engage in the planning and review process for PCT*

1.4.4.2 *Multidisciplinary development activities are undertaken.*

1.5: Shared vision

1.5.2 *The vision and values are translated into the objectives of individuals, teams and services.*

1.5.2.1 *There are clear links to the vision in the stated objectives of individuals, teams and services.*

1.9: Shared and active partners

1.9.1 *Patients, service users and carers are involved in defining how their individual services and treatment are delivered.*

1.13: Team development

1.13.2 *There is a definition of roles, responsibilities and relationships within each staff team and between*

Core Competencies (4 selected)

Communication (Level 1&2 refer to NOS) **(level 4)** Establish and maintain communication with various individuals and groups on complex potentially stressful topics in a range of situations.

A] Identifies potential communication difficulties

A] Identifies relevant contextual factors

B] Communicates with people in a manner

C] Recognises and reflects on barriers to effective communication and improves communication

D] Uses a range of skills to improve communication between everyone involved.

NB: This includes supporting the development of teams across traditional boundaries)

Personal & People Development (Level 5 refers to UKCC standards). **(level 5)** Develop own and others knowledge and practice across professional and organisational boundaries.

A] Evaluates the currency and sufficiency of his/her own knowledge and practice, develops PDP, generates and uses appropriate learning opportunities and applies own learning to the future development of work

---

Key Role 1: Prepare for, and work with individuals, families, carers, groups and communities to assess their needs and circumstances.

Unit 1: prepare for social work contact and involvement.

1.2 Element: liase with others to access additional information that can inform initial contact and involvement
 Performance criteria
 C: Follow legal and organisational practice for: confidentiality and sharing information when you contact and liase with individuals and organisations who are providing information.

Key Role 2: Plan, carry out, review and evaluate social work practice, with individuals, families, carers, groups, communities and other professionals.

Unit 4: Respond to crisis situation:

4.4 Element: Review the outcomes with families, carers, groups, communities, organisations, professionals and others.
 Performance criteria:
 A) Collect, analyse, collate and evaluate feedback on actions from all relevant people and organisations.
 E) Record and use review outcomes to inform: the work of your team and organisation; the work of other teams and organisations.

Unit 7: Support the development of networks to meet assessed needs and planned outcomes.

the staff teams that make up the PCT.

1.13.2.1 *Roles and responsibilities are outlined in job descriptions, it is important that team members have access to the other job descriptions within the team, so that overlaps and adjoining responsibilities are understood.*

1.13.2.3 *A wide definition of 'team' is used when developing strategies.*

1.13.4 *Each team within the PCT is encouraged to undertake teambuilding activities, to improve team performance and facilitate interaction.*

1.13.4.1 *Activities include regular team meetings, (that include as part of the agenda internal working arrangements, training and development needs). Away days, workshops on particular issues affecting the team.*

1.13.4.2 *Where teams are made up of staff from more than one organisation all the team members are involved in team building activities.*

1.13.4.3 *There is a mechanism whereby teams can share developments.*

1.13.4.5 *There are effective systems to facilitate team communication and clear decision making processes.*

2: Primary Care

2.5:Practice management

2.5.4.2 *Information on job evaluation and skills and knowledge framework is made available to practices.*

2.12: Education & training & CPD – no mention of training with other professions or teambuilding.

2.16: Demand target management – targets at least 1 collaborative action – but doesn't explain this.

2.16.2.3 *The PCT has a development group for integrated care pathways that includes PHCT members.*

C] *Works with others to develop, identify and implement learning opportunities within and outside the workplace appropriate for peoples learning needs.*

F] *Supports the development of a learning and development culture which encourages everyone to learn from each other and from external good practice.*

NB *This includes supporting the development of teams across traditional boundaries.*

Service development (includes reference to multi-professional working, services may be offered as multi-professional services). **(Level 5)** Develop strategies and policies for service improvement

B] *Discusses and debates with relevant people.*

C] *Agrees with relevant people*

NB: *this includes multi-professional services, a number of agencies, other agencies involved in service delivery, national targets (NSF) and knowledge and skills shortfalls to meet changing service requirements.*

Quality (Level 2 makes reference to National Occupational Standards) Maintaining and improving quality in all areas of work and practice.

(Level 2) D] Alerts the team to developments in quality and recommends how own and others work should change as a result.

(Level 3) D] Evaluates the quality of own and others work and make necessary improvements – this includes poor team practice.

(Level 4) A] *Acts as a role model in quality improvement offering advice and support to others who need it*

C] *Enables others to (others include those from other agencies)*

7.1 Element: Examine with individuals, families, carers, groups, communities and others, support networks which can be accessed and developed.
  Performance criteria:
  A) Identify and collate information on: possible networks that could be accessed locally, regionally and nationally that will enable networks to be developed to meet assessed needs and planned outcomes.

7.2 Element: Work with individuals, families, carers, groups, communities and other to initiate and sustain support networks.
  Performance criteria:
  C) Discuss and agree the ways in which you, your organisation and other organisations can initiate and sustain support networks, including support for: the leadership of the network; to promote the involvement of members
  D) Ensure agreements are kept or re-negotiated.

Key Role 5: Manage and be accountable with supervision and support, for your own social work practice within your organisation.

Unit 16: Manage, present and share records and reports.

16.4 Element: Share records with individuals, families, carers, groups, communities and others
  Performance criteria:
  A) Identify: legal and organisational requirements for sharing information, including the need to maintain privacy, confidentiality and security of information. The criteria for sharing information including: how the information will be accessed and shared; the frequency with which the information will be shared
  B) Share records with individuals, families, carers, groups, communities and professional colleagues according to legal and organisational requirements and the criteria set.

2.16.4 *The PCT has engaged with various national collaborative and 'action on' initiatives.*

2.16.4.1 *At least one collaborative or 'action on' initiative is being undertaken.*

5: Partnership (is 'health focussed)

5.1: Joint development – no specific reference to social care. The term 'agencies is frequently used.

5.2: Joint planning – the first time that social care is mention.

5.2.1.3 –*There is evidence of improved use of resources to meet joint objectives for health and social care.*

5.2.1.4 – *There is evidence of reduced social exclusion.*

5.3: Joint working – promotes the 'Verona Benchmark' as a partnership assessment tool.

5.3.4. *The PCT has an established framework to develop integrated care pathways on a multi-agency basis.*

5.4: Shared service arrangements

5.4.4. *Structures and systems are in place to encourage effective team working across organisations.*

5.6: Integrated service provision

5.7: Partnerships with LA's

5.8: Local strategic plans

5.8.4 *The PCT works with communities and groups to develop and deliver local plans for neighbourhood renewal*

5.8.4.1: *There is active multi-disciplinary and multi-agency work with commonalities.*

5.11: Health Act flexibility's

6: Public health

6.2.4 1 There are inter agency initiatives to tackle the root causes of health inequalities.

Specific dimensions (6 selected -8, 9,10,13,18,19)

8: Addressing health and wellbeing needs

Level 1: F] *Promptly alerts the team when there are changes in individuals' health and wellbeing or any possible risks*

Level 2: H] *Provides information to the team on how individuals' needs are changing and the appropriateness of the programme for the individual*

Level 5 A] *Discusses and agrees with colleagues. who could contribute to different aspects of care .plans of care might involve different professional groups and different agencies.*

B] *Explains clearly to people .own and others roles and responsibilities and how they inter-relate.*

E] *Enables colleagues to develop their competence.*

9: Improving health and wellbeing needs

Level 1: A] *Identifies with others in the team his/her own role in relation to awareness raining and how this role can best be met.*

D] *Alerts others in the team to issues.*

Level 2: Relates to Healthwork UK, 2001 Draft NOS for public health practice. D] *works effectively with others to provide up-to-date and evidence based information*

Level 3: B] *works with others to plan projects, .identify how and by whom the programme will be identified.*

10: Protecting health and wellbeing needs

Level 1: A] *Agrees with the team their role and the groups and individuals whom they should be contacting*

Unit 17: work within multi-disciplinary and multi-organisational teams, networks and systems.

17.1 Element: develop and maintain effective working relationships:
Performance criteria:
A)Identify: your responsibilities and the expectations of your organisation;
B) Negotiate and establish; your responsibilities within the relationship; your expectations of the relationship; the expectations others have of you within the relationship
C) ensure that differences in power and authority are addressed
D) Seek advice, supervision and support in areas of confusion and conflict.

17.2 Element: Contribute to identifying and agreeing the goals and objectives, and lifespan of the team, network or system
Performance criteria:
A) Contribute to identifying how the team, network and system should operate.
B) Agree leadership and other responsibilities within the team, network and system, including where collective action and responsibility is needed.
C) Contribute to; setting up the team, network or system; agreeing its goals, objectives and potential lifespan; agreeing how the work will be reviewed against its objectives; agreeing the criteria for success, agreeing how conflicts will be addressed; setting ground rules to ensure effective working relationships; agreeing how communication and sharing of information will occur; with professional, ethical and organisational boundaries.

17.3 Element: Contribute to evaluating the effectiveness of the team, network or system.
Performance criteria:
A) Contribute to; evaluating the work of the team, network or system in

6.2.6.1 The PCT involves front line practitioners in inter-agency work and multi-disciplinary teams to strengthen communities and improve access to services

6.7.1.1 The PCT integrates its health protection programmes with other partners to ensure effective use of resources

6.7.2.1 There are clear lines of communication with all relevant agencies, including out of hours

6.7.4.2 The PCT participates in multi-agency training and exercise for major incidents ,including terrorist attacks

6.9.1.1 Members of the public health team have identified roles and responsibilities in support of the health protection function , routinely and in emergencies

9. Workforce

9.1: Human resource strategy

9.1.7. The PCT is planning for an integrated workforce.

9.1.8. The PCT is developing new ways of

9.1.8.1 *There are pooled budgets for social services and joint posts with social services.*

9.8.1.2 *Innovative development activities e.g. joint developments activities between health/social services.*

9.7: Training & Development

9.7.1 *There is an education, training and CPD strategy for the PCT which has been discussed and approved by the Board and PEC, that supports a culture where all staff have equal access to all training initiatives and programmes.*

9.7.1.3 *A strategy takes account of the NHS Plan, Agenda for Change, The LDP, NSF's and*
Clinical Governance Strategy.

