

FutureCare

A Training Needs Analysis of the Out of Hospital Workforce across Thames Valley

FACULTY OF SOCIETY & HEALTH

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1.0 Executive Summary

This project was commissioned by the Oxford Academic Health Science Network (Oxford AHSN) and Health Education Thames Valley (HETV). They sought further clarity about the training needs of the community and primary care workforce as they move towards providing more integrated care, and more care in the community. This report will help inform organisational decisions and strategies for the development of a future workforce that is truly fit-for-purpose with the ability to provide integrated, person-centred care closer to home. As the landscape of care continues to change over the next few years, it will be increasingly important to make sure there is the right workforce, trained to embrace roles that ensure patient care remains robust during the reformation of clinical services; bringing care closer to home.

Co-ordinating services to provide care to patients is difficult and the patient experience is often fragmented with a sense of 'falling through the gap' (DH, 2013). In addition to this experience, the population is aging and presenting to services with more complex needs (Oliver, Foot & Humphries, 2014). Patient care in the community is becoming more integrated, but there are significant challenges including services with differing structures, processes, commissioning and professional expectations. One way to implement these changes is to alter the training and education of the workforce (CfWI, 2013). There have been a number of recent reviews into the healthcare workforce (Cavendish, 2014; Willis, 2012; 2015), with calls for greater community focus, inter-professional learning opportunities, more appreciation for the work undertaken by health and social care assistants, and more flexible career and qualification pathways.

This project used a mixed methods approach including three phases (a timeline is outlined in Appendix iii): a questionnaire of community/primary/social care workforce; mixed focus groups of frontline clinicians; and semi-structured interviews with key informants (e.g. learning and development or integrated care leads). The project scope included a total of 9 NHS providers, 11 CCGs, 9 local authorities, as well as independent contractors such as care home staff and GPs. This scope presented access and engagement challenges, requiring sustained engagement to collect data from relevant participants. There were a total of 534 people engaged throughout the three phases, with a wide range of nurses, GPs and AHPs represented. Social

workers were challenging to access for the survey, so as a result the views of social care were sought deliberately during the interview phase.

The findings suggest that participants were concerned with communication (in particular the communication between organisations) and incompatible IT systems. The poor understanding of roles between services was identified, with suggestions for rotational or joint roles and inter-disciplinary training as possible solutions. The suggestion of a 'New Who' was made, with this new role residing in GP practices with a multi-professional scope and significant risk management and assessment skills. This could be using the model of specialist paramedic, nurse or clinical social worker, as they will need to access both health and social care arenas to provide a more co-ordinated care programme to help patients stay in the community with more complex needs. There were capacity issues noted, particularly in community nursing and social care. There were gaps noted in skill mix and knowledge, with requests for long term conditions, diabetes and COPD knowledge, in particular. A more consistent and considered use and support for care assistants was also suggested. Participants suggested that leaders and managers need to more visibly support the integration of care, and universities should be able to respond more quickly to changes in service needs to help with transforming the workforce.

The project makes a number of key recommendations including:

1. More inter-professional education and training opportunities are needed.
2. Inter-professional modules are recommended during pre-qualifying education for professionals.
3. Increased co-location of shared services, particularly of social and community care services.
4. Introducing and supporting more rotational and joint posts between community and hospital services.
5. Supporting and developing career pathways for community and practice nurses¹.

¹ It is noted that HEE have a draft District and Practice Nurse pathway under consideration, and it is recommended that this is implemented at pace once approved.

6. Utilising the *Care Certificate* and *Advanced Care Certificate* to develop the career pathway and application of HCAs.
7. Development of a 'New Who', a role that undertakes more involved work with vulnerable or frail patients within general practice surgeries. This role should include a cross-professional approach, senior clinical decision-making ability, and access to both health and social care records and referral facilities.
8. Improving communication between organisations, most importantly the flow of IT information between services and clinician's knowledge of services in other organisations. Improving web-based information for many services can help achieve this.
9. Developing of specific knowledge and skills, particularly of long term conditions, diabetes, mental health and COPD for community staff.
10. A further review of the workforce is recommended in 2-3 years to determine whether there have been changes to workforce knowledge, skills and service delivery.

A more detailed list of recommendations can be found on pages 73 - 75.

2.0 Introduction

This report considers a variety of topics to explore how a group of different workforces need to alter to provide more integrated care in the community, out of hospitals.

People are living longer with more complex needs, and this is creating pressure on the systems providing care. The historic divisions between health and social care, and acute and primary care are no longer suitable for providing the care that people need. There are additional drivers, such as reducing budgets, and rising costs that are encouraging innovation. Patients have higher expectations of services, and are expecting services to be available outside of working hours.

This project sought to understand what the workforces of health and social care need to change the way they deliver care. It engaged with community health, primary health, acute health, social care, and voluntary agencies to answer this question:

What does the Thames Valley health and social care workforce need to provide more integrated care 'out of hospital'?

Some specific aims of this project were:

- To understand the workforce training needs of the workforce, specifically in relation to integrated care.
- To explore the level and quality of integrated working across the region.
- To identify areas of best practice across the region.
- To identify areas of particular pressure or need.
- To make a series of recommendations for the region to improve and encourage care that can be delivered closer to home, taking into account the specific locality pressures and needs.

The Oxford AHSN and HETV commissioned Buckinghamshire New University to undertake this evaluation to inform their workforce strategies going forward. This report therefore is specifically related to the Thames Valley region, and only considers national or international information as it may be related to the local experience.

This evaluation used a mixed methods approach in three phases to answer the above question and aims. Phase one included a broad survey of relevant staff (estimated to be between 42-50,000 staff) across acute, primary and community health, social care and voluntary/independent organisations. Phase two included focus groups of mixed clinicians, and phase three targeted interviews with key informants (such as integrated care, learning and development or service improvement leads). Because of the mixed methods nature of the project, this report uses the terms *participants* for people included in focus groups and interviews and *respondents* for those people that responded to the survey, when the samples are combined, *participants* is used.

When reading this report, some caveats should be considered:

- The number of organisations considered in the scope (described in more detail in Chapter 4 – Project Design), which caused access and engagement challenges.
- The different sectors engaged, requiring different language and recruitment strategies. These differences required relying on dissemination of recruitment materials by managers to their staff, and requesting managers to identify potential staff to complete surveys or attend data gathering events. This dissected recruitment strategy results in lower response rates, but was necessary given the range of organisations involved.
- The changing nature of service provision in community health and social care delivery. For example, during the project timescale NHS England announced 'Vanguard Sites' (more detail on page 11), and a further round of Better Care Fund monies, which will continue to impact on service delivery.

This report is structured as follows: Chapter 3 includes a literature review key recent texts and research findings which are relevant to a study about integrated care and the training needs of the workforces; Chapter 4 describes the methods used; Chapter 5 includes findings from both interview/focus groups and survey; Chapter 6 outlines the recommendations, best practice examples from the region, and the limitations of the project.

3.0 Literature Review

Healthcare reform over the past twenty years has mandated many changes in patient management and service delivery, with managed care becoming the prevailing form of organised healthcare (Edwards, 2014). Reforms attempt to respond to the many challenges arising from changing demographics and increased demand for health and social care services. Current policies appear to have placed a disproportionate emphasis upon competition at the most vulnerable interface between primary and secondary healthcare services (Irani 2008) (*cf* practice based commissioning, payment by results). Simultaneously, the health and social care services face key challenges to increase clinical productivity, improve services for prevention, and the management of long-term conditions.

The number of people dying before age 65 has fallen from 48% in 1948 when the NHS was founded, to 14% in 2011 (Oliver *et al*, 2014). Furthermore, the number of people now aged over 85 years has doubled in the past three decades, with one in five people predicted to be over 85 by 2030 (Office for National Statistics, 2013). In short, the population is aging and presents with more complex needs than previously (Oliver, Foot & Humphries, 2014). While many people stay healthy, active and independent for longer, others will likely live with complex co-morbidities, disability and frailty as they age (Spiker & MacInnes, 2013), and will increasingly require treatment in the community. Changing patterns of diseases, technological advances, and demographic changes have driven these changes in life expectancy and outcomes (Robertson *et al*, 2014), but are to be managed using the same or less resources due to fiscal austerity measures and scrutiny (Robertson *et al*, 2014). Kasteridis *et al* (2015) assert multi-morbidity rather than age is the key driver of health and social care costs are associated. The number of chronic conditions that a person has is generally the most important predictor of costs. This is an important consideration when redesigning healthcare services because it reduces the information requirements for the design and calculation of capitated budgets to support integrated care, allowing budgets to be constructed in localities that are able to count the number of conditions a person has (Kasteridis *et al*, 2015).

Increasingly, people who have complex and ongoing care needs require support from multiple agencies and various professionals to maintain independent living

(Lehnert *et al*, 2011). Currently, responsibility by a single agency to manage such cases has been recognized as elusive, fragmented and uncoordinated, with individuals and their families left to navigate and negotiate through the system as best they can (Lehnert *et al* 2011). Patients also expect a different level and type of service than previously, with requests for 24/7 care and increased accountability for patient experience (The Kings Fund, 2012). As a result, the promise of integrated care services as a means of reforming healthcare delivery has to date proved challenging and problematic.

There has been a shared acknowledgement of these challenges for health and social care services. As a result, politicians, clinicians and managers of NHS health and social care services propose a common ambition; the development of more integrated care, and the delivery of more care in primary and community settings (Ham *et al* 2013). They recognise the need to reconfigure and reform delivery systems to meet these challenges. Similarly, political changes following the 2010 election prompted reform of healthcare delivery with the expectation to change: GP commissioning; strengthening public and patient engagement; clarity on the clinical evidence base; and consistency with patient choice (Curry *et al* 2013).

The following sections consider what we understand by integrated care, the financial costs associated with its delivery, and an overview of the evidence of the education and training required to support changes to care delivery. The intention is to inform and support the transformation of services because there is a requirement to radically change the way we invest resources; the concept of integrated care is purported to be the medium to achieve this.

3.1 Why Implement Integrated Care?

Integrated care (and the transformation of care delivery) arose from longstanding concerns about the organisation of care across three sectors of healthcare (primary, secondary and tertiary) (Shaw *et al*, 2011). The call for integrated health and social care services is not new, but does appear to becoming more insistent and determined (DH, 2013; Coalition for collaborative care, 2014; Thomson, 2014). Organisational separations between health and adult social care has added to the fragmentation of services for users. These separations have caused a number of

issues for service delivery: a lack of service co-ordination for users; structural and cultural isolation of generalist from specialist medicine; and divisions between adult social care and health care (Shaw *et al* 2011). Integrated care is a term used to reflect a service response to these concerns. Proponents of integrated care state that it will improve the patient experience, achieve greater efficiency and value from health care delivery systems, and improve the co-ordination of care to an increasing elderly population with increasing incidence of chronic disease. The term is not universally defined, as Armitage *et al* (2009) identifies 175 definitions and concepts of integrated care, primarily being recognised as an organising principle for care delivery.

Successive changes in healthcare policy over the past 60 years attempted to integrate care differently. Chronologically, in the 1960's the term 'multidisciplinary care' was used; 'partnership working' in the 1970's; and 'shared care and disease management' in the 1980's and 1990's (Stein and Reider, 2009). Currently the term 'integrated care' can be most helpfully defined as a range of diverse initiatives seeking to address service and care fragmentation, whilst they may differ in underlying scope and values. Between 1997 and 2010 the Labour Government emphasised the need for greater integration as a drive towards improved quality, efficiency and patient outcomes, manifested as 'patient-centred care', 'shared decision-making' and 'integrated care pathways' (Shaw *et al*, 2011).

More recently, policies provide further opportunities to extend integrated care, and propose working towards an NHS that is less insular and fragmented and promotes working across health and social care boundaries, in addition to between hospitals and practices (DoH 2010). The *Long Term Conditions Compendium of Information*, 3rd ed. (DH, 2012) recommended the introduction of 'neighbourhood care teams' which including community services, AHPs, social services, specialist nurses and linked to GP practices. The Department of Health, Association of Directors of Adult Social Services, NHS England and Health Education England (plus 8 other national bodies) re-stated their support for integrated care in 2013 with a paper outlining their 'shared commitment' (National Collaboration for Integrated Care and Support, 2013). This paper outlines that national changes will be led by local initiatives, and will require workforce training and development, and states this as one of its key aims:

'To stimulate working cultures that actively encourage integrated care and support, we commit to supporting localities in workforce training and organisational development, working with relevant Local Education and Training Boards (LETBs).' (NCICS, 2013: 36).

In the strategy document *Five Year Forward View* (2014), NHS England suggest one of the three priorities is to 'break down barriers in how care is provided, between family doctors and hospitals, between physical and mental health, between health and social care' (NHS England, 2014: 3). The Willis review, *Shape of Caring* (Willis, 2015), into nursing and healthcare assistant education and training, suggests:

'There will need to be an increase in the number of registered nurses and care assistants supporting a local community through the provision of an integrated service model that is flexible enough in order to meet the anticipated changes in service demand and to deliver the majority of safe and effective care outside hospitals.' (Willis, 2015: 21).

As a mechanism for supporting the implementation of the *Five Year Forward View* (NHS England, 2014) selected 29 'Vanguard Sites' across England². These are separated into sites focusing on three areas: integrating primary and acute care; multispecialty community providers; and enhanced care in care homes. None of these 29 sites are in the Thames Valley area, but the outcomes of these evaluations should be helpful in identifying applicable innovation going forward.

In addition to these reviews of nursing and HCAs, the Royal College of GPs and The College of Social Work recently published the joint report *GPs and Social Workers: Partners for Better Care: Delivering health and social care integration together* (RCGP & TCSW, 2014) advocating 'knocking down the "Berlin Wall"' divide between the two cultures of health and social care. The report suggests that 'Social workers and GPs regularly fail to understand each other's unique role, responsibilities and perspectives, barriers that may have to be dismantled through inter-professional education, co-location and informal networking, among other things' (ibid, p. 8).

Fragmentation of services can arise from poorly co-ordinated services, delivered by a variety of care providers. This type of provision can make navigation of the system difficult for both users and providers of the service (Edwards, 2014). The former Secretary of State for Health, Frank Dobson, once called this divide the 'Berlin Wall' (Dickinson, 2014). The ambition of the integration of services is to deliver services

² <http://www.england.nhs.uk/ourwork/futurehhs/5yfv-ch3/new-care-models/>

across providers with minimal duplication and disruption and with high quality outcomes and patient experience (Edwards, 2014). It is essential to align methods to goals across professional groups, teams and organisations for service transformation. Types of integration and allied integrative processes are well documented in the literature. While useful in describing different aspects of integrated care, the range of sources also show the multifaceted nature of integrated care, and can lead to confusion (Curry *et al* 2013).

The need to build multidisciplinary care for people with complex needs is essential, and if managed successfully will reduce hospital care and simultaneously improve patients' quality of life. Effective care co-ordination requires local community engagement and working closely with multidisciplinary teams (Goodwin *et al* 2013). Proponents of integrated care suggest simplifying services with the creation of community teams using a shared set of skills (with the inclusion of some staff with specialist skills to provide input through education and support in complex cases). These simplifications are challenged by weak communication networks/connections between primary care and hospital services (Edwards, 2014). Key features of this model necessitate a coherent geography and organisational leaders that promote high-quality communication and working relationships between staff, both internally and externally. Importantly, the implications of the model is yet unproven (Ham & Walsh, 2013). As financial and service pressures facing the NHS and local government intensify, the need to transform and improve service delivery in this way and efficiently utilise resources effectively while meeting patients expectations, has never been more challenging (Bennett & Humphries, 2014). The pooling of resources across health and social care boundaries is important in realising this service transformation (Ham & Walsh, 2013).

Locally, the Thames Valley region includes nine boroughs and has 2.3 million residents. HETV's vision for integrated care is 'to ensure that people's experience of healthcare across the Thames Valley is of treatment and care that is integrated, provided by teams that are patient-centred and treat people in a holistic way' (HETV, 2013: 13). Two of the six strategic themes of the Workforce Development Strategy relate to integrated care with 'Integrated, person-centred care' and 'Care closer to home'. Some priorities in the Strategy are for:

1. Improved skills and competencies to care for the whole person (mental and physical health needs, social needs and co-morbidities)
2. Individuals who are flexible and adapt to new requirements
3. Training placement opportunities in different sectors
4. More integrated teams, improved team working (including leadership and management skills)

These aims, themes and strategies suggest a local desire to provide more integrated care, closer to home.