9.7.2.3 *There is a senior multi-*

E] *Provides accurate information to the team*

F] *Alerts the team promptly to risks and seeks advice on the actions they should take.*

13: Production of communication, information & knowledge

Level 1: A] *Agrees with the team the data and information that is to be collected, collated and reported and how this is to be done.*

B] *Communicates appropriately with those involved throughout the process.*

18: Partnership

Level 2: E] *Shares and takes account of own and others 'knowledge and skills and advances in practice.*

G] *Shares information with others consistent with agreements made and consistent with own role.*

Level 3: A] *Understands and values others' roles and contributions.*

B] *Enables others' to contribute effectively*

C] *Acknowledges the nature and context of others' roles.*

Level 4: A] *Identifies and promotes the advantages and disadvantages of partnership working and the purpose of partnership working*

D] *Works with others to develop agreed arrangements and action plans that contain. communication and channels, roles and responsibilities, who is responsible for undertaking different actions*

E] *Appropriately supports and encourages people to understand their contribution to partnership working, work effectively together, share achievements.*

Level 5: A] *Identifies and selects methods that facilitate partnership working.*

achieving its goals.
B) Making changes and improvements that will enhance the quality of the team, network or system and the working relationship of its members.

17.4 Element: Deal constructively with disagreements and conflict within relationships.
Performance criteria:
A) Identify the causes, and ways in which, disagreements and conflicts should be addressed
B) use mediation and advocacy to assist resolution of conflicts
C) work with others to resolve disagreements and conflicts
D) Where resolution is not possible, work with others to identify how conflicts and disagreements will be managed.

E) Seek advice and guidance, supervision and support from within and outside the organisation when agreements and solutions cannot be reached.

Key Role 6: Demonstrate professional competence in social work practice.

Unit 18: research, analyse, evaluate and use current knowledge of best social work practice.

18.2 Element: Use professional and organisational supervision and support to research, critically analyse and review knowledge based practice.
Performance criteria:
A) Use supervision and teamwork to identify different sources of knowledge that can inform best practice.
C) Use procedures and practices and prioritise time commitments to ensure that you have sufficient time to; review and evaluate the effectiveness of team practice.

Unit 19: Work within agreed standards of social work practice and ensure own professional development:

disciplinary group or committee with a brief for overall planning and co-ordination of staff development, education and training and teaching activities within the PCT.

9.7.3 *There is a co-ordinated approach to training and education across the health economy, including joint initiatives across health and social care.*

9.7.3.1 *Education and training plans are shared with other agencies.*

9.7.3.2 *Training sessions run by the PCT are publicised and open to staff from local authority, voluntary organisations and other partner organisations, where the training is applicable to these staff.*

19: Leadership

Level 3: A] *Identifies clear benefits, goals and processes for developing knowledge, ideas and work practice and communicates these effectively to others in the work team*

E] *Enables others to understand their contribution, take an active part in the process, informally network with others, share achievements jointly with other colleagues.*

F] *Overcomes barriers to development and constructively challenges those whose views and actions are not consistent with development.*

Level 5: A] *Identifies clear benefits, goals and processes for developing knowledge, ideas and work practice and communicates these effectively to other agencies and communities.*

B] *Links the development of knowledge, ideas and work practice to their role, functions, interests and concerns of others.*

F] *Enables people to communicate their views about improvements and listens to what they are saying.*

H] *Overcomes barriers to involvement including those within senior and influential positions.*

K] *Supports and encourages people*

19.1 Element: Exercise and justify professional judgement.
Performance criteria:
A) Apply professional knowledge and skills to the social work processes of; referral
C) Explain and justify (both verbally and in writing) the rationale for your professional judgements and decisions when working with differences in perspectives from: other professionals; others within your own team and organisation.

19.3 Element: Work within the principles and values underpinning social work practice.
Performance criteria:
C) Ensure that, in team working, others are aware of the specific values and principles of work.

19.5 Element: Use supervision and support to take action to meet continuing professional development needs.
Performance criteria:
C) Take action to meet continuing professional development needs.

Unit 21: Contribute to the promotion of best social work practice.

21.3 Element: Work with colleagues to contribute to team development.
Performance criteria:
A) Identify formal and informal ways that can be used to contribute to, and support the development of colleagues
B) Clarify the most appropriate methods and contexts for helping to develop colleagues.

Key

- 🟩 Team working
- 🟧 Communication
- 🟪 Role awareness
- 🟦 Personal and professional development
- 🟦 Practice development and leadership
- 🟥 Partnership working

Appendix 5:
Policy Framework Mapping Tables:
National Occupational Standards for Care and Social Care (Skills for Health 2003)

Mapping of six key review themes for education and training to deliver integrated health and social care within four skills, knowledge and competency frameworks

Draft Overarching core standard A-E (A,C,D selected)

A - Working directly with people to encourage and promote their well being and potential across the continuum of dependency/independency needs.

C - Working collaboratively with others inside and outside own organisation to plan and implement an integrated effective service.

D - Carry out organisational activities that support, deliver and manage health & social care services.

Level 2 Analysis

A1: Develop effective relationships to maximise and promote peoples wellbeing

A4: support people to manage their own personal health and social wellbeing.

C1: Work effectively as team members

C2: Support interdisciplinary and multi-agency collaboration

C3: Develop and work collaboratively with public networks

D1: Plan, implement and review services and programmes.

D8: Contribute to the development of policy and services.

New/Developed standards

CU9: Contribute to the development and effectiveness of work teams.
CU9.1 Contribute to effective team practice
CU9.2 Contribute to the development of others in the work team
CU9.3 Develop oneself in own work role.

CU7: Develop one's own knowledge and practice
CU7.1: Reflect on & evaluate ones own values, priorities, interests and effectiveness.
CU7.2: Synthesize new knowledge into the development of ones own practice.

CU10: Contribute to the effectiveness of work teams.
CU101 Contribute to effective team working
CU102 Develop oneself in own role.

SC15: Develop and sustain arrangements for joint working between workers and agencies
SC15.1 Evaluate potential for joint working with other workers and agencies
SC15.2 Establish and sustain working relationships with other workers and agencies
SC15.3 Contribute to joint working with other workers and agencies.

All of the above standards are broken down into specific learning outcomes listed below;
CU = Care Unit   SC = Social Care Unit

CU7.1.4	SC15.1	CU9.1.6
CU7.1.4	SC15.1.2	CU9.1.6
CU7.1.7	SC15.2.6	CU9.2.4
CU7.1.8	SC15.3.2	CU9.2.4
CU7.1.5	SC15.3.5	CU9.2.4
CU7.1.7	CU10.1.2	CU9.2.2
CU7.10	CU10.1.1	CU9.2.4
CU7.2.1	CU10.1.8	CU9.2.6
CU7.2.1	CU10.2.1	CU9.2.8
CU7.2.2	CU10.2.2	CU9.2.5
CU7.2.3	CU10.2.3	CU9.2.7
CU7.2.5	CU10.2.5	CU9.2.7
CU7.2.5	CU9.3.3	CU9.3.1
CU7.2.4	CU9.1.7	CU9.3.4

Appendix 6:
Allied Health Professional Self Assessment Document (part of the NatPaCT Primary Care Trusts Competency Framework, NHS Modernisation Agency 2004)

This self assessment tool sets out a framework to encourage expansion and reform. Part of this framework alludes to "Increased flexibility between services and between staff to cut across outdated organisational and professional barriers". The Allied Health Professionals' roles are central to this and to the NHS Plan (Department of Health 2000b) key priorities, one of which is rehabilitation and intermediate care – joining up health and social care. Eight themes were identified as being "particularly significant" for the delivery, modernisation and commissioning of Allied Health Professional services. Three of these; workforce, performance management and access and choice and partnership promote integrated health and social care (See Box 11). Unlike the NHS Knowledge and Skills Framework, the National Occupational Standards for Health and Social Care and National Occupational Standards for Social Work, the NatPaCT Allied Health Professional's Self-Assessment Document places a great emphasis on integrated care and working across boundaries. It actively promotes practitioners to seek out opportunities for integrated working and it is the only framework to mention inter-professional education as a teaching and learning strategy to promote integrated working.

> **Box 12: Allied Health Professional Self-Assessment document (NHS Modernisation Agency 2004)**
>
> **A2: Workforce**
>
> **A2.4:** *The Primary Care Trusts addresses the implications for AHPs of: lifelong learning: working together, Learning together.*
>
> **A6: Performance management**
>
> **A.6.2:** *AHP's are actively involved in multi-agency and inter-disciplinary teams and initiatives to deliver NSF's, access targets and other local and national strategic initiatives and targets.*
>
> **A7: Access & choice**
>
> **A.7.3:** *AHPs are encouraged and supported to develop better and new ways of working, and are included in Primary Care Trusts developments from initial concept through to delivery e.g. as a result ofSingle assessment process*
>
> *Integrated Health and Social Care services and/or teams (across the health and social care spectrum i.e. including primary and secondary care)*
>
> **A.7.4:** *AHPs work as part of a multi-agency, whole systems approach across health, education and social care, focusing on the patient pathway and needs of the local community.*
>
> **A.7.10:** *AHPs are proactive in working with colleagues across the health and social care spectrum to ensure safe and effective transition for patients and carers across sectors (link to "partnership" section).*
>
> **A8: Partnership**
>
> **A.8.1:** *Lead AHPs contribute to local partnership working and interagency planning teams, and have access to AHP networks to ensure their effectiveness.*
>
> **A.8.2:** *AHPs are enabled to work across agency and organisational boundaries to ensure a seamless service for patients.A.8.3: The Primary Care Trusts uses the AHP's experience in working across boundaries to further the development of Integrated Health and Social Care.A.8.6: AHPs participate in the delivery and participation of multi-agency and inter-professional education and training and research and development opportunities.*

Appendix 7:
Summary of Studies included in the Review (based on research designs)

Author & Date	Research Methodology	Sample & Data Collection
Author: Caan, W.; Streng, I.; Moxon, R.; Machin, A. **Year:** 2000 *A joint health and social services initiative for children with disabilities.* British Journal of Nursing 5 (2) 87 - 90	'co-operative' review	• The whole children's disability team. • Quantitative semi-structured questionnaire
Author: Carlisle, S.; Elwyn, G.; Smail, S. **Year:** 2000 *Personal and practice development plans in primary care in Wales.* Journal of Interprofessional Care 14 (1) 39 - 48	Methodology: Action research design using qualitative methodological approach.	• Participant observation • In-Departmenth interviews • Documentary evidence • Co-coordinators, primary care workers, facilitators, HA selection panels
Author: Closs, S. J. **Year:** 1997 *Discharge communications between hospital and community health care staff: a selective review.* Health & Social Care in the Community. 5 (3) 181 - 197	Methodology: selective literature review	• Search strategy included MEDLINE & CINAHL • Inclusion & exclusion criteria presented • Years searched – 1985 – 1995
Author: Dalley, J.; Sim, J. **Year:** 2001 *Nurses perceptions of physiotherapists as rehabilitation team members.* Clinical Rehabilitation. 15: 380 - 389	Methodology: Qualitative exploratory study	• Purposive sample of 8 experienced qualified nurses grades C-E • Interviews
Author: Einzig, H.; Curtis-Jenkins, G.; Basharan, H. **Year:** 1995 *The training needs of counselors in primary medical care* Journal of Mental Health 4: 205- 209	Methodology: Quantitative- not adequately described. Survey and telephone interviews	• 25 questionnaires (RR=24) • Telephone follow up (RR=11) • Trained counselors.
Author: Fakhoury, W. K. H.; Wright, D. **Year:** 2000 *Communication and information needs of a random sample of community psychiatric nurses in the UK* Journal of Advanced Nursing. 32 (4)871 - 880	Methodology: Quantitative cross-sectional survey of a random sample	• Cross sectional random survey (RR=55%) • Community Psychiatric nurses
Author: Farmakopoulou, N. **Year:** 2002 *What lies underneath? An inter-organisational analysis of collaboration between education and social work.* British Journal of Social Work. 32, 1051 - 1066	Case study: The author adopted an integrated theoretical approach through a mixed method design.	• Postal survey (RR=84%) • Semi-structured interviews • Education staff, social workers, parents of case study children (n=6)

Author & Date	Research Methodology	Sample & Data Collection
Author: Freeman, M.; Miller, C.; Ross, N. **Year:** 2000 *The impact of individual philosophies of team work on multi-professional practice and the implications for education.* Journal of Interprofessional Care. 14 (3) 237 - 247	Qualitative case study using Grounded Theory approach	• 6 multi-disciplinary teams • 124 team members • Observation • Interviews
Author: Freudenstein, U.; Yates, B. **Year:** 2001 *Public health skills in primary care in South West England – a survey of training needs, obstacles and solutions.* Public Health. 115: 407 - 411	Questionnaire survey	• Survey (RR=67%) • Directors of public health, directors of nursing, directors of midwifery, nursing advisors in health authorities, Chief officers of Primary Care Trust's, Chairman of boards
Author: Gibb, C. E.; Morrow, M.; Clarke, C. L.; Cook, G.; Gertig, P.; Ramprogus, V. **Year:** 2002 *Transdisciplinary working: evaluating the development of health and social care provision in mental health.* Journal of Mental Health. 11 (3) 339 - 350	Soft systems methodology used to 'embrace an action research approach'	• 3 uni-professional focus groups • Social workers, Community Psychiatric Nurse's, CSW's • Followed up with multi-professional focus groups • 13 interviews with stakeholders. • Individual interviews with sample of 10 team members.
Author: Hardy, B.; Hudson, B.; Waddington, E. **Year:** 2000 *The Partnership Assessment Tool* Nuffield Institute for Health & Social Care, Community Care Division, Leeds	Report on development of a Partnership Assessment Tool.	• Worked with five Primary Care Trust's and Nuffield Institute.
Author: Higham, P.; Spooner, A. **Year:** 1998 *Alice Johnson: case study research of collaborative practice within community care* Health Care in Later Life 3 (2) 111 - 128	Case study	• Opportunistic sample • Care manager, SW, DN, Warden, Agency manager • Structured interviews.
Author: Hudson, B. **Year:** 2002 *Inter-professionality in health and social care: the Achilles heel of partnership?* Journal of Interprofessional Care. 16 (1) 7 - 17	Qualitative using a theoretical framework to guide the analysis.	• Individual interviews (n=81) • Focus groups (n=9) • "wide range of professionals from health and social care settings".
Author: McDonald, A. L.; Langford, I. H.; Boldero, N. **Year:** 1997 *The future of community nursing in the UK: district nursing, health visiting and school nursing* Journal of Advanced Nursing. 26: 257 – 265.	Survey and discussions with respondents - ?focus groups/ theme day.	• Questionnaires • 24 trusts (RR=22) covering three community nursing services, district nursing, health visiting and school nursing

Author & Date	Research Methodology	Sample & Data Collection
Author: McNeal, M.; Oster, R.; Alema-Mensah, E. **Year:** 1999 *Health professions student's opinions of interdisciplinary health care teams.* National Academies of Practice Forum. 1 (1) 17 - 23	Methodology: Survey	• 8 item survey 'Interdisciplinary Instrument'. • 98 medical students, 48 nursing students, 24 social work students who had enrolled on a community health course.
Author: Millward, L.J.; Jeffries, N. **Year:** 2001 *The team survey: a tool for health care team development* Journal of Advanced Nursing. 35 (2) 276 - 287	Methodology: Survey	• Psychometric tool • 10 teams, 124 members
Author: Nandan, M. **Year:** 1997 *Commitment of Social work staff to interdisciplinary care plans: an exploration* Social Work Research 21 (4) 49 - 59	Survey	• Social workers with a bachelor's degree in SW or related discipline who were participating in Interdisciplinary Care plan teams. • Survey
Author: Nochajski, S. M. **Year:** 2001 *Collaboration between team members in inclusive educational settings* Interprofessional Collaboration in Occupational Therapy. 15 (3/4) 101 - 112	Qualitative	• Convenience sample of students with disabilities • 17 regular educators, 12 special educators, 7 occupational therapists, 8 speech and language therapists. • Semi-structured interviews.
Author: Peck, E.; Towell, D.; Gulliver, P. **Year:** 2001 *The meanings of 'culture' in health and social care: a case study of the combined Trust in Somerset* Journal of Interprofessional Care. 15 (4) 319 - 327	Mixed method	• Senior managers, all trust staff, self-selected trust staff, elected members/ non-executive directors of the LA, health authority including all members of the joint commissioning board. RR = 44% in 1999 and 34% in 2000 • Postal survey • Annual exploratory groups • Structured interviews.
Author: Secker, J.; Pidd, F.; Parham, A. **Year:** 1999 *Mental health training needs of primary care nurses* Journal of Clinical Nursing 8: 643 – 652	Mixed method	• Survey • Six meetings – semi-structured interviews • 30 nurses in 2districts

Author & Date	Research Methodology	Sample & Data Collection
Author: Simpson, A. **Year:** 1999 *Focus on training* Nursing Times. 95 (47) 66-68	Qualitative – response evaluation	• 83 participants including Community Psychiatric Nurse's, service users, carers, lecturers, representatives from voluntary organisations and care support workers • Focus groups (n=125) and interviews (n=158)
Author: Slater, P. **Year:** 2002 *Training for No Secrets: a strategic initiative* Social Work Education. 21 (4) 437 - 448	Action research	• Frontline and managerial staff from a range of health and social services agencies across statutory/ independent divide. • Post it note evaluations
Author: Stanley, D.; Reed, J.; Brown, S. **Year:** 1999 *Older people, care management and inter-professional practice* Journal of Interprofessional Care. 13 (3) 229 - 237	Multi-method used to generate eight qualitative case studies.	• Interviews (n=45) • Clients, care manager, family members, carers, home care staff, health care staff
Author: Taylor, J.; Blue, I.; Misan, G. **Year:** 2001 *Approach to sustainable primary health care service delivery for rural and remote South Australia.* Australian Journal of Rural Health. 9: 304 - 310	Case study	• Structured interviews (n=73) • GP's, AHP's, registered nurses, administration staff. • Anonymous survey (80 consumers, 17 health care students)
Author: Werrett, J.A.; Helm, R.H.; Carnwell, R. **Year:** 2001 *The primary and secondary care interface: the educational needs of nursing staff for the provision of seamless service.* Journal of Advanced Nursing. 34 (5) 629 – 638	Triangulated methods using focus groups to generate questions for questionnaires.	• Focus groups • Questionnaires • Random stratified sample (RR=23.8%) • Acute care and primary care nurses grade D – I

References

Alpay L & Russell A (2002) *Information technology training in primary care: The nurses' voice,* CIN: Computers, Informatics, Nursing 20 (4) 136 – 142.

Avis M (1994) *Reading research critically. I. An introduction to appraisal: Designs and objectives,* Journal of Clinical Nursing 3: 227 – 234.