The Oxford Academic Health Science Network has 'Out of Hospital Care' as one of its 10 clinical networks with an aim to link together 'service providers, clinical innovators and researchers across the Oxford AHSN region to understand how we can provide a health and social care model that meets the needs of our changing population' (AHSN, n.d.a). The AHSN developed a service and innovation map³ covering the region, and have a key aim to use patient and public involvement 'to answer the question of how a modern care system should respond to the challenge of sudden illness in patients who live with frailty – which can be physical, cognitive or social frailty' (AHSN, n.d.b).

3.2 Outcomes of Integrated Care

Currently the patterns of demand illustrate that a small number of patients consume a very large proportion of total resources (Curry *et al*, 2013). Edwards (2013) identified that in some places the average spend per person was 81 times higher for those in a high risk category compared with those in a low risk category. Furthermore, people in the high risk category had on average seven times more emergency admissions, three times the length of stay, two and a half times more primary care contacts, and twenty two more contacts with community health systems (Bestsenny *et al*, 2013). Similarly, high risk category patients receive 54 per cent of the total social care spend compared with 14 per cent of those at moderate risk.

³ <http://www.oxfordahsn.org/our-work/clinical-networks/out-of-hospital-care/services-and-innovations-map/>

Despite the attractive potential of integrated care, evidence demonstrating its effectiveness remains mixed. In the United States (US) some large-scale examples demonstrating reduced hospital admissions and readmissions are presented in the literature (Curry *et al*, 2013). Reported success within the United Kingdom (UK), demonstrate reduced emergency bed stays by 24% for over 75s and 32% for over 85s (Bestsenny *et al*, 2013). Conversely, a recent evaluation of sixteen integrated care organisations across England produced equivocal results, with no demonstration of reduced emergency admissions (Curry *et al*, 2013). A US Evercare project trialled in England in 2005 is not dissimilar, although was scored highly for patient satisfaction (Singh and Ham, 2006).

Ling *et al* (2012) argue that the size and complexity of the intervention is important to determine progress and is complicated when organisations do not have full control of the full range of activities involved in the service delivery, largely because of communication barriers. Securing professional engagement across integrated care pilot areas can present barriers to implementation, for example when: professional groups felt marginalised; GPs were reluctant to engage; staff felt they were inadequately prepared; training to support specific change was absent, and if leadership was ineffective (Ling, *et al*, 2012).

Ouwens *et al* (2005) systematic review identified effect outcomes of integrated care and stated that functional health status was the most frequently reported. Furthermore only one study showed a positive outcome. Seven of thirteen reviews demonstrated a trend for reduced hospital length of stay, and for readmissions, although only significant in three reviews. The only positive significant pooled effect on mortality was found in organised in-patient stroke care, and, in four of seven reviews that had performed economic analyses, any financial benefits that were identified were based on a small number of studies (Ouwens *et al*, 2005).

When evaluating seven international case studies, Goodwin *et al* (2014) reported variance in the care models being implemented, and demonstrated that older people with complex health and social care needs were managed in different ways. Some models were designed to improve user experience and home-based independence through greater continuity of care between health care professionals, while other models had a more explicit focus to reduce utilisation rates in hospital and home

care, in order to reduce costs (Goodwin *et al*, 2014). All seven programmes recognised that improved co-ordination of care aimed to improve and elicit more cost effective outcomes. This was not always the observed outcome, arguably because none of the professionals working within the case studies had access to fully shared electronic patient records, compromising effective communication. Edwards *et al* (2014) supports the need for effective communication, arguing that delayed transfers of care to the community arise because of missed opportunities. These were said to occur as a consequence of poor co-ordination, recognition and communication between discharge teams, and the ability to respond promptly.

Vroomen *et al*'s (2012) US study compared a multidisciplinary integrated care model for residential homes to usual care, and found costs were higher in the residential group to the usual group, concluding integrated care was not cost effective. In trying to make sense of the results they argued that differences in quality indicators, additional costs associated with travel to secondary care, and the amount of money decision-makers are prepared to spend on care, affected the results. Conversely, a similar study in New Zealand found comparable costs between the residential care and usual care (Brown *et al*, 2009).

A north west London pilot approach involving two hospitals, two mental health providers and three community health care service providers, five municipal providers of social care, two non-governmental organisations and 103 GPs, aimed to improve health outcomes and reduce unnecessary hospital admissions by proactively managing people living with diabetes, and/or those aged over 75 years. The aim proposed was to create greater access to integrated care outside hospital by enabling effective working of professionals across organisations (Curry *et al*, 2013). Results demonstrated that while engagement and commitment to the project was high the complex nature of governance arrangements gave rise to accountability issues and clarity of decision making. Furthermore, while the vision and broad principles were seen as timely and positive by health and social care professionals, active engagement by clinicians was variable (Curry *et al*, 2013). Results also indicated that 56% of professionals were dissatisfied with the integration particularly in relation to information technology systems (IT) and other clinical records. Increased face-to-face contact with professionals; enhanced inter-professional

learning and improved clinical knowledge were reported as positives, while dissatisfaction with the number of meetings, time commitment and the financial costs of these were seen as barriers. Other reported outcomes included: a lack of input from nurses and social workers in the presentation of cases; a slow care planning process; no real differences in the level of emergency admissions; improved inter-professional communication; and a better relationship between the user and the GP were also reported (Curry *et al*, 2013).

Bennett & Humphries (2014) reported that areas with well-developed, integrated services for older people were found to have: lowered readmission rates; lower rates of hospital bed use; and, in areas with low bed use, the patient experience was good. A further pilot study in Torbay, that developed an integrated health and social care economy reported: a reduction in the number of delayed transfers of care from hospital; reduced emergency bed day use for over 85s by 32%, and for over 65s to the lowest in the region, at 1920 per 1000 population compared to an average of 2698 per population 2009/10 (Thistlewaite, 2011). This latter study received 'Better Care' government funding that was provided to support the transformation and integration of health and social care services (Bennett & Humphries, 2014) using new and existing CCG resources.

The Torbay pilot study was useful in providing an insight into the early implementation of a large-scale change, and the components required to establish integrated care successfully. Behavioural change by professionals was modest and demonstrated the need to more fully engage both professionals and patients, while balancing this with the need to develop more streamlined decision making and governance processes. In so doing, the project reinforces the notion that complex change within the NHS takes time to achieve due to the density of the task. Addressing these issues requires a demanding set of service redesign changes (Philp, 2012). The success of transforming healthcare to offer improved out of hospital care necessitates the balancing of skills between professionals providing and supporting this model of care, and therefore the assessment of training needs is essential.

3.3 Training Needs

Health Education England's (2014) mandate outlined priorities for workforce planning, education and training, and the resources available to support this. An increased focus on managing complex conditions using the skills of the generalist and the movement of care outside dedicated areas was proposed together with closer links to the social care sector. Development of a flexible primary care workforce that possesses greater generalist skills to support community health and preventative services was identified as a priority (HEE, 2014). NHS England's *Five Year Forward View* (2014) outlines that it will support the development, training and implementation of a modern workforce that is 'flexible' and 'future-proof', which will require new ways of training to implement these different models of working.

It is essential to commission a workforce that is fit for purpose, and represents value for money while providing a return on investment. Importantly, the nature of disease and innovations in care need to be considered when preparing the workforce to meet patient expectations. Training needs analysis facilitates workforce change because it seeks to identify specific problem areas in organisations including: management support; develops data for evaluation; and determines the cost and benefits of training (Brown, 2002). There are suggestions that workforce redesign will be a major part of the challenge to provide more integrated care (CfWI, 2013, 2014; Dodd and Allen, 2014).

Recently, there have been a number of high-profile reviews into education and training of healthcare staff. *Quality with Compassion* (Willis, 2012), the report of the Willis Commission into nursing education, suggests that the workforce is changing, with the need for more care provided in the community. This change requires more community placements, more inter-professional learning (both prior to qualification and as continuing professional development). There are also concerns that nursing needs clearer career pathways, particularly in the community, to allow for a greater diversity of directions for nursing careers. *The Cavendish Review* (Cavendish, 2014), whilst not solely focussed on the training and education of healthcare assistants (HCAs) and support workers, did explore this area in some depth. This review found a huge number of HCAs providing care in health, but also that the 'social care support workforce dwarfs that of health' (Cavendish, 2014: 6). It also found that the

NHS tends to treat nurses and HCAs as separate workforces, with a need to determine how changes in education in one area (such as the introduction of graduate standard for nurses) will change the nature of career progression and work expectations for HCAs. There was a concern noted in the Review that HCAs and support workers are not able to have the same career progression opportunities that may have been available previously, with a call for 'bridging programmes' and a robust career framework for carers. The review recommended a nationally recognised *Care Certificate* in order to assist service providers to train, manage and support the largest part of their workforces. The Certificate has been piloted by Health Education England, Skills for Care and Skills for Health, and is due to be implemented nationally throughout 2015 (HEE, n.d.).

Both of these reviews have been updated by the recent Willis review (Willis, 2015), *Shape of Caring*. This review into nursing and HCAs education and training describes developing the workforce to work out of hospitals, with a need for increased leadership, advanced knowledge and practice skills, such as prescribing, diagnostic and clinical decision-making. It also describes that the career pathways of nurses and HCAs can be too rigid, with calls for greater generic knowledge, and more flexible roles and pathways. If care is to be delivered more within the community, there are needs to resolve the workforce knowledge and skillset needs, in order to be able to safely manage this change.

Training needs analyses identify the knowledge, skills, and abilities staff require to meet organisational developments and improve performance. Budget restrictions and a lack of progression and organisation in staff education, together with variations in the knowledge and skills of staff can be problematic in identifying and supporting appropriate training across professional disciplines (Staniland, 2011). Supportive structures need to be recognised by management if effective training to support new innovations is to succeed (Staniland, 2011). These include, but are not exclusive to: formal guidelines for study leave allocation; the allocation of adequate resources; recognition of mandatory training separate to continuing professional development; balancing the needs of the service and increasing demands on time; and, a record of training undertaken by staff within the organisation. Systematic collation of training needs can then facilitate the identification of gaps with the organisational demands,

determine the implications for training and education for all professionals, and ensure the right quality and quantity of resources needed are recognised and provided.

3.4 Conclusion

The need to improve the treatment and management of long-term conditions is a major priority facing health and social care services. Recognition of the care required to support people to live with long-term conditions will require a radical re-design of service, and must involve patient input (Coulter *et al*, 2013). The numbers of people living with multiple complex conditions is projected to rise. A shift in thinking from high cost, reactive and hospital led care towards preventative, proactive care based closer to home that focuses on wellbeing, responsiveness and quality of life has been identified (Coulter *et al*, 2013). Integrated care provides an opportunity for this to happen, and requires understanding of the demand for healthcare, the engagement of clinicians and healthcare staff across all disciplines and across health and social care, and necessitates change to the workforce from within.

Evidence of pilot studies (Bardsley *et al*, 2013; Brown *et al*, 2009; Coulter *et al*, 2013; Curry *et al*, 2013) demonstrate that there is no single approach to service transformation. Challenges to developing these services include, but are not exclusive to: the need for strong leadership and a culture receptive to change; powerful partnerships between clinicians and commissioners; a provider organisation that supports service innovation; workforce capacity; a workforce that spans secondary, primary and community care; clear clinical governance arrangements; financial incentives and evaluation (Robertson *et al*, 2014). Furthermore, there is a necessity for agreed funding rather than payment by results (previously reported as a barrier), to enable joint working across sectors. Current evidence supports a shift to out-of-hospital care that may not yield savings because we do not yet completely understand the cost implications of transforming care delivery (Robertson *et al*, 2014). There remains uncertainty to unmet demand and the impact on costs of historic service provision and the scale of the innovation.

What is certain is that training and education is a key factor for changing service delivery, and is integral to meet the specific requirements of new initiatives like integrated care. The identification of what training and education is required needs more research in order to better understand the link between inter-professional training and integration (Institute for Public Care, 2013). Training is a key factor in relation to changing roles and responsibilities because of the challenges it brings, especially when it threatens professional identities. Bereton *et al* (2012) identified that training and education increase the chances of successful staff engagement; however for this to be successful it requires specific, focussed and effective investment.

4.0 Project Design

The project was designed to analyse the training needs of the ‘out of hospital’ workforce across the Thames Valley region. This workforce was defined as services that work in community health, social care (related to adults), primary care/GP practices, voluntary and charitable services, and acute hospital care with outreach or community-focus (such as discharge services). The project used a *sequential mixed methods* design (Creswell and Plano Clark, 2011), which suggests using a variety of data collection tools sequentially to answer an overarching question. This allowed the different findings as *triangulation* to provide a deeper and more holistic analysis (Mertens and Hesse-Biber, 2012).

4.1 Geographic and organisational scope

Geographically, the region includes Buckinghamshire, Oxfordshire, Milton Keynes and Berkshire’s six unitary authorities (Bracknell Forest, Reading, Slough, West Berkshire, Windsor and Maidenhead, and Wokingham). Organisations do not consistently fit within these political boundaries, with some services provided as a portion of services from outside the area (such as Milton Keynes community health provided by North West London NHS Foundation Trust, and Heatherwood and Wexham Park Hospitals provided by Frimley Park NHS Foundation Trust). Some of the clinical commissioning groups have joined to form collaboratives (such as: Berkshire West Federation, comprised of Newbury, North and West Reading, South Reading and Wokingham CCGs; and Berkshire East Federation, comprised of Windsor, Ascot and Maidenhead, Slough, and Bracknell and Ascot CCGs).

The project scope included a total of 9 NHS providers, 11 CCGs, and 9 local authorities. There were a number of independent contractors engaged during the project, and they are not represented by the organisations, requiring engagement through professional and service deliver networks. The organisations are outlined in relation to geography below:

- Oxfordshire
 - Oxford University Hospitals NHS Foundation Trust
 - Oxford Health NHS Foundation Trust
 - Oxfordshire County Council
 - Oxfordshire CCG
- Buckinghamshire

- Buckinghamshire Healthcare NHS Trust
- Buckinghamshire County Council
- Chiltern CCG
- Aylesbury Vale CCG
- Milton Keynes
 - Central and Northwest London NHS Foundation Trust
 - Milton Keynes Council
 - Milton Keynes CCG
- Berkshire
 - Royal Berkshire Healthcare NHS Foundation Trust
 - Berkshire Healthcare NHS Foundation Trust
 - Frimley Park NHS Foundation Trust
 - Berkshire West Federation CCGs
 - Berkshire East Federation CCGs
 - 6 Unitary Authorities
 - Bracknell Forest Council
 - Reading Council
 - Slough Council
 - West Berkshire Council
 - Windsor and Maidenhead Council
 - Wokingham Council
- South Central Ambulance Service

4.2 Samples

The different data gathering tools required different groups of participants. The samples were selected or recruited to provide as wide a distribution as possible across the region and services. Given the scope of the project and the number of organisations, this required a range of recruitment strategies. The project team used stakeholder engagement events and meetings to connect with the different organisations and various parts of the workforce. This included professional networks like the GP deanery, the Learning Environment Leads network, and the Practice Nurse network. There was a launch event held on 18 November 2014 with 224 professionals invited, with several from each organisation, including engagement with General Practice colleagues (via CCGs and GP Deanery). This event was to engage organisations and outline the project, with participation expectations outlined.

The roles sought for survey and focus group responses were:

- GP or other community medical professional
- Practice nurse
- Community or district nurse

- Health care assistant
- Social worker (adult social care – older people or learning disability teams)
- Allied health professionals
 - Occupational Therapist
 - Physiotherapist
 - Paramedic
 - Pharmacist

The focus group participation included a request to have a mixed group of attendees, in order to facilitate discussion.

The interview sample was purposively selected, and the roles sought were leads or strategic managers of education, service improvement, community health, public health, or integrated care. Because there was a range of organisations in the project, these roles varied in title and seniority, and profession.

The table below outlines the samples from each phase of data gathering. A more detailed outline can be found at Appendix ii.

Role	Launch	Focus Groups	Survey	Interviews	Total
Nurse/midwife *	2	22	211	1	236
Doctor **	1	3	94	0	98
AHPs ⁺	4	8	68	0	81
Social Worker	1	0	15	2	17
L&D lead/specialist	6	8	7	5	26
HCA/assistant ⁺⁺	1	3	40	0	44
Other (including health scientist)	4	0	26	2 (integrated care leads)	32
Total	19	44	461	10	534

*Nurse/midwives include: Community/District, Practice, School Nurses, midwives/community midwives and Health Visitors, including senior nurse managers

**Doctors include: GPs, Paediatric, Gerontology, and Psychiatric consultants including GP commissioners

⁺AHPs include: Occupational therapists, physio therapists, paramedics, dieticians, pharmacists, podiatrists, speech and language therapists, clinical psychologists

⁺⁺HCA/assistants include: care workers/assistants, social work and health care assistants, physio technician, rehabilitation and therapy assistant, emergency nurse assistant and senior administrator

4.3 Data collection

The project used three methods of data collection: an online survey; focus groups (preliminary and validating); and one-to-one interviews.

4.3.1 Survey

The survey included 47 questions, 5 qualitative and 32 quantitative questions. The 32 quantitative questions included 2 Likert-scale and 30 multiple-choice questions. Survey questions were designed using input from the Launch event (18 November 2014, with each organisation in the scope invited), as well as from findings generated by the preliminary focus group discussions (February 2015). The survey questions were piloted with a range of professionals including community nurses, social workers and HCAs. The launch event included senior learning leads, commissioners, social care and AHP attendees, and the preliminary focus groups included community nurses, AHPs, discharge nurses, GPs, senior nurse managers and learning development leads. This range of attendees allowed for a wide-ranging set of questions to be developed in response to the suggestions.

The survey was constructed using Bristol Online Survey and was open from 2nd March to 30th April 2015 (Appendix viii), with three calls for completion. These recruitment requests were sent to each organisation in the scope, with key contacts identified through our stakeholder engagement activities; recruitment requests were often sent to several key managers in the organisation for dissemination to the workforce.

Survey Respondent Recruitment

Survey respondents were recruited using a snowball (chain/referral) sampling method via an email invitation, explaining the project and including the survey link. This email was sent to a number of key contacts in each of the organisations that agreed to disseminate the survey and email amongst their colleagues. The survey was also sent to voluntary agencies and through local professional networks in order to reach independent contractors.

The survey received 461 responses. There are more details about the survey respondents in section 5.1.1.

4.3.2 Interviews and Focus Groups

Qualitative methods were used for several functions: to explore the topic; to generate the concepts used in the survey; and to validate the survey findings. These are

important ways that mixed methods projects use different types of data gathering to triangulate the findings to improve validity (Flick, 1992). All interviews and focus groups were transcribed verbatim.

Focus Groups

The topic guide included eight open questions (Appendix v), devised from suggestions from professionals in the Launch event, and piloted with a range of professionals including community nurse, social worker and health care assistant.

The participants for focus groups included mixed groups from these roles: practice nurses, community and district nurses, health care assistants, adult social workers, occupational therapists, physiotherapists, community pharmacists, community development project lead, and training lead for allied health professionals. A more detailed outline of attendees is available at Appendix ii.

Preliminary Focus Groups

These focus groups were used to explore the topic of workforce transformation and training to integrate care in the out of hospital workforce. The findings were used to generate the questions used in the survey. Three preliminary focus groups were conducted in February 2015, one each in Buckinghamshire, Berkshire and Oxfordshire, with a total of 22 participants attending.

Validating Focus Groups

These focus groups were used to validate the survey findings. During the discussions, participants were asked about topics that were identified in the survey. Seven Focus Groups were conducted between the 13th and 27th of April 2015, across Thames Valley. Two were held in Buckinghamshire, two in Berkshire, two in Oxfordshire and one in Milton Keynes.

Interviews

A total of eight interviews took place between 30th April and 15th May 2015. The interview schedule used 8 open-ended questions (Appendix v).

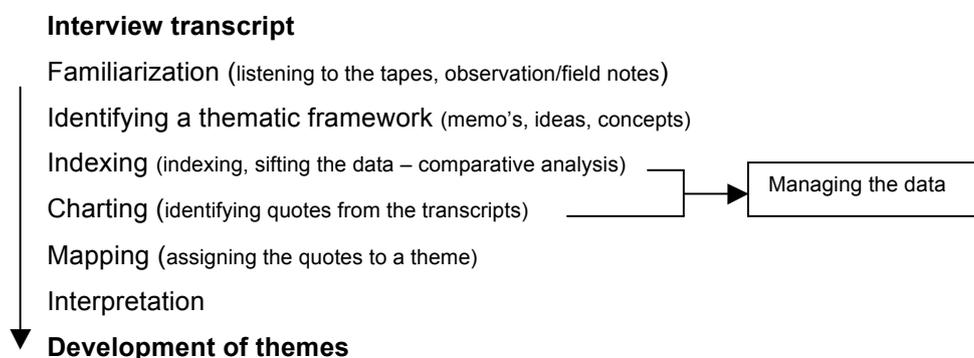
Of the eight interview participants, one worked in Buckinghamshire, one from SCAS, one for Milton Keynes, two from Oxfordshire and three from Berkshire. The interview

participants were recruited purposively, and selected for their ability to discuss the training needs of the community health and social care workforce for their area.

4.4 Data analysis

The wealth of data generated throughout required the use of an analytical methodology that could manage the array of data and contextualise the material. A systematic approach was used to sift, chart and organise the data according to key issues and themes (Ritchie and Spencer, 1994). This approach to data analysis allowed simultaneous and cross-interview analysis to iteratively shape future data collection activities to address the research questions (Stake, 1995). The stages of the analytical framework are illustrated below.

Data Analysis Process



4.5 Ethical Considerations

The research proposals, interview schedule, focus group topic guide, participant information sheets, participant consent forms were all approved by the University Ethics Committee at Buckinghamshire New University (code *UEP2015Jan02 Schaub*). Because of the serial nature of the project ethical approval for focus groups was received on 11th February 2015, ethical approval for the survey was received on 26th February and ethical approval for the interviews was received on 24th April 2015.

The voluntary nature of participation was emphasised to all participants used throughout the projects data collection. Participants for the focus groups and interviews were required to give informed consent by signing a consent form before

the recordings began. Participants were given information sheets fully explaining their role and the research, and were given the project lead and research assistants email addresses if they wished to ask further questions. Participants were also given the opportunity to ask questions before and after their participation in the focus groups/interviews.

Consent to participate in the survey was assumed by completion. The participants were informed that the focus groups and interviews would be audio recorded and transcribed by professional transcribers. The recordings were downloaded onto a password-protected computer, erased from the digital recorder and access to the information was restricted to the research lead. All data that was collected was stored confidential in university premises in a secured office on a password-protected server, consistent with the tenants of the Data Protection Act. Confidentiality and anonymity of the participants and their data was maintained throughout and data was handled in line with data protection requirements.

NB: Because of the nature of the project and the small number of individuals in some samples, much care has been taken to ensure that individuals are not identifiable. This has required that some samples have needed to be collapsed significantly to help protect participants' confidentiality.

4.6 Access

Access was granted via agreement with senior managers of each organisation, and through professional networks, via an introductory letter co-signed by the commissioning organisations (Appendix x). There was also engagement across professional networks, such as via the GP Dean for the area, and through professional networks of voluntary and independent contractors. This engagement allowed for the survey to reach a wider range of participants than only via the organisational dissemination route. Attendees for focus groups were also invited, but these were challenging to attend for attendees from outside of large organisations (such as Trusts or Councils) because of less availability of cover for attendance.

4.7 Project Management

External Meetings

At least 12 meetings were held during the project with external stakeholders including HETV and AHSN representatives including GP Dean, Health Deans and professional network links. There were also regular update meetings with the commissioners, including an interim report for HETV Board (02/03/2015, found in Appendix iv).

Internal Meetings

There were fortnightly update meetings, as well as six-weekly project meetings. These helped to retain project focus and deliver on project outcomes.

5.0 Qualitative Findings: Interviews, Focus Groups and Survey

Below is an itemised account of the themes found in the qualitative data. These themes include the foremost issue of communication, both inter-organisational and intra-organisational, as well as IT and information sharing issues. Confusion and poor understanding of roles and boundaries were also stated by participants, with co-location identified as a key response to assisting in delivering more integrated care in the community. Also identified is a 'New Who', a more generically skilled professional with a multi-disciplinary approach that is connected to GP surgeries, and able to spend longer than 20 minutes with patients, engaging them across both health and social care needs, to support them from needing hospital admissions to resolve changes in their care needs.

Issues of capacity were noted by the participants, with concerns particularly pressing for community nurses. These issues of capacity were exacerbated by local pressures, such as low unemployment, and the nearby competitive impact of London weighting and areas with lower costs of living. These resulted in issues of recruitment and retention, with concerns that as staff had their skills improved, the service often lost them to other roles or organisations.

There were a number of gaps noted by participants in skills and service delivery. There was a strong sense that community staff across the roles need upskilling, particularly to manage patients with greater complexity of needs and more risk. Specific conditions, such as diabetes and COPD, as well as other long-term conditions were noted as knowledge areas needing improvement for the workforce. Greater knowledge of how to improve patient self-management was noted by participants. The community workforce was seen as needing greater generalist knowledge with access to specialist services, concordant with service provision within the acute settings. Leaders and managers were suggested as needing to assist care integration by leading the process from the front, and helping to resolve issues for the workforce.

The methods and types of training that were recommended are predominantly experiential and multi-disciplinary. Multi-organisational training is highly

recommended, with a need for GPs and social care to be involved with other sectors for training involving ‘common issues’ or mandatory knowledge. This allows for more informal connections to be made during these sessions which will improve knowledge of other services. Rotational posts from community to hospital and back were noted, as were shared posts (part community, part hospital), as these were seen as bringing knowledge of service provision and advances in care between the different sectors, and improving care across the sector. In order to support services to engage with increased pace of change, universities need to improve their ability to respond more quickly to requests for new and different provisions. Also noted was the impact that competitive tendering has on services, as this may decrease organisational desire to work collaboratively with neighbouring services.

The following sections outline these themes in more detail, with examples taken from representative transcripts. Where possible, as much detail about the participant is noted. Participants are referred to by their role (if possible), and if more than one from each role is selected for a quote, they are numbered to differentiate between responses. There are also selections taken from survey free-text responses. These responses are usually very brief. There are more examples for each theme described, but all relevant quotes are not repeated here.

5.1 Communication

The single largest area of concern noted by participants was about communication. This communication can be divided into three areas: between organisations; within an organisation; and IT/information sharing. There were approximately 311 quotes from the survey (of 461 respondents) about communication, and the vast bulk of focus group and interview transcripts dealt with challenges in communicating when providing healthcare in the community. Many of these quotes simply stated it was the single most important factor to resolve, such as this response to what is the single most important factor to improve healthcare in the community, “improved communication.” A particular concern was noted by several focus group attendees about newly-qualified staff and their ability to communicate across the complicated community care landscape, such as this comment from a focus group: ‘when I see

some of the newly qualified staff coming out and – they're not great at communicating. Of all different types, you know, they're just – they feel sort of overwhelmed and swamped at times.'

Inter-service Communication

Communication between services was a particularly vexing issue for participants, with concerns that there is significant time wasted when searching for ways to refer patients for services, that the response to referrals is inconsistent, and the transitory nature of referring knowledge; that referral process are changing so often, and with such poor dissemination that staff are unable to keep up. Some areas had greater communication issues, such as Berkshire, with participants finding the array of organisations and structures bewildering, and little understanding of provisions nearby, in what patients would see as a part of the same healthcare area.

Here are some indicative examples from focus groups and interviews:

"All areas are exceptionally busy just trying to track down, so it's a social worker trying to track down a district nurse working with the same person"
Senior Social Care Lead I

Interviewer: "How would you sum up community healthcare services as they are today?"

Community Nurse: "I'll just say 'poor communication'".

'So we never know sometimes if the social services have been up on the ward, what they've assessed, how they're assessed it, when they – you know what I mean, they could come and go without us knowing. We might get a verbal handover. But they're not allowed, I don't think, to write in the medical notes. So where we've all gone on to single assessment process, writing notes, OTs everybody, speech, everybody, they are left out of that loop. That's probably one of the biggest things, I think, because you don't have any then – you can't look through the notes and see what the plan is." Supported Discharge Nurse

The survey responses were typically brief, such as the example above, but the below is indicative of a larger response:

"Communication is greatly affected, they are not able to handover the basic re client care and only communicate when real emergencies (but this is

prioritised by their stress levels) so some important communication may be missed as not perceived as urgent.”

Intra-service Communication

Communication within a service was also a challenge for participants, with issues including record-keeping, and lack of consistent care knowledge for patient records. In addition to struggling to know when patients have been seen or assessed, participants were concerned that changes to referral methods were not always well communicated across the organisation.

“Because there isn’t this communication. Like, for example, our services may change and we may offer different things, but you won’t know, and vice versa.” Focus Group attendee

“I was thinking about more training in terms of record keeping etc as well, because I think part of the problem ...is that we all don’t record in the same way. Some people produce reports for you, some people don’t. And it’s always an ethos of when you ask a question, it’s like, “Well ask Jo because she was here this morning,” but Jo doesn’t come on for five more days.”
Occupational Therapist

Internal organisational communication was also an issue noted by survey respondents, with requests to help staff identify routes to referral, and senior staff to resolve issues:

“Educating both the staff and patients about what is available, at present it is impossible to keep up to date with changes, simple information or signposting to where to get information is needed, if the basic are not right then it will always fail.”

Communicating with Patients

Communication skills with patients were identified as needing improvement, with participants stating that clinicians sometimes struggle to explain diagnoses and treatments well, and appropriate expectation-setting (particularly of other service responses). Organisational web-based content is also identified as needing improvement, to assist clinicians to use this content when explaining options to patients and to improve patients’ self-care abilities.

“Yes, as an example, I’ve seen several COPD patients with a new diagnosis, and they don’t even know what that diagnosis is, it hasn’t been explained to them, the implications, the treatment.’ Focus Group attendee

“We need to actually develop our web-based information. You can’t get away from paper leaflets for a certain degree of the population but even the older population are becoming silver surfers. If you are sitting out there with an Ipad with 3G access, you can get it in most places, and a professional can sit down with somebody and say ‘look, this is what’s available’ or you can Google it and this is what’s available, for that person then to actually pick up for themselves.” Social Care Lead

“Oh yes a HCA will come and visit you five times a week” or something. So they’re coming out of an acute hospital. And actually there’s no way, but the expectation is already set, that the patient and/the carer, daughter, mother will receive physio, OT, speech and language therapy, nursing, whatever, five times a week, and we just can’t do that. So there’s the communication between our services and acute services setting expectations as well, I think, is really important.” Focus Group Attendee

IT and Systems Issues

Issues with IT and system interfaces were a large concern for participants. There is a number of case recording systems in use across acute, community, primary and social care, and many of these systems do not interact. This requires the clinicians to send letters to each other to outline care plans and keep each other updated.

“We’ve got our electronic patient record in the acute trust, and in the community trust, they’ve got something called RIO and they don’t match”
Practice Development Nurse

“Needs to be increased emphasis for IT systems to join up” Learning Development Lead

‘The IT systems, because, for instance, where we work, the district nurses and podiatrist, I don’t know about physio, and the practice nurses all use different IT systems. So, for instance, if the patient has been seen by the district nurses, we can’t see what they’ve done and they can’t see what we’ve done.” Focus Group Attendee

“One major thing is not a joined up IT system’ GP, Focus Group Attendee

“And the biggest communication problem for us is IT. Massively. We have completely different systems to the district nurses, so they can’t log on to EMIS, we can’t get on to their system. So everything we do is by fax which is ridiculous” Focus Group Attendee

Survey responses also indicate IT system incompatibility as an issue, with these examples representative of some responses:

“Get rid of RIO and DATAx. Use one system only”

“Common IT systems would prevent repeat assessments”

“Improved communication and transparency (an IT system that is accessible to ALL relevant clinicians would be a huge step forward). Current system has areas of overlap between clinicians and potential for omissions.”

Information Sharing

These communication issues (personal and informational) create challenges for information sharing for clinicians and organisations.