Barr H & Waterton S (1996) *Interprofessional Education in Health and Social Care in the United Kingdom, Report of a CAIPE Survey,* CAIPE. London.

Barr H (1996) *Interprofessional Education. Today, Yesterday and Tomorrow. A Review,* CAIPE, London.

Barr H (2001) *Interprofessional Education. A Review,* CAIPE, London.

Biggs S (1993) *User participation and interprofessional collaboration in community care,* Journal of Interprofessional Care 7 (2) 151 – 159.

Bywaters P & McLeod E (2001) *The impact of new labour health policy on social services: A new deal for service users health?* British Journal of Social Work 31: 579 – 594.

Caan W, Streng I, Moxon R, Machin A (2000) *A joint health and social services initiative for children with learning disabilities,* British Journal of Nursing 5 (2) 87 – 90.

Callaghan G, Exworthy M, Hudson B & Peckham S (2000) *Prospects for collaboration in primary care: relationships between social services and the new PCG's.* Journal of Interprofessional Care, 14 (1) 19 – 26.

Calloway M, Morrissey J, Topping S & Fried B (2001) *Recent Developments in Alcoholism,* 15. 73 – 96, Academic/Plenum Publishers, New York.

Carlisle S, Elwyn G & Smail S (2000) *Personal and practice development plans in primary care in Wales,* Journal of Interprofessional Care, 14 (1) 39 – 48.

Critical Appraisal Skills Programme (2003).

Closs SJ (1997) *Discharge communications between hospital and community health care staff: A selective review.* Health and Social Care in the Community 5 (3) 181-197.

Cutcliffe JR & McKenna HP (1999) *Establishing the credibility of qualitative research findings: The plot thickens.* Journal of Advanced Nursing, 30 (2) 374 – 380.

Cullum N (1999) *How to decide if review articles are trustworthy and relevant for practice,* Nursing Times Learning Curve 3 (6) 4 – 6.

Dalley J & Sim J (2001) *Nurses' perceptions of physiotherapists as rehabilitation team members,* Clinical Rehabilitation 15: 380 – 389.

Davis C (1998) *The cloak of professionalism* – In Allot M and Robb M (1998) *Understanding Health and Social Care, An introductory reader,* 190-197.

Department of Health (1989) *Caring for People: Community Care in the Last Decade and Beyond,* Her Majesty's Stationery Office, London. Cited in Øvretveit J (1993) *Coordinating Community Care. Multidisciplinary Teams and Care Management,* Open University Press, Buckingham.

Department of Health (1995) *Scottish Children's Act* – Cited in: Nochajski SM (2001) *Collaboration between team members in inclusive educational settings.* Interprofessional Collaboration in Occupational Therapy 15 (3/4) 101 – 112.

Department of Health (1997) *The New NHS: Modern, Dependable,* The Stationery Office, London.

Department of Health (1998a) *Our Healthier Nation. A Contract for Health,* The Stationery Office. London.

Department of Health (1998b) *Partnerships in Action. New Opportunities for Joint Working Between Health and Social Services. A Discussion Document.* Department of Health, London.

Department of Health (1998c) *Modernising Health and Social Services National Priorities Guidance, 1999/00 – 2001/02,* Department of Health, London.

Department of Health (1999a) *The Health Act.* Her Majesty's Stationery Office (HMSO), London.

Department of Health (1999b) *Modernising Health and Social Service: Developing the Workforce,* Department of Health, London.

Department of Health (1999c) *Making A Difference. Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare,* Department of Health, London.

Department of Health (1999d) *Saving Lives: Our Healthier Nation,* The Stationery Office, London.

Department of Health (1999e) *'New national healthy school standard launched',* Press Release, Ref no: 1999/0587, Department of Health, London.

Department of Health (1999f) *Agenda for Change – Modernising the NHS Pay Systems,* NHS Executive, Health Service Circular 1999/227, Department of Health, London.

Department of Health (2000a) *A Health Service for All the Talents: Developing the NHS Workforce: Consultation Document on the Review of Workforce Planning,* Department of Health, London.

Department of Health (2000b) *The NHS Plan.* (ch. 7), The Stationery Office, London.

Department of Health (2000c) *'No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse',* Department of Health, London.

Department of Health (2001a) *Working Together – Learning Together,* Department of Health, London.

Department of Health (2001b) *Health and Social Care Act,* The Stationery Office, London.

Department of Health (2001c) *National Service Framework for Older People,* Department of Health, London.

Department of Health (2002a) *Liberating the Talents. Helping Primary Care Trusts and Nurses to Deliver the NHS Plan,* Department of Health, London.

Department of Health (2002b) *Improvement, Expansion and Reform: the Next Three Years Priorities and Planning Framework 2003-200,* Department of Health, London.

Department of Health (2002c) *Funding Learning & Development for the Healthcare Workforce. Review of NHS Education and Training Funding. A Consultation Document,* Department of Health, London.

Department of Health (2002d) *Primary Care Workforce Planning Framework.* Department of Health, Leeds.

Department of Health (2003a) *Older Persons Strategies: Linking Housing to Health, Social Care and Other Local Strategies.* Department of Health, London.

Department of Health (2003b) *Improvement, Expansion and Reform: The Next Three Years. Priorities and Planning Framework 2003 – 2006.* Department of Health, London.

Department of Health (2003c) The Victoria Climbié Inquiry. Report of an Inquiry. Her Majesty's Stationery Office (HMSO), London.

Department of Health (2003d) *The NHS Knowledge and Skills Framework (NHS KSF) and Development Review Guidance – Working Draft.* Department of Health, London.

Department of Health (2002e) *Developing a shared framework for health professional learning beyond registration.* Letter from the office of Professor Maggie Pearson, Deputy Director of Human Resources, Department of Health, Leeds.

Department of Health (2002f) *Consultation on the draft Mental Health Bill.* Department of Health, London.

Droogan J & Cullum N (1998) *Systematic reviews in nursing.* International Journal of Nursing Studies 35: 13 – 22.

Einzig H, Curtis-Jenkins G & Basharan H (1995) *The training needs of counsellors in primary medical care.* Journal of Mental Health 4: 205 – 209.

Elwyn G & Smail J (1999) *Integrated Teams in Primary Care.* Radcliffe Medical Press Ltd, Oxon.

Fakhoury WKH & Wright D (2000) *Communication and information needs of a random sample of community psychiatric nurses in the United Kingdom,* Journal of Advanced Nursing 32 (4) 871 – 880.

Farmakopoulou N (2002) *What lies underneath? An inter-organisational analysis of collaboration between education and social work,* British Journal of Social Work 32, 1051 – 1066.

Farrell MP, Schmitt MH & Heinemann GD (2001) *Informal roles and the stages of interdisciplinary team development.* Journal of Interprofessional Care 15 (3) 281–259.

Fink SL (1992) *High Commitment Workplaces.* New York. Quorum Books. Cited in Nandan M (1997) *Commitment of social services staff to interdisciplinary care plan teams: An exploration.* Social Work Research 21 (4) 49 – 259.

Flocke S (1997) *Measuring attributes of primary care: Development of a new instrument.* The Journal of Family Practice 45 (1) 64 – 74.

Freeman M, Miller C & Ross N (2000) *The impact of individual philosophies of teamwork on multi-professional practice and the implications for education.* Journal of Interprofessional Care 14 (3) 237 – 247.

General Social Care Council (2002) *Code of practice for employers of social care workers and for social care workers.* General Social Care Council, London.

Gibb C, Morrow M, Clarke C, Cook G, Gertig P & Ramprogus V (2002) *Transdisciplinary working: Evaluating the development of health and social care provision in mental health.* Journal of Mental Health 11 (3) 339 – 350.

Glendinning C, Rummery K & Clarke R (1998) *From collaboration to commissioning: developing relationships between primary health and social services.* British Medical Journal 317:122-128.

Glendinning C, Abbott S, Coleman A (2001) *"Bridging the gap": New relationships between primary care groups and local authorities.* Social Policy and Administration 35 (4) 411-425.

Glendinning C (2002) *Partnerships Between Health and Social Service: Developing a framework for evaluation.* Policy & Politics 30 (1) 115 – 127.

Glendinning C (2003) *Breaking down barriers: integrating health and care services for older people in England.* Health Policy 65 139 – 151.

Goacher B, Evans J, Welton J & Wedell K (1998) *Policy and Provisions for Special Educational Needs: Implementing the 1989 Education Act,* Cassell Educational Ltd, London. Cited in Farmakopoulou N (2002) *What lies underneath? An inter-organisational analysis of collaboration between education and social work* British Journal of Social Work 32, 1051–1066.

Grant, M.J. & Brettle, A (2000) *Developing a review question: A spiral approach to literature searching, 3rd Symposium on Systematic Reviews: Beyond the Basics,* Oxford, 3-5 July 2000.

Gross MS (1997) *The technology and tactics of physician integration.* Health Care Information Management 11(2) 23 – 41.

Guba EG (1990) *The Paradigm Dialog.* Sage Publications Ltd, London.

Hardy B, Hudson B & Waddington E (2000) *What Makes a Good Partnership? A Partnership Assessment Tool.* Nuffield Institute for Health, Community Care Division, Leeds.

Hart C (1998) *Doing A Literature Review. Releasing the Social Science Research Imagination.* Sage Publications Ltd, London.

Hart E & Fletcher J (1999) *Learning how to change: A selective analysis of literature and experiences of how teams learn and organisations change.* Journal of Interprofessional Care (13) 53 – 63. Cited in Gibb C, Morrow M, Clarke C, Cook G, Gertig P, Ramprogus V (2002) *Transdisciplinary working: Evaluating the development of health and social care provision in mental health.* Journal of Mental Health 11 (3) 339 – 350.