“Without a clear mandate to, you know, work more closely together and to have a shared IT system, that becomes very different for people to get it right across the board.” Integrated Care Lead

“Practitioners are just not sure how they can share information on a wide range of issues, so I think on a case by case basis that’s OK, but when you actually look at adult social care sharing information with the community health provider on a large scale basis, people are unsure of how best to proceed.” Senior Social Care Lead

5.2 Roles/Boundaries/Location

Changes to organisational structure, and moving care closer to home has created some issues for clinicians, whilst being a key site for service transformation. There is a lack of understanding of each other’s roles (between health and social care, or acute and community health), and a stated need for a new level/type of professionals, the ‘New Who’, to undertake work in general practice surgeries with patients in sessions longer than 20 minutes. This professional is described as having a multi-professional skill set, but able to access information and referrals from across the health and social care landscape. When bringing services together, there is also the concern that roles can become less defined, and support needs to be given to clinicians to retain their sense of identity (and assist with their ongoing career pathway opportunities). There are also issues of discrepancy which require careful management when co-locating staff from different organisations.

During the stakeholder launch, a new role was suggested with a “need for new level of professionals in GP practices – OT/Practice Nurses/SW” identified. These new professionals were suggested as needing to:

- Be trusted and credible (control over defining and training up staff will improve this)
- Have ‘buy-in’ from key staff
- Have the engagement skills of a health visitor and diagnostic skills of a paramedic
- Do 20% of the interventions, 80% can be done by “patient activation practitioner”
- Focus on keeping the patient well.

Understanding professional/disciplinary roles

Many of the participants suggested that clinicians need to have a better understanding of each other’s roles, and that this lack of understanding impacts on patient care and the speed of service delivery. There were requests for more intra-organisational shadowing and rotational opportunities to improve this understanding.

“When they were being asked about what would be more helpful to help them to work in a more integrated way, I think one of the biggest things that came out of that was around understanding what each other did ... So, we spent some of that time actually helping them to understand what certain people did across that pathway and understanding the specialisms that are there but also understanding what everybody contributes to that pathway, so, when to refer or what to refer.” Learning and Development Lead I

“There needs to be, perhaps, inter-disciplinary understanding of each other’s roles but also across organisations” Social Care Lead

“There is not sufficient understanding of roles between the various care providers / key partners. Individuals do not have enough understanding of each others skills and expertise and may end up working against each other rather than together” Learning and Development Lead II

“More understanding of working life in the community – shadowing, rotational posts, peer review, audit.” Community Health Nursing Lead

The survey responses included concerns with lack of understanding, as well.

“No idea about discharge planning, “Now, now, now, do it,” you know, that’s their, you know, they’ve got no idea about how the system works at all.”

“Staff need to be trained to leave the cultures of SS Healthcare behind and devise a new innovative integrated care model, not just different people working in same place protecting their own unique practice.”

These changes may not be supported by the larger professional bodies, and may have a long-standing history of competition and some antipathy between the professions.

“The approving body and the Royal College would probably say, ‘you know, we don’t need that module or we don’t that in here so whilst it’s not hurting, if you haven’t got something else, you won’t pass the assessment’. So I think we haven’t engaged well enough the colleges and the registrant bodies to say ‘now is the time to recognise working across several different registrant groups’ and ask for their help to enable us to do that. Because if they fail to recognise that need, then I think we’ll struggle. So that would be my biggest comment.” Learning and Development Lead III

“Somebody mentioned earlier about barriers between the different disciplines. And maybe historically there’s sometimes negative feelings about other disciplines, you know. I mean I used to think the district nurses just sat in an office and waited for people to come in. I’m sure there are misconceptions about people’s roles.” Focus Group Attendee

Merging roles & teams

There were significant benefits seen by merging roles and teams, with co-location being identified as a key determinant of successful transformation. These merged roles sometimes caused confusion for some areas, with requests to re-assert professional boundaries and identity. There were also issues noted with contractual differences for staff from different organisations that can become more apparent when working together in a shared workspace.

Co-location

“I’m a firm believer, I think the co-location is critical, I think it will create those human bonds and relationships that will cause them to work together as a team... It’s about bringing together people who are going into people’s homes and have them do that in a more effective and focused way.” Integrated Care Lead

“Sharing the kitchen, yeah, having a kitchen area. You learn so much in the kitchen. So you find you know, just through conversation you find out an awful lot.” Learning & Development Lead II, Community Health

Survey respondents also thought that co-location was important:

“Working together in the same buildings so you can have closer contact giving the patient more holistic care.”

“We need to sing from the same hymn sheet and provide a holistic service to our residents. Geographical boundaries are a huge issue as health and SS in our area cover different areas!”

“Co-located teams that allow for prompt deployment, understanding of roles and the holding of up to date information re services available”

There were some contractual issues that become more apparent when working in close quarters.

“Created lots of issues because you know, for the people employed through health got paid a slightly different mileage rate than the ones that were employed through the Council and they got slightly different holiday... The most difficult part of having joint services is having people from two different employers in the same team, and that causes so many problems. It’s not just annual leave. It’s not just the inequities; it’s also the complications and the complexities for the managers to manage. If you’ve got a manager in social care that’s got health employees and doesn’t quite understand the policy”
Learning and Development Lead III

5.3 Staffing/Workload/Capacity

There are some issues noted by participants about staffing levels, and recruitment and retention. Some of these issues are area-specific, because of the implications of living and working so close to areas that pay the differential London weighting. There are also specific pressures because of living in areas with high costs of living (in comparison to nearby regions) and low unemployment. These combine to create a workforce that is challenging to recruit, and difficult to retain. There were concerns noted that when clinicians were upskilled they often left a service, taking this enhanced knowledge and skills out of the service. Capacity is noted as an issue, particularly within the community, where there are services that have no upwards ‘cap’ on caseloads for individual clinicians. This can create a situation where the time spent in each session is reduced in order to fit more patients into the same amount of time.

Recruitment and Retention

“Recruitment and retention is an issue and getting the right skill mix and competencies ... Across the board recruitment and retention is an issue... I think that’s not just within the more statutory services, it’s a real issue in the home care market, so providers out there really have a lot of difficulty getting the right staff.” Integrated Care Lead

“It’s not been invested in, and everyone’s now saying ‘out of hospital is where we’ve got to be’... ‘Oh my god, we haven’t got enough people out there’”.
Social Care Lead

“But, as a social worker, at the minute, we are, I think we’re usually a team of about ten and we’ve got six vacancies. So we’re 60% short” Social Worker, Focus Group Attendee

“We have a real struggle with allied health professionals in recruitment at the moment, there’s lot of vacancies and I think it’s the same in nursing. And we really struggle to get staff.” Focus Group Attendee, Occupational Therapist

“There is that issue, if you go off and do a diabetic course for six months, and then, you know, people then go off to be a diabetic specialist nurse, and then you’ve lost a really qualified nurse.” Focus Group Attendee, Nurse

Survey responses identified recruitment and retention as an issue, noting the geographic issues.

“Our area has a problem with recruitment due to the high cost of living in the county - nurses are attracted to London to work because they get paid a weighting to compensate for the higher living costs. This should be extended to larger cities, for example Oxford where it is just as expensive to live and work as it is in London.”

Capacity Issues

There were issues noted across the responses about capacity within the service. Participants described that clinicians often worked more than contracted hours, with a sense of constant ‘backlog’ of work that was never fully completed. These capacity issues resulted in staff being unable to access training that was offered.

“Some attempts are sort of more internal informal training has been made. But due to the district nurse capacity issues, attendance was poor. We just couldn’t get people there.” Focus Group Attendee

“And they often haven’t got the capacity to do that.’ Absolutely. And I think capacity is one of the big things.” Focus Group Attendee

Survey respondents also suggested issues of capacity and workload:

“There's not enough of us so we're all doing double the amount of work and getting worn out more quickly.”

“The nurses are too busy to explore other aspects of the patient which may impact on their overall health, for example if they are visiting to do a dressing, but do not identify that the patient is upset, confused etc. this is particularly affected by the inability for staff to provide continuity of care where different members of staff are visiting at each visit due to capacity, sickness levels etc.”

“Not enough capacity to cope with shift of work from secondary to primary care”

“Staff are sometimes working above capacity, this increases the risk of patient harm or untoward incident happening”

5.4 Skills and Knowledge Gaps

Participants discussed a number of gaps that they identified. They stated that a number of roles in the community need upskilling including: practice nurses; community staff (community nurses and HCAs); community doctors; and administrative/reception staff. Participants suggested that the community needed to have improved clinical responsibility and risk management skills to manage more complex patients in the community. This suggestion was coupled with a concern of a lack of confidence in the ‘out of hours’ services for both health and social care. The professionals that choose to work in these services were identified as ‘hard to reach’, and possibly with a focus on personal or family needs, with a career being secondary. This was suggested to lead to less engagement in training and education, and unwillingness to engage in opportunities.

There were some specific gaps that were identified as needing improvement. Mental health and long-term conditions, specifically diabetes and COPD were both identified by a number of participants as areas of knowledge that needed enhancing in the community. Knowledge of how to improve patient self-management was also suggested – with a concern that if this is not improved, clinicians will continue to undertake tasks and decisions for which they no longer have the resources and time. Generalist knowledge was suggested as needing to improve, in order to allow

patients of greater risk to be managed more safely. Finally, there were issues of knowledge and approach by leaders and managers that were identified.

5.4.1 Upskilling Different Professionals

There were a number of different roles that were seen as requiring skill development or broadening. Because the roles are quite different in knowledge and responsibility, these will be discussed separately. General practice nurses, community staff, administrators and receptionists, community medical doctors and HCAs are discussed in order in the following section.

Practice Nurses

Practice nurses were suggested as having been 'de-skilled' in their current role, but being well-placed for increased clinical responsibility. This increase will need development in order to manage the risk. There were variations noted for the level of support that practice nurses receive for developing skills to manage increasingly complex clinical risk.

“Relying on there being training available for practice nurse, so that they’re able to build up that speciality and, also, having practice nurses that are willing and interested in taking on that role. ... I do think there’s something about making practice nursing much more attractive, as well, I think it’s always been seen a bit [of a] poor relation.” Learning and Development Lead

“They used to tap into the university stuff and their issues at the time were about you know, getting released and getting that support and, I know, it did vary, hugely across GP practices, about the level of support they were given. Some felt they had no support, at all and then they’d just have to move to another, another practice.” Integrated Care Lead

“One minute I’m in the surgery and the next minute I’m going out to cover the district, it’s unfeasible, it’s such a speciality.” Practice Nurse, Focus Group Attendee

Community Staff

Participants suggested that community staff need to be upskilled to safely manage greater risk and more complicated clinical situations in the community.

“Upskilled because if you know, if you’re wanting to give blood transfusion in the home or IV antibiotics or things like that, they need to be more highly skilled, don’t they. ... Bit of a mixture, actually, between paramedics and emergency care practitioners, really, and nurses that we need would need to have a similar skill set of somebody that works in a reasonably senior role in A&E.” Learning and Development Lead

“We haven’t developed our staff in the community to the level of skills that are actually now required for the community.” Social Care Lead

“Lots of areas where the work has been pushed out into the community or asked to hold into the community without actually upskilling our staff in advanced assessment and advanced risktaking, to hold those patients safely and confidently, both through the GP and all the way through the AHPs down to the nursing.” Integrated Care Lead

Administrative/Reception Staff

“But to come on to the admin and clerical roles, I think they have a significant role going forward ... it’s not necessarily just about the training, it’s about having the career progression that sits alongside that.” Social Care Lead

“And I think it’s always just trying to get – but I think that’s, possibly there’s a need for more update sessions for admin, reception staff.” Focus Group Attendee

Community Medics

“We haven’t looked to see what it is we need in our medical workforce. That new role, which is that interface doctor. Some people have got community gerontologists, ‘well, it’s more than that – it’s the interface doctor, it’s more than a GP, it isn’t an acute physician – it’s that specialist in the community who can look after people and take the risk of managing them in the community that has still got that general practice head on but isn’t an A and E consultant or a medical consultant or necessarily a gerontologist because it’s not all about gerontology, it’s about managing adults with a range of long-term complex conditions, who might or might not be dying, in the community.” Integrated Care Lead

HCAAs

“There is another opportunity to actually take on another range of tasks, at a slightly higher level than the healthcare assistant level has been in the past... I think that could grow and become a better more informed individual, better

able to cover some of the tasks that might currently be done by the skilled workforce, the registered workforce.” Learning Development Lead

“So we looked at what percentage of the role of a qualified nurse, working in the community, could be done by an unqualified member of staff. It really surprised a lot of the nurses, that so much could be done.” Learning Development Lead

5.4.2 Clinical Responsibility and Risk Management

Participants suggested that community clinicians need to be encouraged and supported to ‘hold the problem’, with the increase in risk, to enable patients to be cared for in the community without being admitted to hospital.

“It just makes sense. Because it's that iterative understanding of “well that's the thing that you do”, as opposed to, you know, “I will pass that thing over, I don't understand” Social Care Lead

“Nurses taking responsibility to make the pts care seamless.” Survey response

“I think people are batting the problem back and forth between the services sometimes.” Focus Group Attendee

Out of Hours Clinical Skills/Trust

There was a lack of trust noted by participants for ‘out of hours’ services and clinicians. This lack of trust equated to higher hospital admissions, and concern noted for their responses to situations.

“There does seem to be high numbers of admissions into the hospital... I think there is an issue here that we, I think our night time care in the community is, is very patchy.” Integrated Care Lead

“Quite a lot of social and community care needs when the normal day service is not available or indeed is not able to come.” Learning Development Lead

“Care during the night is very weak.” Focus Group Attendee

5.4.3 Hard to Reach Staff Groups

There was a noted concern by some participants that there are groups of clinicians that are more challenging to reach for training and development. Twilight shift were suggested as 'hard to reach' for a variety of reasons: the role may be chosen for the way it fits into family life, and may indicate lower career aspirations, as they may be secondary to family needs.

"Twilight district nursing service that works up until 2 o'clock in the morning from a training point of view, they've always been a very difficult group to difficult to engage... they're not so interested in career development.' Learning and Development Lead

"It is very difficult to get people who've been working for a very long time, who are not keen on CPD, who've got away with not doing CPD, to actually get them doing CPD that has an assignment attached to it." Learning Development Lead II

5.4.4 Specific areas of knowledge or gaps in service delivery

There were a number of specific areas of knowledge that were identified as needing to be improved across the workforce. Knowledge about mental health and long-term conditions (particularly diabetes and COPD) were noted by a number of participants. Some of these specialist skills were suggested as needing to be extended into the community with a higher level of skill, and more commensurate with that skill used in the acute sector.

Mental Health

"Quite a strong requirement I would suggest across the board is mental health awareness." Social Care Lead

"If we were able to have MH managed better, it would relieve the pressure on our service significantly." Survey respondent

Diabetes

"What we have done though, we've identified – there was a huge training gap around diabetes for district nurses." Focus Group Attendee

"So now we've got the opposite end where the [diabetes] skill is very low in the service, not having had training for years. And the patients are very complex. So there's a huge amount of risk." Focus Group Attendee

Long Term Conditions

“We’ll need much more long-term conditions training and sort of case management type training, frail elderly pathway, absolutely. I mean they’re an absolute priority in my mind.” Focus Group Attendee

“I think long-term condition management in housebound patients is a real gap, as in proactive management rather than reactive care to issues that are raised. And that’s a definite gap.” Focus Group Attendee

“I would love specific OT training for working with COPD, I have to go to college of OT to get that training.” Survey response

Specific Knowledge Areas

Some areas were not consistently mentioned across the data, but given the scope of the project, are mentioned here for inclusion in possible workforce plans.

“Annual health checks by GPs for LD patients and Annual Reviews LAC living out of area.” Learning Development Lead

“It’s those clinical skills or things that we don’t see that often. So, for example, tracheostomies, we might get one in one team.” Focus Group Attendee

“I think you’ve got a big area of social care that aren’t recognising these patients are getting more complex, we need to train our staff more to deal with that.” Focus Group Attendee

“I think we need to be able to have more prescribers, non-medical prescribers, who have those clinical assessment skills to be able to assess clinically in the home to prescribe to prevent people bouncing into hospital.” Focus Group Attendee

Improving Patient Self-management

Participants suggested improvement was needed in assisting patients with developing improved self-management abilities.

“We learn an awful lot from social care around the person as an individual, about being supported to make their own decisions and that they don’t have to be the correct decision, as we would see them.” Focus Group Attendee

“Supported self-assessment model, where someone may have some social care needs but have primarily, a very long-standing relationship with the district nurse or with their heart failure nurse, and actually, they’re probably

best placed to undertake some of that social care function instead of introducing another professional into that person's life." Social Care Lead

"It's all part of trying to shift the ownership of looking after one's own long-term conditions, maybe from the institute of Health into the patient's care... the patient and the carer, I should say." Learning Development Lead

"Perhaps the health professionals being educated in encouraging self-management because I think ... it's that you look after that patient and do everything for them. You know, times have changed." Focus Group Attendee

"Patients require more help understanding / advocacy is important a lot of patients do not have that, i.e no family or family unable to help" Survey response

5.4.5 Generic Skills

Participants noted that a greater amount of generic skills were needed. They suggested a need to move to a model of generalists with access to specialists when required. This would require a higher degree of generalist knowledge and skills than they currently hold.

"There's a kind of generic fairly high level training need that sits across a whole load of professionals who do work together on a daily basis." Social Care Lead

"So, you know, do you in one car put a physio, a paramedic, a nurse with mental health specialism and an OT? Do you put them in one car, or do you say that one or two people have those core skills?" Learning Development Lead

"I think the key in future will be 'let's try and find a multiskilled person who actually can do all the various things in one visit rather than have several visits.'" Learning Development Lead II

"So is the district nursing model right? Or is there a different role, multiskilled role, that actually can support this and therefore continue to deliver an effective service, but at a lower cost." Learning Development Lead II

"Employ staff with basic assessing skills with evidence of ability to work alone, train to cover all aspects of nursing, they are often the only person visiting patients weekly." Survey response

5.4.6 Leadership/Management Needs

There were gaps stated by participants about leaders and managers. They suggested that if senior managers within health and social care did not seem to be working collaboratively, that the services struggled to provide care that was integrated. Related to the risk management needs identified above, leaders and managers were seen to need to manage greater risk in the community, and to be supported to do so. Time for managers to reflect on the changes needed, in order to make changes that are considered, rather than reactive, was also suggested.

“It's how that happens at all tiers of, of organisations, in terms of having that joined-up view of how things should be working, if at a senior level there isn't that join-up and that shared vision, then there's going to be a point where there's a conflict and, and quite often, that's felt either at the front line or just in the tier above, in terms of we can see we'd like to do this but, actually, we were told we, not necessarily that's not the direction of travel.” Social Care Lead

“A number of district councils on top of the county council on top a couple of CCGs and that's quite difficult to get a shared vision of this is how we're going to support the local population, and, yeah, that does require quite strong leadership.” Social Care Lead

“They don't have the same governance structures, whereas in providers, and I think in our provider – in the past – our governance structures have not necessarily been clinically led and have been detrimental to taking risks. And so you've got a lot of previously strategically quite risk averse sort of leadership, if you like. And, and then on the ground, what that's translated to is blame and fear and so the clinicians become completely risk averse. So we need to change that culture.” Focus Group Attendee

There were a number of survey responses that included this as an area of need:

“Leadership and management are the tools to make things happen - so over to you, you need the right leaders to engage the grassroots and ensure the right change happens for patient care. But good leadership, management and engagement is key, not bulldozing or sly politics.”

“Appropriately trained leaders and managers that have the patient's best interests at the centre of all the decision-making processes”

“By recruiting leadership that is confident and capable of working within an integrated pathway.”

5.5 Training Methods and Types

Participants stated that experiential learning and placements were important to change the service delivery. There was a strong suggestion that the training needs to be more multi-disciplinary, and multi-organisational. There were recommendations for rotational posts, from community to acute, in order to improve the knowledge and skills for both arenas. There are some specific issues noted, such as a challenge with placement for paramedics that may have significant issues if not addressed. Universities were suggested as needing to improve the speed at which they respond to requests from service, with a much swifter timescale identified as necessary to address the quickly shifting landscape of changing to more integrated care. Changing clinicians approach from a needs-led assessment to an outcome-based approach was suggested as important, as was leadership and management skills for community staff. The latter is to improve the ability of community staff to manage patients with more complex issues without transferring to hospitals. The change to the commissioning process was identified as creating services which were more cautious about collaborative working, as they were competing for delivering services.

5.5.1 Multi-disciplinary and Experiential Learning

Experiential learning was identified as important, in particular because it allowed staff to gain knowledge of the terminology used in different services. Education and training needed to be multi-disciplinary to enable staff to gain a broader skill set and improve their understanding of other professionals' roles.

“The training is done separately; there isn't a lot of shared learning.” Social Care Lead

“The classroom-based element within that but also, then when people go on placements, again, it's within that professional group, that learning isn't across the board. I think that's missing an opportunity” Social Care Lead

“I've probably learnt things just sat in this room for the last twenty minutes. So I would happily support the idea of different professionals and different services having joint training in some way and involved in networking so that we can understand what everyone does and the pressures and whether we can actually communicate better.” Focus Group Attendee

“Case study approach to training sessions with multi agencies attendance (particularly including GPs) all presenting their involvement.” Learning Development Lead

Survey responses:

“Training and training people across agencies at the same training sessions to promote working together and supporting each other.”

“Training is not multi-disciplinary and mostly e-learning therefore staff do not meet staff from other areas.”

Participants suggested a need to move towards a more outcomes-based approach, instead of focusing on responding to needs.

“We almost got to get people’s blinkers off and get them looking at what else is out there ... “what do you want to achieve, what, what would good look like for you?” And what else is out there to help you achieve that?” Integrated Care Lead

Some participants suggested that more rotational posts were needed, from community to hospital and back, in order to improve the knowledge of each sector about the others’ services.

“Introduce rotational posts to all staff to experience acute and primary care; ‘if there were any rotational roles for people who particularly wanted it, then that could be quite attractive, and give them a really good insight. And then if they went back to the hospital, then they could say ‘we need to do this because it would help when the patient’s back out in the community’ because they’ve got first-hand knowledge” Practice Development Nurse

“More understanding of working life in the community – shadowing, rotational posts, peer review, audit.” Learning Development Lead

5.5.2 Competition and Collaboration

It was suggested as a challenge to bid competitively, but work collaboratively with the changes to commissioning. Participants suggested that this caused organisations to be cautious when supporting nearby services and working with the same patients.

“The new commissioning landscape has really knocked partnership on the head... I think it's all this commissioning and tendering stuff out that’s ruined that.” Learning Development Lead

“Different providers ... tend to work against each other because the tendering process has at times positioned services against each other.” Learning Development Lead II

“The new Government (following the General Election) needs to reverse the trend of 'bidding' for services and restore the NHS + start to pump back in the millions of £s that have been taken away from NHS budgets over the past 10yrs or so.” Survey response

5.5.3 Paramedic Placements

Placements for paramedics was noted by separate participants from different sectors, and identified as needing attention.

“Because that’s our next big challenge, is paramedic placements, because there’s a massive shortage of paramedics.” Practice Development Nurse

“We considered that the placements of paramedics and others in other placement areas other than the ambulance service is absolutely key, and we know that’s one of the challenges.” Learning Development Lead

5.5.4 HEI Responsiveness

The speed of HEIs to respond to service changes was noted as an issue. The concern was that the rate of change would continue to increase, further outpacing universities ability to provide relevant training and education in the timescales needed by services that are consistently changing.

“It has to be SO well planned before hand that it takes so long to change. And then when you do bid – ‘we think we need this next year’; this is the type of training we need. So much [of it] goes in to the bespoke.” Learning Development Lead I

“There’s something about the lead time in changing that that’s an issue ... I began to challenge a programme, saying ‘why do we need this particular one, why does it need to be accredited, why is it so expensive?’ because there’s a huge turnover of this, we need them every year. .. And it took a year, 18 months, to develop something new.” Learning Development Lead II

5.5.5 Additional Possible Solutions

There are a number of possible solutions that were suggested by participants, but didn't have enough to create an entire theme. Increasing the skill mix, creation of new, 'hybrid' roles that straddle community and hospital, and multi-professional modules in pre-qualifying courses were identified, among others.

"Increase mix of staff coming through 'twilight' and out of hours services in community to improve skill mix and training engagement ... Opening up the horizons for those staff and, actually, getting a mix of staff coming through." Integrated Care Lead

"We've developed a kind of hybrid role called a Co-ordinator role, which are not necessarily qualified staff, so some places would call them Support Workers but ... they can sit across both [health and social care] and can do a holistic assessment, whereas, currently social workers and OT will do separate assessments" Integrated Care Lead

"Using Action Learning Sets to help groups of professionals learn about each other's roles and improve patient care across a region." Survey response

"That's what needs to happen [in] nurse training, where there may be a specialism for a community pathway, whereas before it was just child, adult, mental health or learning disability." Practice Development Nurse

Joint modules during pre-registration education

"Multidisciplinary training and in fact it was a compulsory module that people from different disciplines were kind of made to work together on a small project ... I think the first thing to break down is in the university. Actually teaching together – anatomy and the physiology is the same." Learning Development Lead

Further Potential Solutions

Some possible solutions to the issues include conversion courses for hospital staff to move to community, increased use of simulation and technology-assisted learning, more joint assessments, and the possibility of self-funding training for some professionals.

"Do we need conversion courses from acute to community nursing?" Learning Development Lead III

"Technology-enhanced learning/simulation: 'simulating, simulated exercises .. that's one starting point. As we get more professional at the use of technology-enabled learning." Learning Development Lead II

“As district nurses, we’ll do joint visits with the community matrons. But we won’t do those joint assessments with social workers.” Focus Group Attendee

“I think in the NHS, the training has always been something that was a commitment from the organisation. But the future is that people will have to fund their own training to some extent, I think.” Focus Group Attendee

Leadership/Management Skills for Community Staff

“What we’re going to need is very much more of that cultural change leadership training and support for people. So, for instance, we’re thinking recently about resilience training for staff. So that they’re able to work in this high pressure, high pace of change, risky environment.” Focus Group Attendee

“We’re already running basic coaching skills ... but actually I could see that extending to most clinicians... giving people coaching skills that can be used in patient interactions.” Learning Development Lead

6.0 Survey Findings

This chapter outlines survey responses using, where possible, pie charts to show prevalence of responses. They are grouped into six broad categories: provision of integrated care; communication; training preferences; disseminating good practice and role importance for integrated care; technology use; and staffing and capacity issues.

Quantity and quality of communication was noted by many respondents as an issue that impacted upon providing integrated care. A large number of respondents suggested that compatible IT systems were important as a mechanism to improve communication issues between community, acute and social care services. Most respondents suggested that integrated care training should be mandatory for all clinical staff. Better understanding of roles was found as the most important topic for training, with multi-professional and inter-disciplinary topics also prominent. Learning and development departments were most preferred as the vehicle to receive ongoing integrated care training, with a high percentage also suggesting a desire for inter-agency group provision. Training about finance, budgets and benefits was suggested as possibly improving resource management.

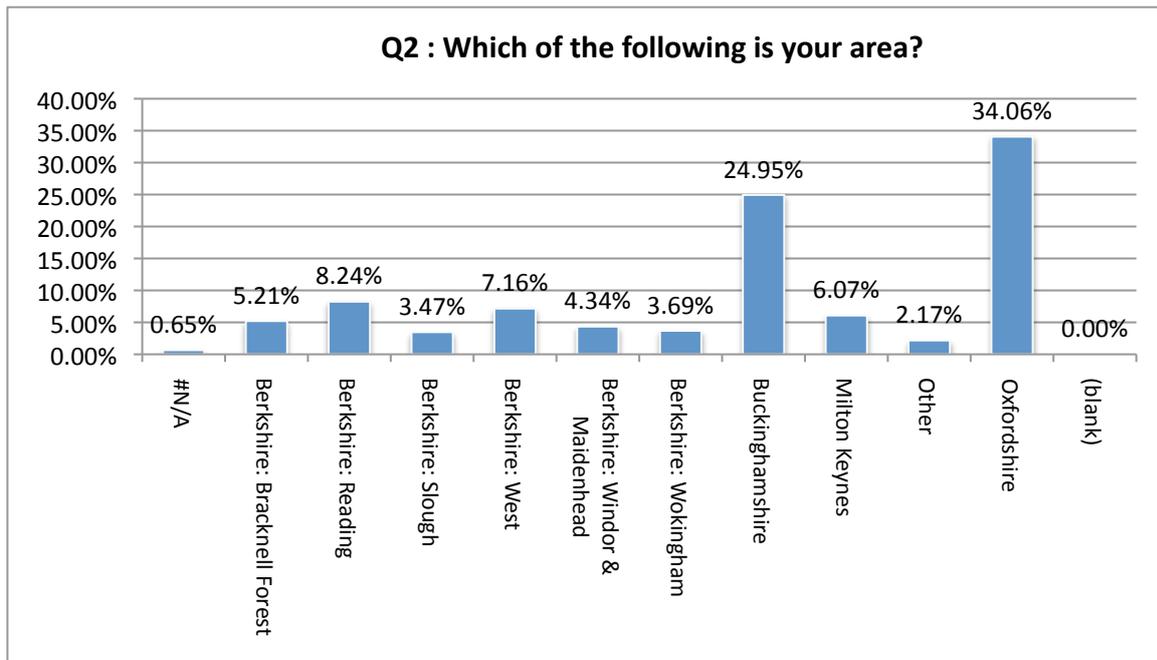
The dissemination of good practice within the service was seen as important in promoting more integrated care, and respondents felt that their organisations disseminated good practice well. GPs and social workers were identified as being central to keeping patients well in the community, with social care being suggested as having the most pressing need for change to service delivery. The use of technology, whilst seen by many respondents as being good, could be improved, as a number of respondents suggested that they didn't always have the most effective technology to undertake their role. Staffing and capacity issues were also noted, with respondents suggesting that community health, and in particular community nursing as an area with the most need. This finding is compared against the respondent profile, with differences noted, and improving the validity of the suggestion.

Below are outlined the types and variety of survey respondents and survey responses exploring each theme. They are divided by question, with a narrative explanation outlining the analysis to each response.

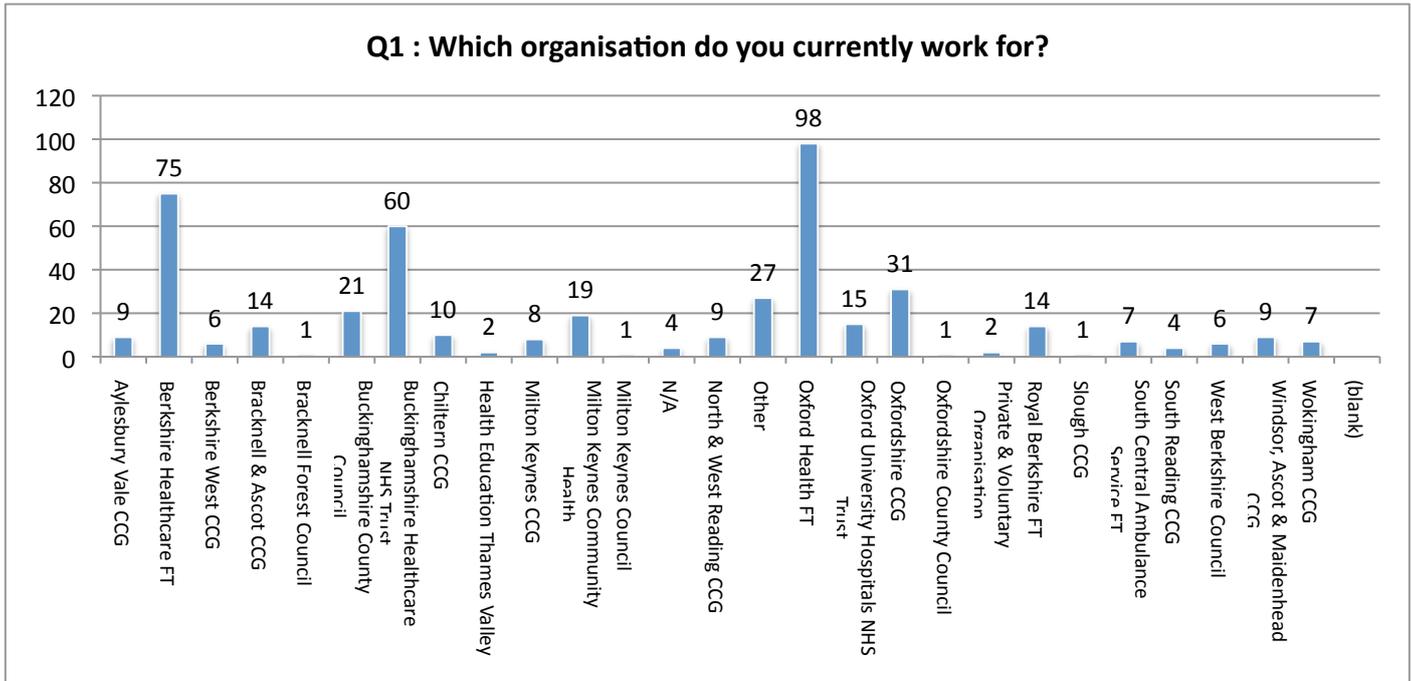
6.1 Survey Respondents

6.1.1 Geographic Area

The highest survey responses were from Oxfordshire (34.06%) and Buckinghamshire (24.95%). When the six unitary authority areas in Berkshire are combined, the response rate for the area is commensurate with the other two large counties (31.6%).