Health Development Agency (2003) *The working partnership, Book 1: Introduction,* Health Development Agency, London.

Henneman EA, Lee JL & Cohen JI (1995) *Collaboration: A concept analysis.* Journal of Advanced Nursing 21 103 –109.

Heyward M & Porter E (2001) *Educating the next generation of health professionals.* Community Practitioner 74(2) 68-70.

Higham P & Spooner AK (1998) Alice Johnson: *Case study research of collaborative practice within community care.* Health Care in Later Life 3 (2) 111–128.

Hudson B, Hardy B, Henwood M & Wistow G (1999) *In pursuit of inter-agency collaboration in the public sector. What is the contribution of theory and research?* Public Management: An International Journal of Research and Theory 1 (2) 236 – 260.

Hudson B (2002) *Inter-professionality in health and social care: the Achilles' heel of partnership?* Journal of Interprofessional Care 16 (1) 7 – 17.

Humphris D & Clark JM (2002) *Shaping a vision for a 'New Generation' workforce,* New Generation Project, University of Southampton.

Huxman C (1993) *Pursuing collaborative practice.* Journal of Operational Research Society 44 (6) 599 - 611.

Jones L, Packard T & Nahrstedt K (2002) *Evaluation of a training curriculum for inter-agency collaboration.* Journal of Community Practice 10 (3) 23 – 39.

Jordan J, Wright J, Wilkinson J & Williams R (1998) *Assessing local health needs in primary care: understanding and experience in three English districts.* Quality in Health Care 7: 83-89.

Kendrick T & Hilton S (1999) *Primary Care: opportunities and threats. Broader teamwork in primary care.* British Medical Journal 314:672.

Kings Fund (2002) *Partnerships Under Pressure. A Commentary on Progress in Partnership-working Between the NHS and Local Government.* Health & Social Care Policy & Development Unit, King's Fund, London.

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

Loxley A (1997) *Collaboration in Health and Welfare. Working with Difference.* Jessica Kingsley Publications, London.

McDonald AL, Langford IH & Boldero N (1997) *The future of community nursing in the United Kingdom: district nursing, health visiting and school nursing.* Journal of Advanced Nursing 26 257–265.

McNeal M, Oster R & Alema-Mensah E (1999) *Health professions students' opinions of interdisciplinary health care teams.* National Academies of Practice Forum 1 (1) 17–23.

Millward LJ & Jeffries N (2001) *The team survey: A tool for health care team development.* Journal of Advanced Nursing 35 (2) 276-287.

Millward L & Purvis R (1998) Teambuilding Technique: *A Critical evaluation.* Defence Evaluation Research Agency. Centre for the Human Sciences, Farnborough, UK.

Mulrow CD & Oxman AD (eds) (1997) *'Quality' scales and checklists.* Cochrane Collaboration Handbook, Section 6.7.2. Cited in: The Cochrane Library, Issue 4, Oxford: Update Software.

Nandan M (1997) *Commitment of social services staff to interdisciplinary care plan teams: An exploration.* Social Work Research 21 (4) 49–259.

National Health Service Executive (2000) *NHS Executive/ Committee of Vice- Chancellors and Principles – A Partnership Statement.* NHSE, London.

NHS Modernisation Agency (2004) National Primary and Care Trust Development Programme. www.natpact.nhs.uk

Nochajski SM (2001) *Collaboration between team members in inclusive educational settings.* Interprofessional Collaboration in Occupational Therapy, 15 (3/4) 101 – 112.

Øvretveit J (1993) *Coordinating Community Care. Multidisciplinary Teams and Care Management.* Open University Press. Buckingham.

Øvretveit J, Mathias P & Thompson T (Eds) (1997) *Interprofessional Working for Health and Social Care.* Macmillan Press Ltd, London.

Oxford English Dictionary (2001) 10th edition, Oxford University Press, Oxford.

Papa PA, Rector C & Stone C (1998) *Interdisciplinary collaborative training for school-based health.* Journal of School Health 68 (10) 415– 424.

Parahoo K (1997) *Nursing Research: Principles, process and issues,* Macmillan Press Ltd, London.

Peck E & Crawford A (2004) *'Culture in partnerships – What do we mean by it and what can we do about it?'* Integrated Care Network, Leeds.

Peck E, Towell D & Gulliver P (2001) *The meanings of 'culture' in health and social care: A case study of the combined Trust in Somerset.* Journal of Interprofessional Care 15 (4) 319 – 327.

Pittilo RM & Ross FM (1998) *Policies for interprofessional education: current trends in the UK.* Education for Health 11 (3) 285–295.

Pringle M (Ed) (1998) *Core values in primary care.* British Medical Journal 317: 1394.

Public Health Resource Unit (2003), *Critical Appraisal Skills Programme (CASP),* NHS, Oxford.

Rainforth B, York J & MacDonald C (1992) *Collaboration Teams for Students with Severe Learning Disabilities.* Paul H Brookes Publishing Company, Baltimore. Cited in:Nochajski SM (2001) *Collaboration between team members in inclusive educational settings.* Inter-professional Collaboration in Occupational Therapy 15 (3/4) 101–112.

Robson C (1993) *Real World Research. A Resource for Social Scientists and practitioner-researchers.* Blackwell, Oxford.

Russell KM & Hymans D (2001) *Interprofessional education for undergraduate students.* Public Health Nursing, 16 (4) 254–262.

Sainsbury Centre for Mental Health (1997) *Pulling Together: The Future Roles and Training of Mental Health Staff.* Sainsbury Centre for Mental Health, London.

Secker J, Pidd F & Parham A (1999) *Mental health training needs for primary health care nurses.* Journal of Clinical Nursing, 8 643-652.

Secker J & Hill K (2001) *Broadening the partnership:Experiences of working across community agencies.* Journal of Interprofessional Care, 15 (4) 341–350.

Shardlow SS, Davis C, Johnson M, Long T, Murphy M & Race D (2004) *Education and training for inter-agency working: New standards,* University of Salford.

Shaw I (1993) *Learning together – Social work and nursing.* Health and Social Care, 1 255–262.

Simpson A (1999) *Focus on training.* Nursing Times, 95 (47) 66–68.

Skills for Health (2003) *Introduction to Modern Apprenticeships,* Skills for Health, Bristol.

Slater P (2002) *Training for No Secrets: A strategic initiative.* Social Work Education, 21 (4) 437–448.

Stanley D, Reed J & Brown S (1999) *Older people, care management and interprofessional practice.* Journal of Interprofessional Care, 13 (3) 229–237.

Stanhope MK (1995) *Primary health care practice: Is nursing part of the solution or the problem?* Family Community Health, 18 (1) 40–68.

Sullivan TJ (1998) *Collaboration – A health care imperative,* McGraw Hill, New York.

Taylor J, Blue I & Misan G (2001) *Approach to sustainable primary health care service delivery for rural and remote South Australia.* Australian Journal of Rural Health 9: 304–310.

Topss UK Partnership (2002) *The National Occupational Standards for Social Work,* Topss, Leeds, England.

Websites

Universities UK (2003) *Partners in Care,* Universities UK, London.

University of Southampton (2003) *New Generation Project.* www.mhbs.soton.ac.uk/newgeneration/

Warren R, Rose S & Bergunder A (1974) *The Structure of Urban Reform.* Lexington Books, Lexington, MA.

Watson GB (1994) *Multi-disciplinary working and co-operation in community care.* Mental Health Nursing, 14: 18–21. Cited in Freeman M, Miller C, Ross N (2000) *The impact of individual philosophies of teamwork on multi-professional practice and the implications for education.* Journal of Inter-professional Care, 14 (3) 237–247.

Werrett J, Helm R & Carnwell R (2001) *The primary and secondary care interface: the educational needs of nursing staff for the provision of seamless care.* Journal of Advanced Nursing, 34 (5) 629–638.

West MA & Poulton BC (1997) *A failure of function: Teamwork in primary health care.* Journal of Inter-professional Care, 11 (2) 205–216.

Wood N, Farrow S & Elliott B (1994) *A review of primary health care organisations.* Journal of Clinical Nursing, 3:243-250.

Zwarenstein M, Atkins J, Barr H, Hammick M, Koppel I & Reeves S (1999) *A systematic review of inter-professional education.* Journal of Inter-professional Care, 13 (4) 417–424.

1) www.commonlearning.net/Project/index.asp
   New Generation project,
   University of Southampton

2) www.fhsc.salford.ac.uk/hcprdu/assessment.htm
   Health Care Practice Research and Development Unit (2001) Assessment tools. (Accessed: 23.04.04),
   University of Salford

3) www.hplbr.org.uk
   The Health Professional learning beyond registration project,
   University of Salford

4) www.modern.nhs.uk
   NHS Modernisation Agency website

5) www.natpact.nhs.uk
   National Primary and Care Trust Development Programme, National Competency Framework,
   NHS Modernisation Agency

6) www.pcet.org.uk
   Shaping the Future for Primary Care Education and Training Project,
   University of Salford

7) www.shef.ac.uk/cuilu/Projstruc.htm
   Combined Universities Inter-Professional Learning Unit,
   Sheffield Hallam University

8) www.skillsforhealth.org.uk
   National Occupational Standards for Care and Social Care,
   Skills For Health

9) www.topss.org.uk
   The National Training Organisation for Social Care in England

Bibliography

Allott M & Robb M (1998) *Understanding Health and Social Care. An Introductory Reader.* Sage Publications.

Alkire Reuland MP (2000) *Collaborative Learning as Professional Socialisation.* Paper presented at the annual meeting of the American Educational Research Association.

Angus DE & Lay CM (2000) Responses of Canada's health care management education programs to health care reform initiatives. *Journal of Health Administration Education.* 18 (2) 182 – 203.