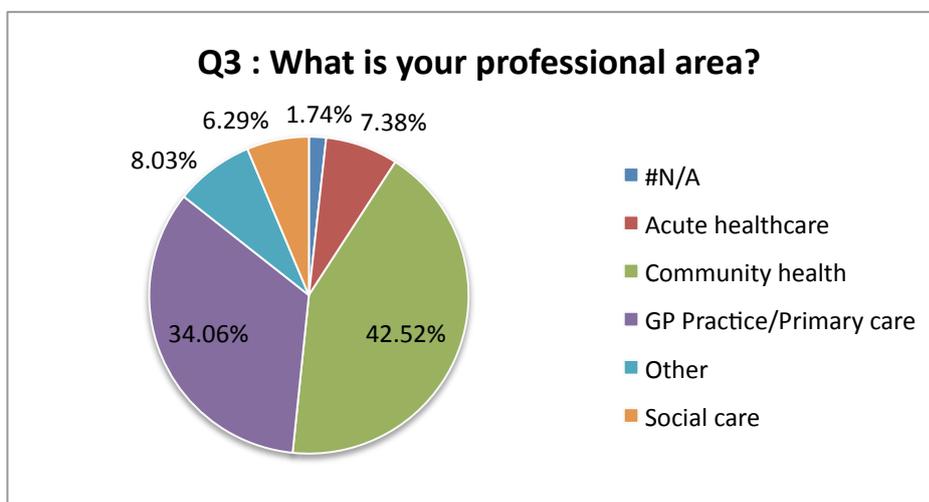


There was a broad spread of responses from the various organisations approached, with the majority of responses from Oxford Health, Buckinghamshire Healthcare, and Berkshire Health. It is notable that a number of respondents suggested 'other' or 'n/a', and the free-text responses indicated that they were independent contractors, such as GPs.



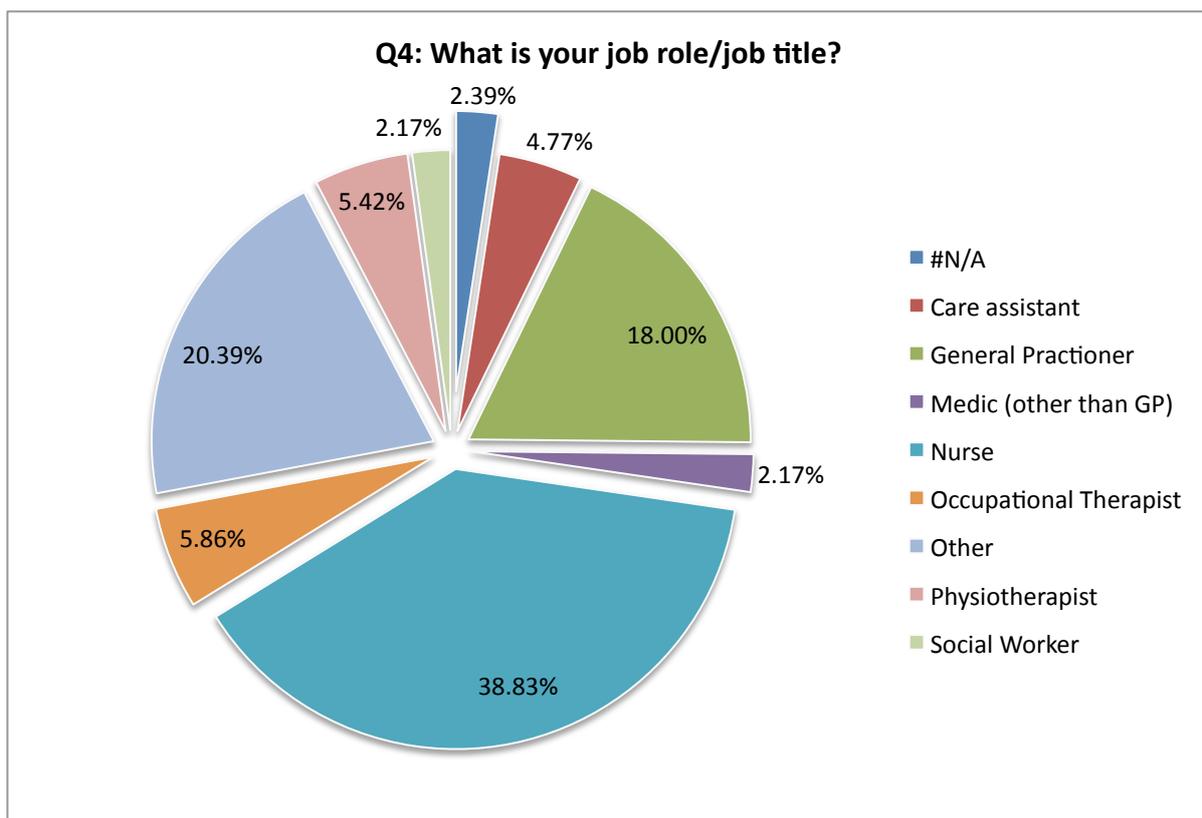
6.1.2 Respondent Professional Area

There was a wide spread of responses about the type of professionals that responded, including the bulk of responses from community health and GP/primary care. There were fewer from acute and social care, with a group of respondents that selected 'other', with many of them suggesting they were from independent contracting or voluntary agencies. It is unsurprising that there is a low response percentage from acute care, as these were not targeted unless they had a community focus to their role.



6.1.3 Respondent Job Role/title

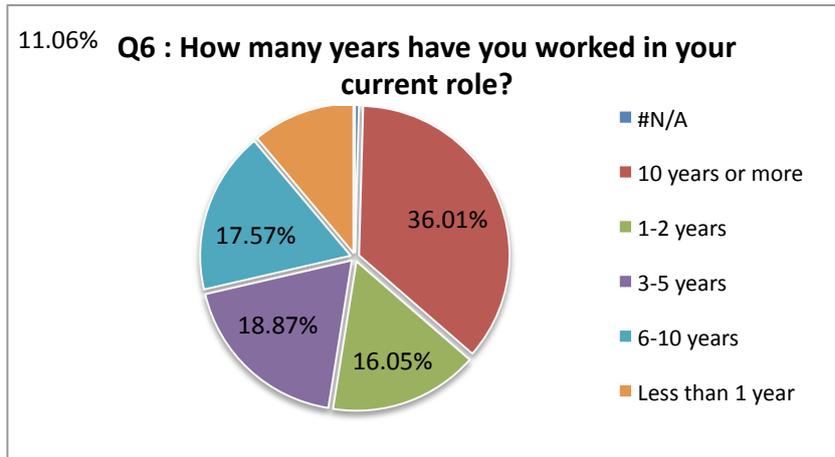
The largest proportion of respondents selected nurse, with a large proportion also selecting 'other', but within the explanation box, many of these respondents would be categorised as part of the nursing profession (including practice nurses and health visitors). The largest other group of respondents was GPs, followed by occupational therapists, physiotherapists, care assistants, and social workers. What is interesting about these responses is that many respondents were unable to find where in the professional spectrum they fit, when reduced to large groups of roles, even though to the wider sector and society they are seen as part of the same profession (such as practice nurses and health visitors being part of nursing).



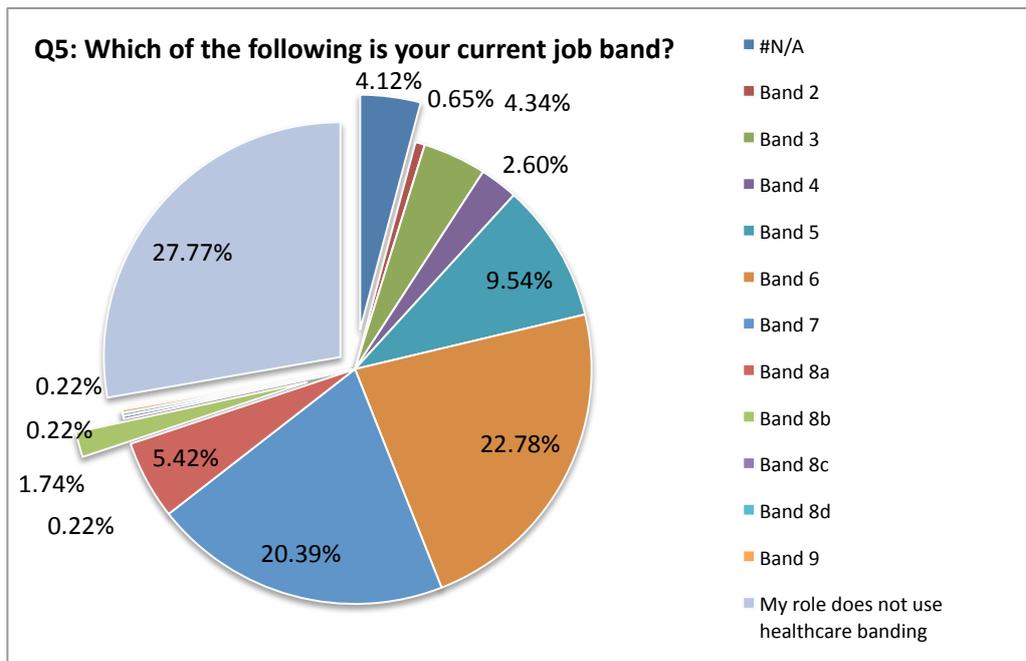
Given the relatively limited number of choices, it is understandable that a small number of respondents chose 'medic (other than GP)' and a high number chose 'other'. Given the wide range of possible respondents, selecting a list of possible responses was challenging, requiring some respondents to select a role that was closest to their role.

Most respondents had been employed in their current role for more than 6 years (53.58%), and fewer than 1/3 for less than 2 years. This would indicate a higher than

suggested amount of stability within the workforce than is indicated within the narrative accounts.



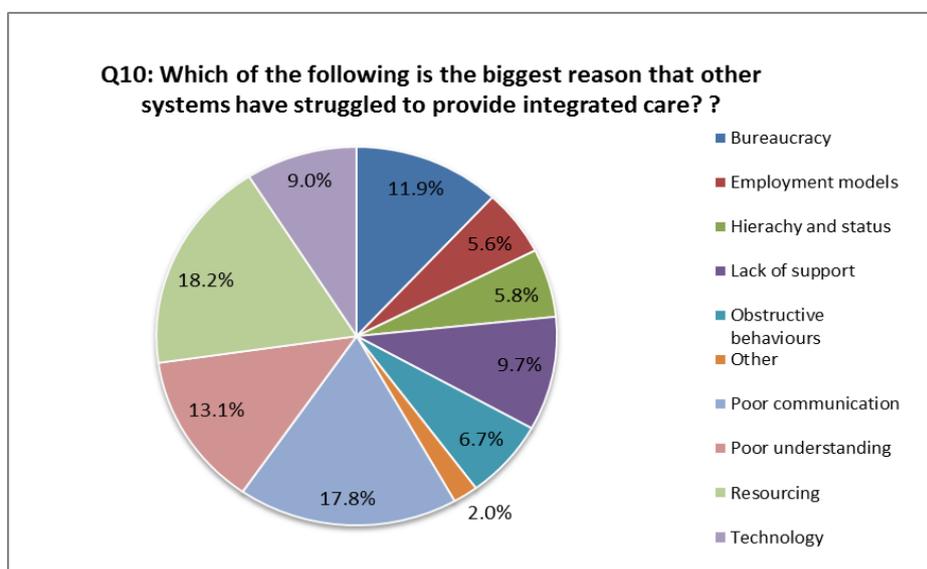
Respondent’s roles were predominantly in first-tier management or with some seniority, as more respondents suggested Bands 6 and 7 than other options (22.78% and 20.39%). Notably, over 1/4 of respondents suggested that their role did not use healthcare banding. Also of interest is the 7.59% of responses that comprised Bands 2-4, which includes HCAs and care assistants. Less than 8% of the responses were from Bands 8-9, which suggest a bulk of respondents were closer to practice than to strategic management posts.



6.2 Provision of Integrated Care

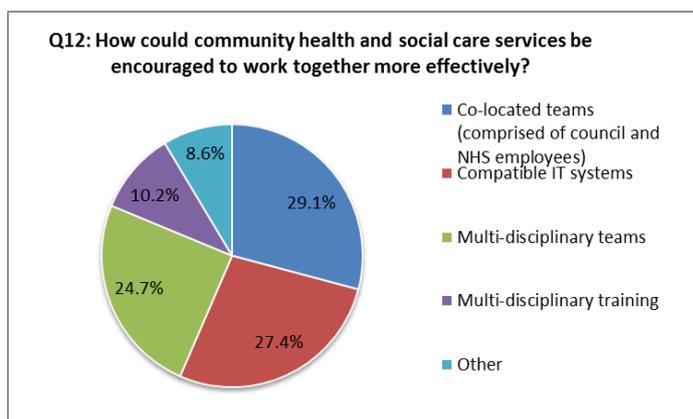
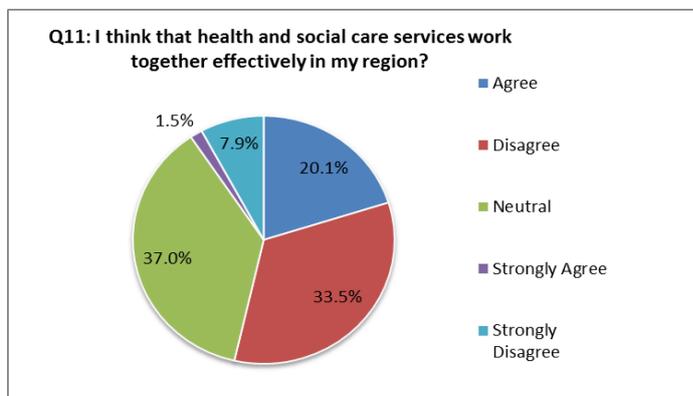
Respondents suggested broadly that they felt concerned with the provision of integrated care within their service, but that they were unsure about the level of concern. There may also be a sense that services across the country are struggling to provide integrated care, with respondents agreeing with this. The inter-agency working between health and social care, and mental health and other services, is seen as an issue, but respondents also suggested uncertainty about this issue. The transition between acute and community provision is not seen as effective, with a higher proportion of respondents suggesting that co-location, compatible IT systems, and multi-disciplinary teams as the most prominent suggestions for solutions.

When describing why other services struggle to provide integrated care, respondents were mixed in their responses. Resourcing and poor communication received almost equitable percentages (18.2% and 17.8% respectively), this was closely followed by poor understanding (13.1%), bureaucracy (11.9%), lack of support (9.7%), and technology (9.0%). Fewer respondents agreed with obstructive behaviours, hierarchy/status and employment models (6.7%; 5.8%; and 5.6%). This would indicate a mixed profile for respondents' thoughts about the barriers to provide integrated care, but that resourcing and communication are the most important to integrate care successfully.

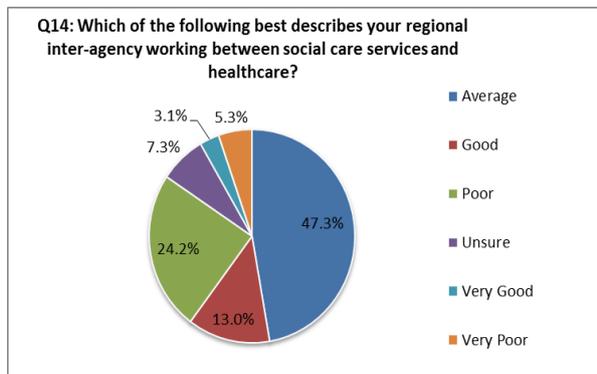


Respondents suggested they did not think there was effective working together by health and social care services in their region, with 41.4% either responding disagree or strongly disagree (33.5% and 7.9%). There is a large proportion that are neutral in their response (37.0%), but fewer suggested they either agreed or strongly agreed (21.6%). This would suggest concerns with the effectiveness of the health and social care intersection.