Annadale E, Hunt K (1998) Accounts of disagreements with doctors. *Soc. Sci. Med* 46 (1) 119 – 129.

Annandale S, McCann S, Nattrass H, Regan De Bere S, Williams S & Evans D. (2000) Achieving health improvements through interprofessional learning in South west England. *Journal of Interprofessional Care.* 14 (2) 161 – 174.

Anonymous (1998) Continuing care and community care: Management and challenges and training implications. Participating in a MESOL workshop in Birmingham, November 21st. *Management Issues in Social Services.* 1 (5) 32 – 36.

Akinsanya JA (2000) The knowledge and value bases of professional education and training: In search of commonalties. *West African Journal of Nursing.* 11 (1) 32 – 36.

Allen C (2000) Peers and partners: working together to strengthen preceptorship in mental health nursing. *Journal of Psychiatric and Mental Health Nursing.* 7 505 – 514.

Audit Commission (1998) *A Fruitful Partnership. Effective Partnership working.* The Audit Commission. London.

Bagnall P (1999) A model of integrated nursing care for children and adolescents. *Nursing Times.* 95 (20) 48 – 49.

Baker M (1998) *Making Sense of the New NHS White Paper.* Radcliffe Medical Press. Oxon.

Balloch S & Taylor M (Eds) (2001) *Partnership Working. Policy and Practice.* The Policy Press.

Barnes D, Carpenter J & Bailey D. (2000) Partnerships with service users in interprofessional education for community health: a case study. *Journal of Interprofessional Care.* 14 (2) 189 – 200.

Barnes D, Carpenter J & Dickinson C (2000) Interprofessional education for community mental health: attitudes to community care and professional stereotypes. *Social Work Education.* 19 (6) 565 – 583.

Barr H (1998) Competent to collaborate: towards a competency-based model for interprofessional education. *Journal of Interprofessional Care.* 12 (2) 181 - 187.

Barr H (2000) Commentary Working together to learn together: learning together to work together. *Journal of Interprofessional Care.* 14 (2).

Barr H, Freeth D, Hammick M, Koppel I & Reeves S (2000) *Evaluations of Interprofessional Education. A United Kingdom Review for Health and Social Care.* CAIPE & British Educational Association. London.

Baylor S (1997) Role strain and role ambiguity revisited. *Journal of School Nursing.* 13 (3). 37.

Bennett N, Blundell J, Malpass L & Lavender T (2001) Midwives' views on redefining midwifery 2: public health. *British Journal of Midwifery.* 9 (12) 743 – 748.

Benson JD (1999) Establishing the ideal classroom. *OT Practice.* Nov (8) 23-24.

Berarducci AA, Delbanco TL & Rabkin MT (1975) The teaching hospital and primary care. Closing down the clinics. *The New England Journal of Medicine.* March 20. 615 –620.

Bingham M (2000) Promoting optimal drug prescribing: One year later. *A Closer Look. Summer 2000.*

Bond M (1997) A learning team in the making. *Journal of Interprofessional Care.* 11 (1) 89 – 988.

Bray JH & Rogers JC (1997) The Linkages project: training behavioural health professionals for collaborative practice wit primary care physicians. *Families, Systems and Health.* 15 (1) 55 – 63.

Bridge PD, Schenk M & Popp S (2000) Evaluating a primary care vertically integrated curriculum in undergraduate medical education. *Family Medicine.* 32 (8) 525-7.

Brown G T & Greenwood J (1999) Occupational therapy and physiotherapist: Similar, but separate. *British Journal of Occupational Therapy.* 62 (4) 163 – 170.

Brown L (2000) The impact of Integrated Health and Social Care teams in Wiltshire. Unpublished work. *Department of Social and Policy Services.* University of Bath.

Bruera E, Michaud M, Vigano A, Neumann CM, Watanabe S & Hanson J (2001) Multidisciplinary symptom control clinic an a cancer centre: a retrospective study. *Support Care Cancer.* 9: 162 – 168.

Bulger R (2000) Commentary on 'achieving improvements through interprofessional learning in south west England. *Journal of Interprofessional Care.* 14 (2).

Burbach F, Donelly M & Stanbridge R (2002) Service development through multi-disciplinary and multi-agency partnerships. *The Mental Health Review.* 7 (3) 27 – 30.

Busse R (2001) A single European market in healthcare? *Issues in European Health Policy.* 4th Issue – April 2001. 4 – 6.

Byles JE, Francis L & McKernon M (2002) The experiences of non-medical health professionals undertaking community-based assessments for people aged 75 years and over. *Health and Social Care in the Community.* 10 (2) 67 – 73.

Carney PA, Pipas CF, Eliassen S, Mengshol SC, Fall LH, Schifferdecker KE, Olson AL, Peltier DA & Nierenberg DW (2002) An analysis of students clinical experiences in an integrated primary care clerkship. *Academic Medicine.* 77 (7). 681 – 687.

Carpenter J & Hewstone M (1996) Shared learning for doctors and social workers: evaluation of a programme. *British Journal of Social Work.* 26 239 – 257.

Carter Y, Jackson N & Barnfield A (1998) The learning practice: a new model for primary health care teams. *Education for General Practice.* 9 182 – 187.

Carter YH, Shaw S & Macfarlane F (Eds) (2002) *Primary Care Research Team Assessment (PCRTA): Development and Evaluation.* Royal College of General Practitioners. London.

Centre for Innovation in Primary Care (2001) *The Shadowing Programme: Promoting Partnership Working Across the Health and Social Care Sectors.*www.innovate.org.uk/library/ Caringolderpeople/Caringforolderpeo ple.htm. (accessed 20/08/2003).

Challis D, Darton R, Donnelly M, Hughes J, Stewart K & Weiner K. (1999) Mapping and evaluation of care management arrangements for older people and those with mental health problems and social services: a comparative study. PSSRU – www.ukc.ac.uk/PSSRU/

Charles M & Hendry E (Eds) (2000) *Training to Safeguard Children. Guidance on Inter-agency Training.* NSPCC.

Charleston S & Denman S (1997) The school nurses contribution to health promotion. *Health Visitor.* 70 (8) 302 – 304.

Charlesworth J (2001) Negotiating and managing partnerships in primary care. *Health and Social Care in the Community.* 9 (5) 279-285.

Clark PG (1997) Values in health care professional socialisation: Implication for geriatric education in interdisciplinary teamwork. *The Gerontological Society of America.* 37 (4) 441 – 451.

Clark T (2002) Commentary: New Labours big idea: Joined-up Government. *Social Policy and Society.* 1 (2) 107 – 117.

Coile RC Jr. (1995) Integration, capitation and managed care: Transformation of nursing for the 21st century health care. *Adv Prac Nurs.* 1 (2) 77-84.

Cole A (1992) Building bridges *Nursing Times.* 88 (4) 44 – 45.

Conti RM & Galante CM (1998) Invited Essays: Executive team building as a management strategy in international health care settings: case study of the planning, implementation and evaluation of a collaborative educational intervention. *The Journal of Health Administration Education.* 16 4439 – 453.

Cook A, Davis J & Vanclay L (2001) Shared learning in practice placements for health and social work students in East London: a feasibility study. *Journal of Interprofessional Care.* 15 (2) 185 – 190.

Cooper H, Carlisle C, Gibbs T & Watkins C (2001) developing an evidence base for interdisciplinary learning: a systematic review. *Journal of Advanced Nursing.* 35 (2) 228-237.

Coyle J (1999) Understanding dissatisfied user's: developing a framework for comprehending criticism of health care work. *Journal of Advanced Nursing.* 30 (3) 723 – 731.

Davey Smith G, Blane D & Hole D (1998) Adverse economic conditions in childhood and cause specific adult mortality: prospective observational study. *British Medical Journal.* 316 (7145) 1631.

David R & Smith B (1987) Research supplement. Preparing for collaborative working. *British Journal of Special Education.* 14 (1) 19 – 23.

Dehn KL, Snow R & O'Reilly KR (2000) Integration of prevention and car of sexually transmitted infections with family planning services: what is the evidence for public health benefits? *Bulletin of the World Health Organisation.* 78 (5) 628 – 639.

Department of Health (1999) *Modernising Health and Social Services National Priorities Guidance 2000/01 – 2002/03.* Department of Health. London.

Department of Health, Social Service and Public Safety (1999) *Fit for the Future – A New Approach. The Governments Proposals for the future of the Health and Personal Social Security in Northern Ireland. Department of Health and Social Services.*

Department of Health. (1999) *Working Together to Safeguard Children.* The Stationery Office. London.

Department of Health and Children (1999) *Children First. National guidelines for the Protection and Welfare of Children.* The Stationery Office. London.

Department of Health (2000) Quality products database http://www.doh.gov.uk/qualityprotects/qp

Department of Health, Social Service and Public Safety (2001) *Training Needs Analysis.* Personal Development Branch (August).

Department of Health, Social Service and Public Safety (2000b) *An Introduction to Personal Social Services.* Social Services Inspectorate.

Department of Health, Social Service and Public Safety (2001) *DHSSPS Corporate Plan 2001/02 – 2003/04.*

Department of Health, Social Service and Public Safety (2001) *Best Practice – Best Care. A Framework for setting Standards, Delivering Services and Improving Monitoring and Regulation in the HPSS. A Consultation Paper (April, 2001).*

Department of Health, Social Service and Public Safety (2002) *Developing Better services. Modernising Hospitals and Reforming Structures.* (June, 2002).

Department of Health (2002) *HR in the NHS Plan.* Strategic Learning and Research Advisory Group for Health and Social Care (StLAR).

Department of Health (2002) Care Trusts. www.doh.gov.uk/caretrussts/index.htm (accessed 04:02:03).