When asked about how to encourage more effective working of these services, respondents suggested co-located teams, compatible IT systems and multi-disciplinary teams as the most prevalent answers (29.1%; 27.4%; and 24.7% respectively). A number of responses selected multi-disciplinary training (10.2%), but there were a number that also selected other (8.6%), which was noted by the free text responses as a combination of the above options, particularly co-location and IT systems.

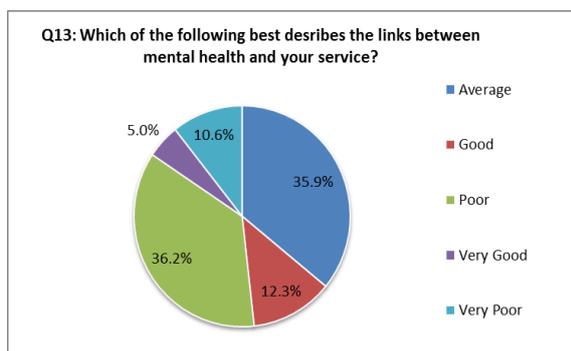


When trying to unpick the inter-agency component of health and social care working, respondents suggested that a large percentage were satisfied. Whilst only 16.1% agreed or strongly agreed, 47.3% stated that it was average. Almost 1/3 of respondents stated the working was poor or very poor (29.5%), suggesting that whilst many felt that the working was good or average, a large number were concerned.

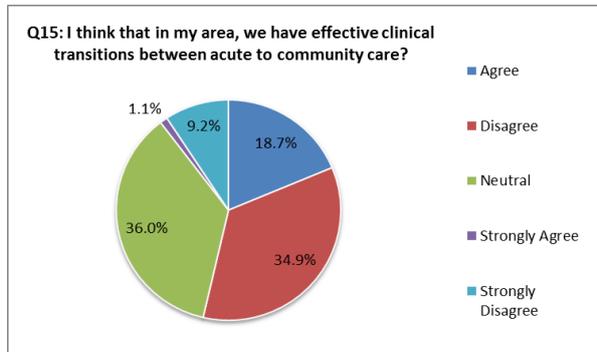


When examined in collaboration with Q. 11 above, this suggests that respondents thought the interagency working was average, but not effective. This could be in relation to how effective other interagency working is seen by the respondents. Importantly, this could be suggesting that respondents are aware that other services may also be struggling with interagency working.

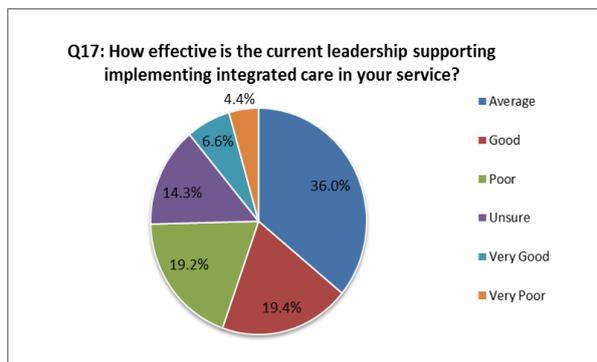
In comparison to the responses about health and social care services, when asked about links between mental health and their own service, 46.8% suggested poor or very poor links. Only 17.3% suggested good or very good links, but over 1/3 of respondents (35.9%) suggested the links were average. This profile has a stronger negative profile, but still retains a high percentage of ambivalence, suggesting that whilst the links are poor/very poor in some areas, that the majority number of areas with at least average, good, or very good links (53.2%).



When examining the transitions between acute and community care, a majority of respondents suggested they felt that they were not effective (44.1%), with a much smaller amount suggesting effectiveness (19.8%). These responses included a large number of neutral answers, over 1/3 (36.0%). This suggests further ambivalence about the effectiveness of the transitions.



When responding to a question about the effectiveness of respondents' current leadership in implementing integrated care, respondents suggested a high amount of ambivalence, with the bulk suggesting an average response. Slightly fewer respondents suggested poor or very poor (23.6%) than good or very good (26%) leadership in supporting the implementation of integrated care.

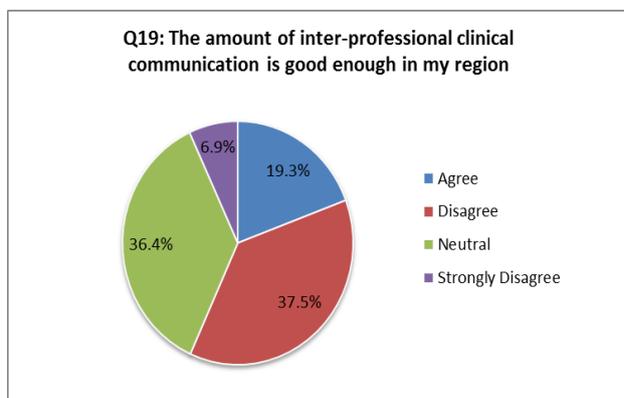


6.2 Communication

Survey respondents suggested concern with both the amount and quality of inter-professional communication in their region. This concern was not unequivocal, however, with a large amount within the neutral category. Compatible IT systems

was chosen by almost 50% of respondents as their choice for how to improve communication between community, acute and social care services.

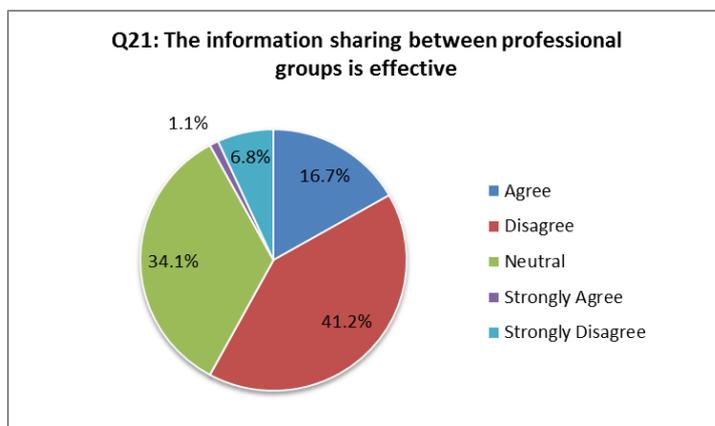
Respondents suggested a mixed, but slightly negative response to whether the amount of inter-professional clinical communication across their region was equivocal. 44.4% suggested either disagree or strongly disagree, with only 19.3% responding as 'agree'. What is important about these responses is that there were no responses of 'strongly agree'. Whilst this does not show a strong negative response, it is not completely equivocal. For instance, if re-calibrated, responses of neutral, disagree or strongly disagree are 80.8% of responses. This would suggest respondents recommend at least some improvement in the amount of inter-professional communication in their region.



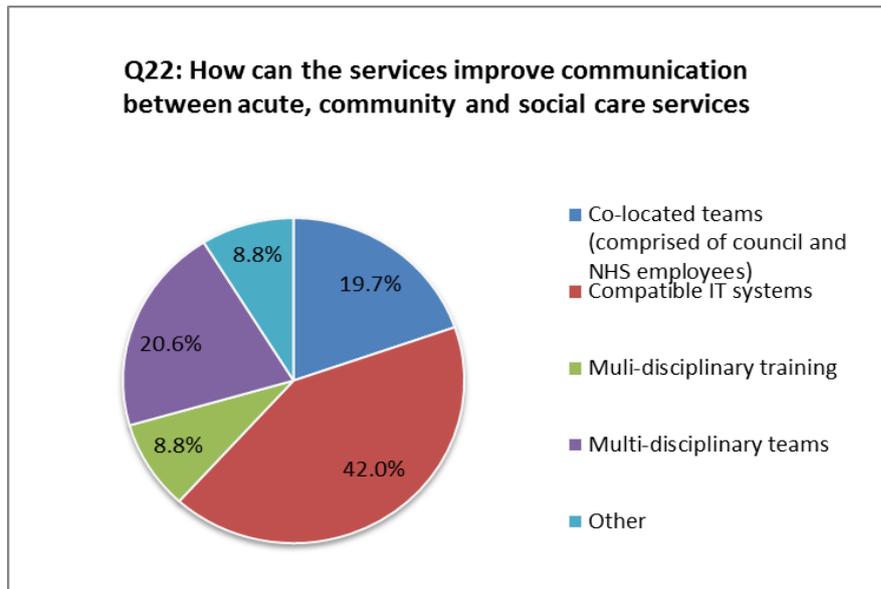
When asked about their thoughts about the quality of inter-professional communication, respondents were broadly similar to above. 43.8% of respondents stated either 'disagree' or 'strongly disagree', with only 20.1% responding with 'agree' or 'strongly agree'. There were a large percentage of equivocal answers, with a full 1/3 of responses as neutral.



When asked about whether they thought information sharing was effective between professional groups, the respondents were more assuredly negative. A full 48% responded either 'disagree' or 'strongly disagree', with only 17.8% responding with 'agree' or 'strongly agree'.



When asked about how to improve communication, and provided with a few of the relevant choices drawn from earlier data collection, respondents suggested a clear preference for compatible IT systems. This answer had 42% of the responses, with the next most selected as multi-disciplinary teams (20.6%) and co-located teams (19.7%) almost equitable. This was followed by the last two choices of multi-disciplinary training and 'other' both receiving 8.8% of the responses.



6.3 Training

When answering questions about training, respondents provided some equivocal and some clear preferences. The majority of respondents stated that communication is important in improving delivery of integrated care and a large majority suggested that integrated care should be mandatory training for all clinical staff.

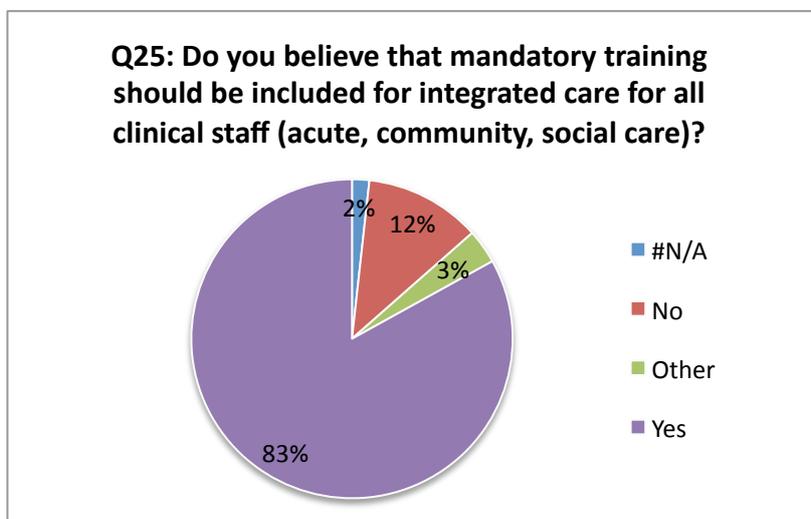
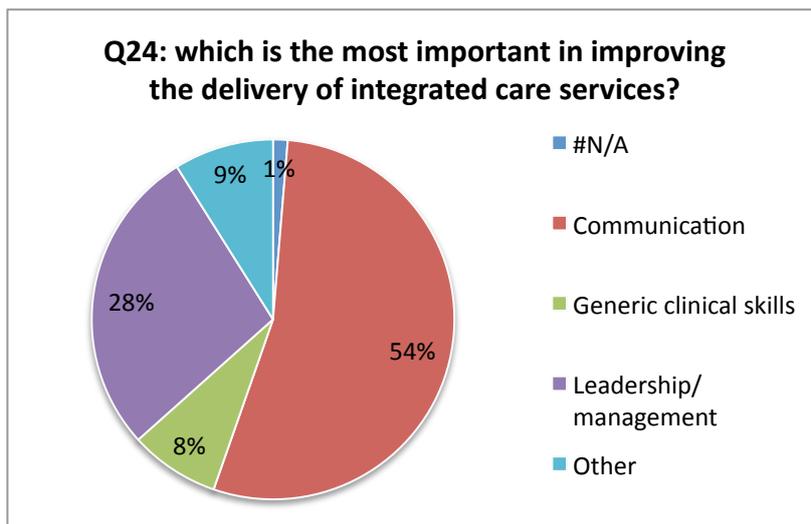
The most important topic to include in integrated care training was better understanding of roles, with a strong secondary topic of multi-professional and inter-disciplinary topics. Face-to-face training is suggested as most effective (with a large proportion suggesting ‘other’, noted as a combination of provisions). Learning and development departments were seen as the best place for respondents to receive their ongoing integrated care training, with a high percentage also suggesting a desire for inter-agency group provision. But there was strong agreement that training about finance, budgets and benefits would assist with better resource management.

Mentorship was suggested as best for providing experience to deliver higher risk care in the community, followed by rotational posts and accredited training. A large percentage of respondents suggested patient safety training for administrators would improve communication and understanding patient needs, but there was also a degree of ambivalence. A more detailed outline of responses to each question follows below with narrative explanation for each.

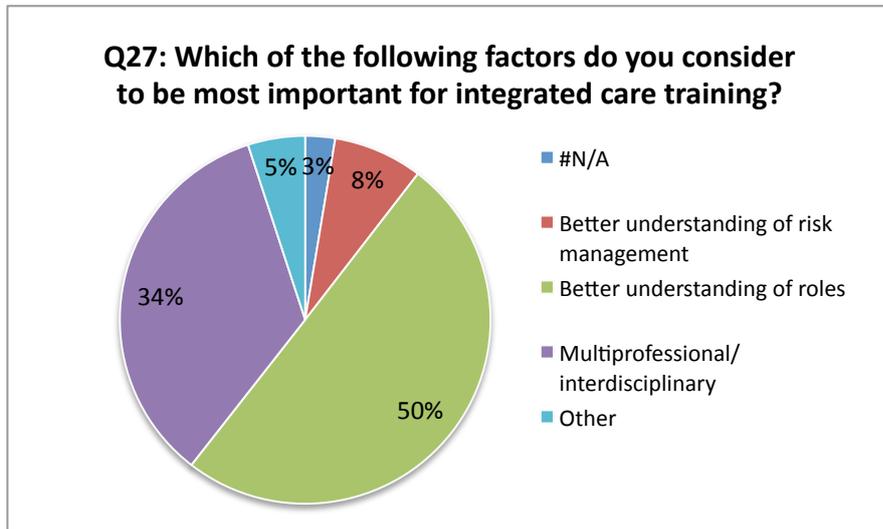
Detailed Responses

Responses suggested a high proportion of respondents thought that communication was the most important factor to improve the delivery of integrated care (54%), followed by leadership and management (28%). Far fewer of respondents think that generic clinical skills or 'other' are most important (8% and 9%).

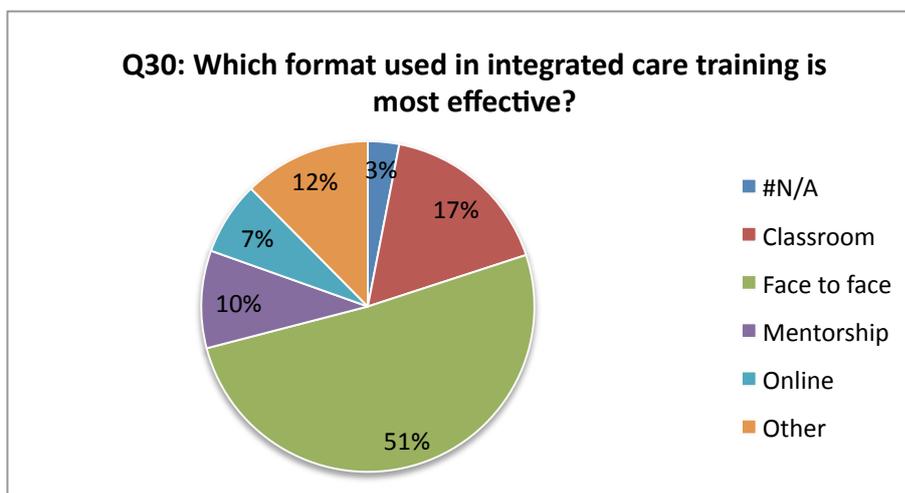
Respondents agreed significantly that integrated care should be mandatory training for all clinical staff, which included acute, community and social care staff (83%). Only 12% thought that this was not necessary.