Department of Health, Social Service and Public Safety (2001) *DHSSPS Corporate Plan 2002/03 – 2004/05.*

Department of Health, Social Service and Public Safety (2003) *From Dependence to Independence. Standards for Social Work Services for Young Disabled Adults.* DHSSPS.

DeSchepper C (1999) Healthier communities through parish nursing. *Health Progress.* 57: 56 – 58.

Dickinson CP, Mateo M, Jackson D & Swartz W (1995) OB-GYN consultants and sharp the birthplace: An exemplar of nurse-midwife and obstetrician interdependence and integration. *Advanced Practice Nurse.* 1 (2) 40 – 48.

Duguid M (1995) Partnerships in health care. *Collegian Journal of the Royal College of Nursing.* 35 – 36.

Easterbrrok L (2002) *Healthy Homes, Healthier Lives. Health Improvement through Housing Related Initiatives and Services.* Care & Repair. England.

Eddy ME & Schermer J (1999) Shadowing; A strategy to strengthen the negotiating style of baccalaureate nursing students. *Journal of Nursing Education.* 38 (8) 364 - 367.

Edwards M (2000) *Partnership arrangements under health act 1999 summary of framework and possibilities.* Kings Fund. London.

Edwards K & Garrety C (1998) Learning to work with social workers. *Nursing Times Learning Curve.* 2 (7) 4-5.

Engelke MK, Britton BP, Burhans L & Hall S (1998) Is there a doctor in the house? Integrating medical education and home health care. *Home Care provider.* 3 (5) 260 – 265.

European Observatory on Health Care Systems. (2002) *Policy brief. Hospitals in a changing Europe.*

Fagin C (1997) How nursing should respond to the third report of the Pew Health Professions Commission. *Online Journal of Issues in Nursing.* December 30.

Farooqi A & Bhavsar M (2001) Project Dil: a co-ordinated primary care and community health promotion programme for reducing risk factors of coronary heart disease amongst the South Asian community of Leicester – experiences and evaluation of the project. *Ethnicity and Health.* 6 (3/4) 265 – 270.

Fellona MO & Rubinstein DeVore L (1999) Oral health services in primary care nursing centers: opportunities for dental hygiene and nursing collaboration. *Journal of Dental Hygiene.* 73 (2) 69 – 77.

Finch J (2000) Interprofessional education and teamworking: a view from the education providers. *British Medical Journal* 321, 1138 - 1140.

Flaherty LT, Garrison EG, Waxman R, Uris PF, Keys SG, Glass-Siegel M & Weist MD (1998) Optimising the roles of school mental health professionals. *Journal of School Health.* 68 (10) 420 – 450.

Fowler P, Hannigan B & Northway R (2000) Community nurses and social workers learning together: a report of an interprofessional education initiative in South Wales. *Health & Social Care in the Community.* 8 (3) 186 – 191.

Frank J & Romeo L (1997) A prescription for ailing GP's. *Care Plan.* June, 19 - 22.

Franklin C & Allen-Meares P (1997) School social workers are a critical part of the link. *Social Work in Education.* 19 (3) 131 -143.

From MA (2001) Creating clinical experiences in a social work agency on aging. *Holistic Nurse Practice.* 14 (4) 67-76.

Glajchen M, Blum D & Calder K (1995) Cancer pain management and the role of social work. Barriers and interventions. *National Association of Social Workers.*

Groves T & Roberts J (1996) Primary care in the United States. *British Medical Journal* 313: 955 - 956.

Golledge J (1998) Is there unnecessary duplication of skills between occupational therapists and physiotherapisttherapists? *British Journal of Occupational Therapy.* 61 (4) 161 – 162.

Goosey D (2002) *Selected Case Studies of Interprofessional Education.* CAIPE. London.

Hacker K & Wessel GL (1998) school-based health centres and school nurses: cementing the collaboration. *Journal of School Health.* 68 (10) 409 – 414.

Hayter J (2000) Day therapy for adolescents: the evolution and practice of a day therapy service. *Young Minds Magazine.* 47, 13 - 17.

Hall P & Weaver L (2001) Interdisciplinary education and teamwork: a long and winding road. *Medical Education.* 35: 867 – 875.

Hann M, Baker D, Hayes J, Wagner A & Barr R. (2001) Methodological issues in the development of a national database for primary care groups and trusts. *Health and Social Care in the Community.* 9 (5) 286 – 293.

Hapgood M & Shaw J (2002) Development of integrated children's services in Exeter: A case study. *MCC: Building Knowledge for Integrated Care.* 10 (5) 29 - 33

Hart C (1999) Keeping teams together. *Nursing Times.* 95 (37) 48 – 49.

Gardner K & Chapple A (1999) Barriers to referral in patients with angina: qualitative study. *British Medical Journal.* 319: 418 – 421.

Gask L, Rogers A, Roland M & Morris D (2000) *Improving Quality. A Practical Guide to the National Service Framework for Mental Health.* National Primary Care Research & Development Centre. University of Manchester.

Geddes M & Benington J (Eds) (2001) L*ocal Partnerships and the Social Exclusion in the European Union. New Forms of Local Social Governance?* Routledge. London.

Hassmiller S (1995) The primary care policy fellowship: An innovative model for interdisciplinary collaboration. *The Journal of Health Administration Education.* 13 (2).

Haughney MGJ, Devennie JC, Macpherson LMD & Mason DK (1998) Integration of primary care dental and medical services: a three-year study. *British Dental Journal.* 184 (7). 343 – 347.

Hawkins JW, Veeder NW & Pearce CW (1998) *Nurse Social Worker Collaboration in Managed Care.* Springer Publishing Company.

Hays R (2001) Rural initiatives at the James Cook University School of Medicine: a vertically integrated regional/rural/remote medical education provider. *Australian Journal of Rural Health.* 9 (suppl.) S2 – S5.

Hayter J (2000) Day therapy for adolescents: the evolution and practice of a day therapy service. *Young Minds Magazine.* 47. pp13 - 17

Hayward M & Porter E (2001) Educating the next generation of health professionals. *Community Practitioner.* 74 (2) 68 – 70.

Henwood M & Hudson B (2000) *Partnership and the NHS Plan: Cooperation or Coercion? The Implications for Social Care.* Nuffield Institute for Health. Leds.

Hibberd PA (1998) The primary/secondary interface. Cross-boundary teamwork – missing link for seamless care? *Journal of Clinical Nursing.* 7: 274 – 282.

Hilton S, Hill A & Jones R (1997) Developing primary care through education. *Family Practice.* 14 (3) 191 – 193.

Hiscock J, Quillan T & Currie N (2000) *Emergency Response Team and Bupa:Two Intermediate Care Facilities in Liverpool.* HaCCRU.

Holtom M (2001) The partnership imperative. Joint working between social services and health. *Journal of Management in Medicine.* 15 (6) 43 - 44.

Howe A (2000) Primary care education for the new NHS: a discussion paper. *Medical Education.* 34: 385 – 390.

Hudson B (2000) Social services and primary care groups: a window of collaborative opportunity? *Health and Social Care in the Community.* 8 (4) 242 – 250.

Hughes L & Lucas J (1997) An evaluation of problem based learning in the multi-professional curriculum for health professionals. *Journal of Interprofessional Care.* 11 (1) 77 – 88.

Hutton H (1999) Primary care groups (news report) *Journal of Nursing Management.* 7: 119 – 121.

Hyer K, Fairchild S, Abraham I, Mezey M & Fulmer F. (2000) Measuring attitudes related to interdisciplinary training: revisiting the Heinemann, Schmitt and Farrell 'attitudes towards health care teams' scale. *Journal of Interprofessional Care.* 14 (3), 249-258.

Iles PA & Auluck A (1990) From organisational to interorganisational development in nursing practice: improving the effectiveness of interdisciplinary teamwork and interagency collaboration. *Journal of Advanced Nursing.* 15, 50 – 58.

Jack R & Mosley S (1997) The client group preferences of diploma in social work students: What are they, do they change and what variables affect them? *British Journal of Social Work.* 27, 893 – 912.

Jackson CL, De Jong I & Oats J (2000) Clinical pathways involving general practice – a new approach to integrated health care? *Australian Health Review.* 23 (21) 88 – 95.

Jenner EA (1998) A case study analysis of nurses' roles, education and training needs associated with patient-focussed care. *Journal of Advanced Nursing.* 27: 1087 – 1095.

Jones RVH (1986) Working Together – Learning Together. *Journal of The Royal College of General Practitioners.* Occasional paper 33.

Jones R & Bartholomew J (2002) General practitioners with special clinical interests: a cross-sectional survey. British *Journal of General Practice.* Oct 2002.

Jones A (2000) the role of practice nurse trainers in raising standards within PCG's. *Nursing Times.* 96 (20) 39.

Kanavos P & McKee M (2000) Cross-boarder issues in the provision of health services: are we moving towards a European health care policy? *J Health Serv Res Policy.* 5 (4) 231 – 236.

Kerwick S, Jones R, Mann A & Goldberg D (1997) Mental healthcare training priorities in general practice. *British Journal of General Practice.* 47, 225 - 227.

Kings Fund (1999) *Regeneration and Mental Health. Training and Work Partners.* Briefing 2. November.

Kvamme OJ, Olesen F & Samuelson M (2001) Improving the interface between primary and secondary care: a statement from the European Working Party on quality in family practice. (EQuiP) *Quality in Health Care.* 10: 33-39.

Lethbridge J & Brookes C (1997) Health promotion in Eastern and central Europe and the newly independent states. *Health Visitor.* 70 (3) 107 – 109.

Littlewood J, Webb E, Beer N & Lazou E (2000) A survey of postgraduate education programmes and research interests of GP's in community trusts in an inner city are. *The Journal of The Royal Society for the Promotion of Health.* 120 (2) 96 – 99.

Local Government Association (2000) *Partnerships with Health. A survey of Local Authorities.* Research Briefing November 2000.

Lopez SA, Torres A & Norwood P (1998) Building partnerships: A successful collaborative experience between Social Work and Education. *National Association of Social Workers. Inc.*

Mac Kinnon JL & MacRae N (1996) Fostering geriatric interdisciplinary collaboration through academic education. *Physical and Occupational Therapy in Geriatrics.* 14 (3) 41 – 49.

Malone C & Mackenzie R (2000) In the know. *Health Service Journal.* Sept 2000. 28 – 29.

Martin V (1999) Working together to develop health service managers. *Journal of Management in Medicine.* 13 (1) 41 – 50.

McColl A, Roderick P, Gabbay J, Smith H & Moore M (1999) Author response letter. *British Medical Journal.* 318: 804 – 805.

Merrow S & Segleman M (1989) Nurse-pharmacist collaboration in clinical nursing education. *Nursing Connections.* 2 (3) 55-63.

Morgan S (1999) *Care About Education. A Joint Training Curriculum for Supporting Children in Public Care.* DfEE. Department of Health.

Moroz A, Prufer N, Rosen Z & Eisenberg C (2000) Important qualities in physiatrists: perceptions of rehabilitation team members and patients. *Arch. Phys Med Rehabil.* 81: 812 -816.

Jones M & Salmon D (2001) The practitioner as policy maker analyst: a study of student reflections of an interprofessional course in higher education. *Journal of Interprofessional Care.* 15 (1) 67 - 77.

National Carers Strategy Project (1999) *Caring About Carers A National Strategy for Carers.* Department of Health.

National Audit Commission (2001) *Hidden Talents: Education and Training for Healthcare Staff in NHS Trusts.* Audit Commission. London.

Neal R & Linnane J (2002) Improving access to continence services: action in Walsall. *British Journal of Community Nursing.* 7 (11) 567 – 578.

Netting FE & Williams FG (1998) Can we prepare geriatric social workers to collaborate in primary car practices? *Journal of Social Work Education.* 34 (2) 195 - 210.

Newton J & Waters V (2001) Community palliative care clinical nurse specialists descriptions of stress in their work. *International Journal of Palliative Nursing.* 7 (11) 531 – 540.

Nicolai LC & Psych M (1997) Win some, lose some: about integration projects of women's health care. *Women's Health Issues.* 7, 2, 88-91.

Nyberg K, Gottval K & Liljestrand J. Midwives and doctors in Sweden: A successful collaboration. *MIDIRS.* 9 (4) 439 – 442.

O'Doherty E, Casson M, Black M, Hasson F & Griffith M (2000) Developing practice with health and social care professionals on smoking and pregnancy in Northern Ireland. *Health Education Journal.* 59, 297 – 307.

Parsell G, Spalding R & Bligh J (1998) Shared goals, shared learning: evaluation of a multi-professional course for undergraduate students. *Medical Education.* 32, 304-311.

Patford J (2001) Educating for cross-disciplinary collaboration: Present trends and future possibilities. *Australian Social Work.* 54 (3) 73 - 82.

Pearson P & Spencer J (Eds) (1997) *Promoting Teamwork in Primary Care. A Research Based approach.* Arnold.

Pirrie A, Wilson V & Stead J (1997) Evaluating multi-disciplinary education work in progress. *Journal of Interprofessional Care.* 11 (2) 228-229.

Pittilo M, Morgan G & Fergy S (2000) Developing Programme Specifications with professional Bodies and Statutory Regulators in Health and Social Care. *Quality Assurance in Education.* 8 (4) 215- 221.

Pittilo RM & Hutchinson L (2002) The enhancement of quality in higher education – implications for health care education and training. – ltsn resources.

Pope R & Graham L (1999) Maternity car of low risk women: identification of continuing education needs. *The Practising Midwife.* 2 (7) 30 – 34.

Poulin JE, Walter CA & Walker JL (1994) Interdisciplinary team membership: A survey of gerontological social workers. *Journal of Gerontologiocal Social Work.* 22 (1/2) 93 – 107.

Powell J, Lovelock R, Bray J & Philip I (1994) Involving consumers in assessing service quality: benefits of using a qualitative approach. *Quality in Health Care.* 2 199-201.

Prestwood S (2003) It's not how big your Primary Care Trusts is – it's what you do with it. *Primary Care Report.Co.Uk.* accessed 13/08/03.

Prosser J (2001) Standard two primary care. *Mental Health Care.* 4 (8) 258 - 261.

Redworth F, Jones-Tatum L & Atkin J (1999) District nurses and home carers 2: collaborative education. *British Journal of Community Nursing.* 4 (10). 538 – 542.

Reeves S (2000) Community-based interprofessional education for medical, nursing and dental students. *Health and Social Care in the Community.* 8 (4) 269 – 276.

Reser B (1998) Role strain among school nurses. Editorial letter *Journal of School Nursing.* 14 (1) 49 - 50.

Rolls L & Coupland K (2002) Improving serious mental illness through interprofessional education. *Journal of Psychiatric and Mental Health Nursing.* 9 317 – 324.

Rooks JP (1998) Unity in midwifery? Reality and alternatives. *Journal of Nurse-Midwifery.* 43 (5) 315 - 319.

Rondeau KV (2000) A response to : " Responses of Canada's healthcare management education programs to health care reform initiatives. *The Journal of Health Administration Education.* 18 (2) 205 – 211.

Pozner A, Hammond J & Ling Ng M (1998) *Working Together. Images of Partnership.* Pavilion Publishing Ltd.

Rummery K & Glendinning C (2000) *Primary Care and Social Services: developing New Partnerships for Older People.* Radcliffe Medical Press.

Saltman RB, Figueras J & Sakellarides C (Eds) (1998) *Critical Challenges for Health Care Reform in Europe.* Open University Press.

Schneider H & Palmer N (2002) Getting to the truth? Researching user views of primary health care. *Health Policy and Planner.* 17 (1) 32-41.

Schaaf RC, Swenson Miller K & Burke J (1995) A collaborative approach to meeting the need for quality personnel training in early intervention. *Occupational Therapy in Health Care.* 9 (2/3) 51 – 73.

Silverman D (2000) *Doing Qualitative Research. A Practical Handbook.* London. Sage.

Sims J, Rink E, Walker R & Pickard L (1997) The introduction of a hospital at home service: a staff perspective. *Journal of Interprofessional Care.* 11 (2) 217 – 224.

Sitzia J & Wood N (1997) Patient satisfaction: A review of the issues and concepts. *Soc. Sci. Med.* 45 (12) 1829 – 1843.

Socolar RRS & Reives P (2002) Factors that facilitate or impede physicians who perform evaluations for child maltreatment. *Child Maltreatment.* 7 (4) 377-381.

Southern DM, Appleby NJ & Young D (2001) Integration from the Australian GP's perspective. *Australian Family Physician.* 30 (2) 182 – 188.

Stalker K, Gilliard J & Downs MG (1999) User perspectives on what works. *Int. J. Geriart. Psychiatry.* 14 120 – 134.

Stark S, Warne T & Street C. (2001) Practice nursing: an evaluation of a training practice initiative. *Nurse Education Today.* 21: 287 – 296.

StLAR (2002) Joint Ministerial Review of the Role of Primary Care Trusts in Relation to Learning and Research in the New NHS. www.doh.gov.uk/hrinthenhs/learning/ section4a/Primary Care Trusts-review-final-stlar-paper-rest.doc (accessed February 03).

Stobbs P (1999) *Making it Work Together. Advice on Joint Initiatives Between Education and Social Services Departments.* National Children's Bureau.

Sullivan H & Skelcher C (2002) *Working Across Boundaries: Collaboration in Public Services.* Palgrave Macmillan. Location.

Sweeney K, Stead J & Cosford L (2000) Evidence-based practice: Can this help joint working? *Managing Community Care.* 8 (5) 21 – 27.

Tinsley JA, Sutor B & Agerter DC (2000) Educational links between psychiatry and family practice. *General Hospital Psychiatry.* 22: 62 – 65.

Westbrook LO & Schultz PR (2000) From theory to practice: Community health nursing in a public health neighbourhood team. *Adv. Nuts Sci.* 23 (2) 50 – 61.

Whittington C & Bell L (2001) Learning for interprofessional and inter-agency practice in the new social work curriculum: evidence from an earlier research study. *Journal of Interprofessional Care.* 15 (2) 153 – 169.

Wilcock PM & Headrick L (2000) Interprofessional learning for the improvement of health care: why bother? *Journal of Interprofessional Care.* 14 (2).

Williams B, Coyle J & Healy D (1998) The meaning of patient satisfaction: An explanation of high reported levels. *Soc. Sci. Med.* 47 (9) 1351 – 1359.

Wills K & Case-Smith J (1995) Perceptions and experiences of occupational therapists in rural schools. *American Journal of Occupational Therapy.* 50 (5) 370 – 379.

Wilson J (1997) Integrated care management. *Nursing Management.* 4 (7) 18 - 19.

Woods ER, Samples CL, Melchiono MW, Keenan PM, Fox DJ, Chase LH, Tierney S, Price VA, Paradise JE, O'Brein RF, Mansfield CJ, Brooke RA, Allen D & Goodman E (1998) Boston HAPPENS Program. A model of health care for HIV-positive, homeless and at-risk youth. *Journal of Adolescent Health.* 23S: 37 – 48.

World Health Organisation, Division of Diarrhoeal and Acute Respiratory Disease Control. (1995) Integrated management of the sick child. *Bulletin of the World Health Organisation.* 73 (6) 735 – 740.

Wukasch R N , Blue C L & Overbay J (2000) A Curriculum Model for an Integrated Senior Year Clinical Experience. *Nursing and Health Care Perspectives.* 21 (2) 71 – 75.

Notes

Notes

Notes