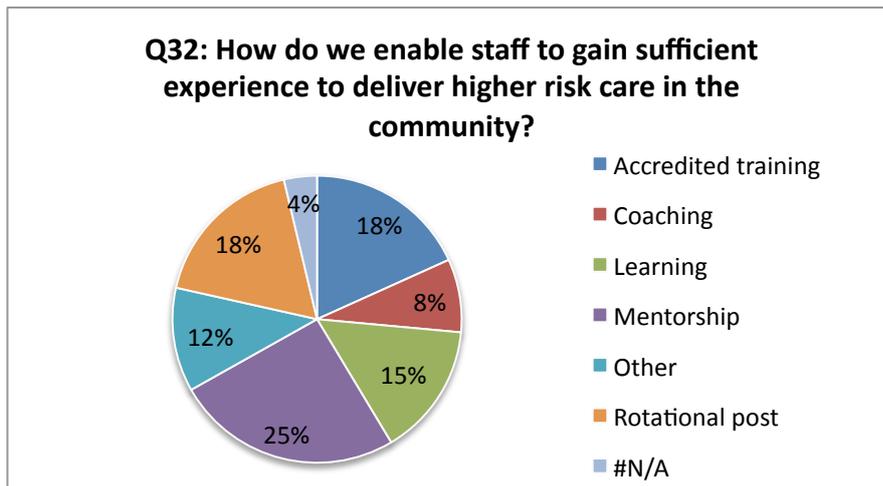
The majority of respondents thought that better understanding of roles was the most important factor to include in training about integrated care (50%). This was followed by 1/3 of respondents suggesting that multi-professional and interdisciplinary concepts needed to be included (34%). Far fewer thought that risk management or 'other' was most important (8% and 5% respectively).



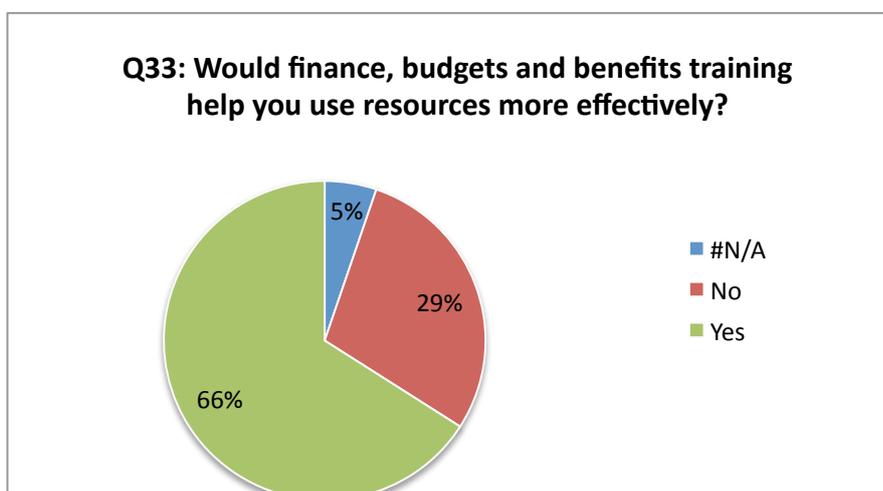
Respondents were strongly in favour of face-to-face training as the most effective format for integrated care training (51%). This was followed with significantly fewer suggesting classroom training (17%), and mentorship (10%) or online (7%). A significant proportion suggested 'other', with a number of respondent suggested that a mixture of training styles was needed, including experiential and classroom training as the most suggested.



When responding about how to enable staff to deliver higher risk care in the community, respondents suggested mentorship more frequently (25%). This was closely followed by rotational posts and accredited training (both 18%). Classroom learning (denoted here as ‘learning’) and ‘other’ were selected less frequently by respondents (15% and 12% respectively).

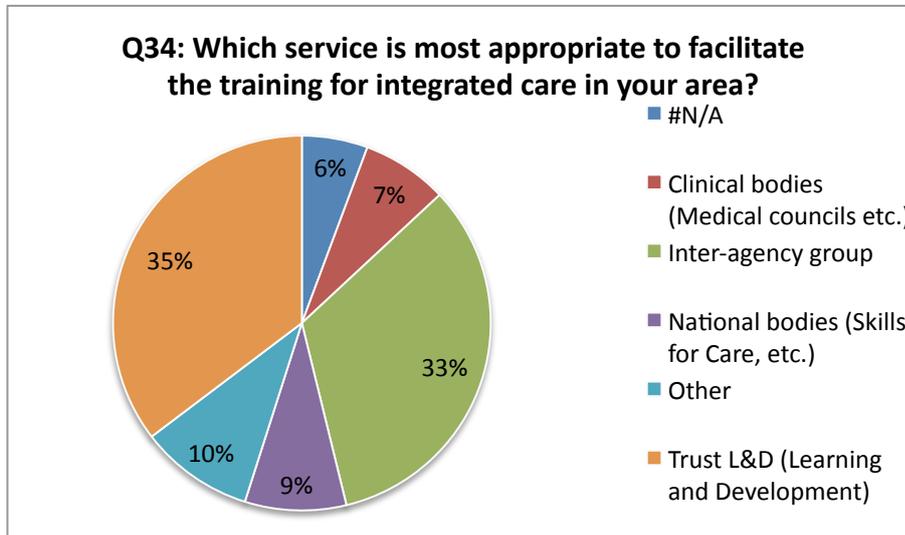


Respondents suggested strongly that finance, budgets and benefits training would help them to use resources more effectively (66%). Less than 1/3 of respondents (29%) thought that this would help them use resources more effectively.

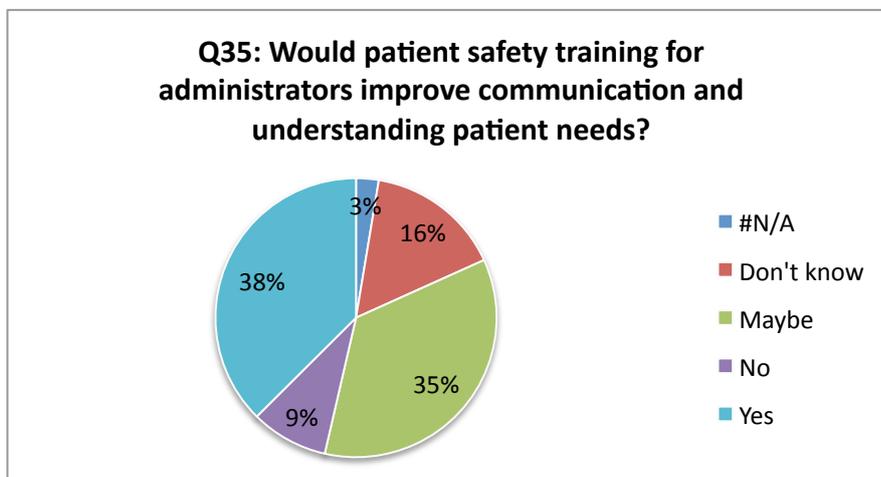


When asked about which service or organisation was most appropriate to facilitate integrated care training for their service area, most respondents chose Trust Learning and Development (35%), followed closely by Inter-agency group (33%),

suggested as a group of agencies working together. Far fewer respondents chose 'other' (10%) and national bodies (9%; such as Skills for Care) and clinical bodies (7%; such as Medical councils). This suggests that respondents are again suggesting the need for multi-disciplinary training, and showing a preference for multi-agency training.



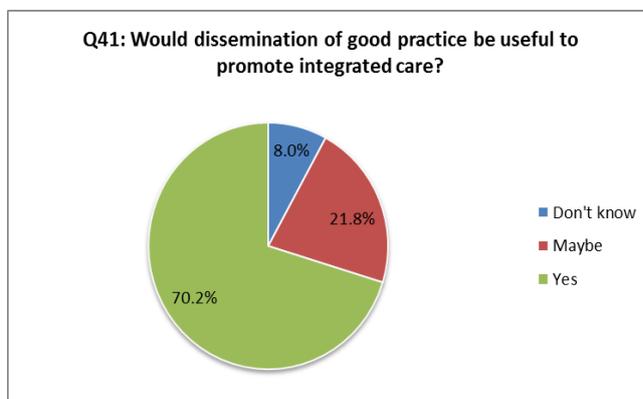
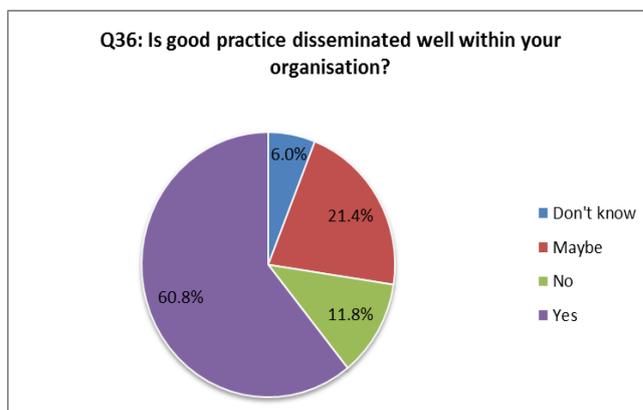
Respondents were also asked about whether patient safety training would improve communication and understanding of patient needs. They were more equivocal in their response, with more than 2/3rds suggesting 'yes' or 'maybe' (Yes, 38%; Maybe, 35%), and only 9% suggesting 'no'. Notably, 16% answered 'don't know', which suggests further ambivalence about respondents' thoughts about the need for this.



6.4 Disseminating Good Practice

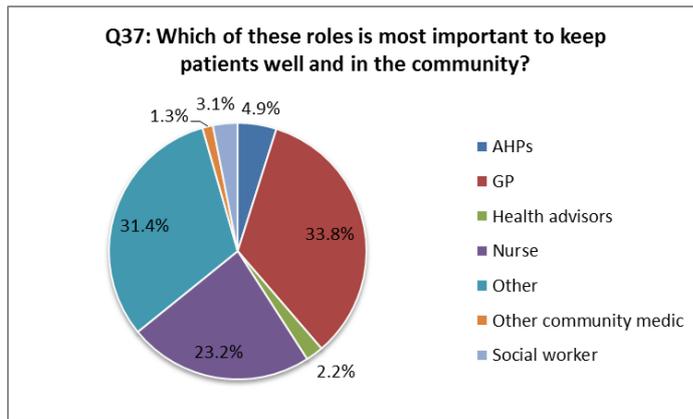
These two sections are grouped together because they relate to service delivery and organisational dissemination of good practice. Respondents suggested that they felt that their organisations disseminated good practice well, and that this was important to promoting integrated care.

Questions 36 and 41 both sought respondents' thoughts about best practice. The bulk of respondents suggested that good practice was disseminated well (60.8%) and that disseminating good practice would be useful to promote integrated care (70.2%). This is followed by 33.2% of respondents that suggest that either they don't know or don't think that good practice is disseminated well, suggesting that there remains some room for improvement. Notable here is the lack of any responses that suggest that the dissemination of good practice isn't important to promoting integrated care; none of the respondents selected 'no' as an option.

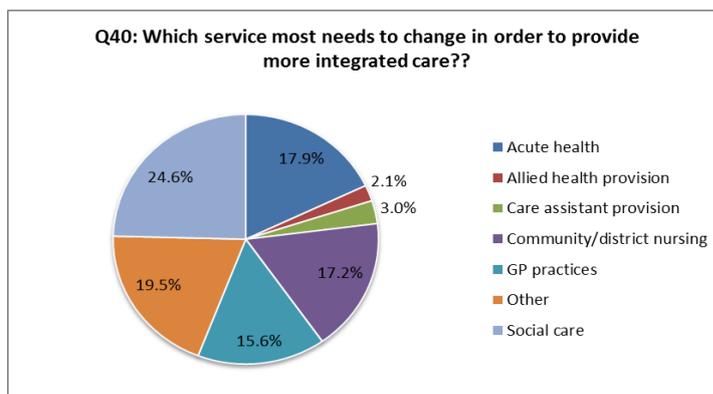


Roles and Service Importance to Improve Integrated Care

When asked about which roles and services are important in providing integrated care, respondents had a more balanced response profile. Responses were almost equally divided between GPs and social workers as the two most important roles to keep patients well and in the community (33.8% and 31.4%), followed by nurses (23.2%). There were far fewer responses suggesting that AHPs, health advisors or other community medics were most important (4.9%; 2.2%; and 1.3% respectively).



Respondents also gave a mixed response to which service needed the most change to provide care that is more integrated. Responses were divided, but with social care being identified by 24.6% of respondents as needing to change the most. This was followed by a broad grouping of four categories between 15-20% of responses: 'Other' (19.5%); Acute health (17.9%); Community/district nursing (17.2%) and GP practices (15.6%). Care assistant and allied health provision were the least selected (3% and 2.1%).



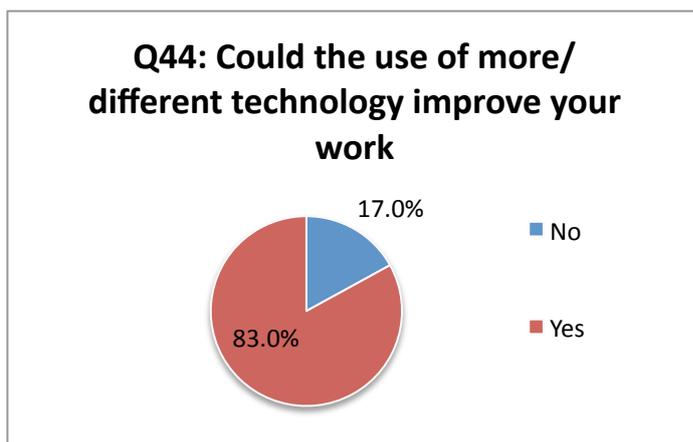
6.5 Use of Technology

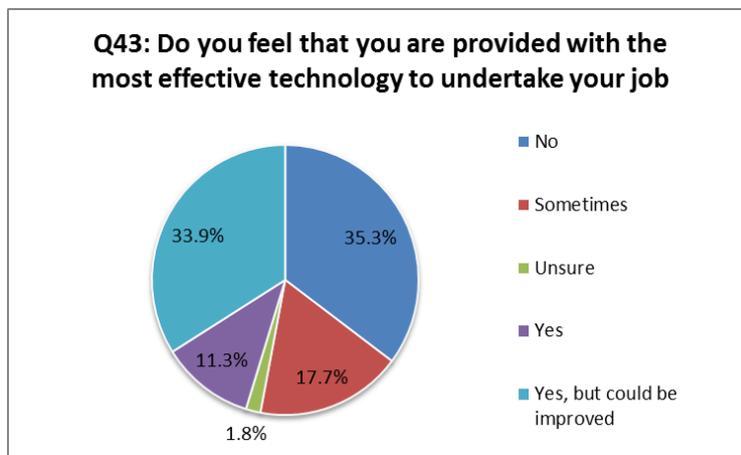
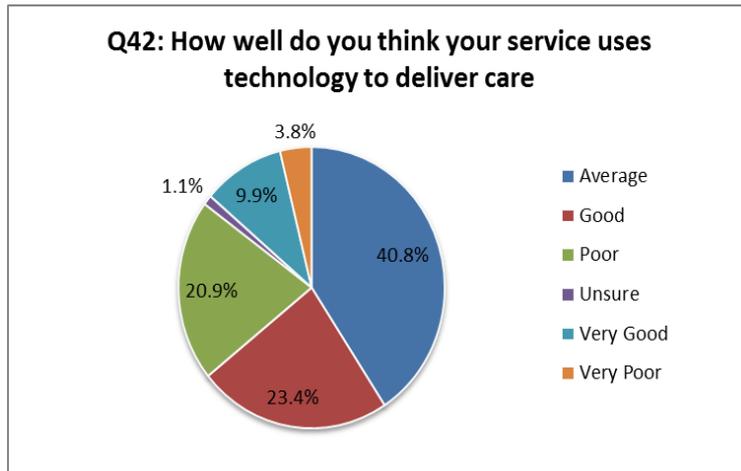
Respondents strongly suggest that using more or different technology could improve their work (83% agreeing), with far fewer responding that more is not needed (17%).

Fully 1/3 of responses stated that they thought their service used technology well or very well (33.3%), but more suggested the service use was only average (40.8%). Notably, almost a quarter of respondents stated that the service use was either poor or very poor (24.7%). This would suggest that respondents think that their services use technology well, but there is continued room for improvement. When taken in conjunction, these two questions suggest that respondents think that with different technology, their service could improve its delivery.

Interestingly, when this question is unpacked with a more detailed question, 35.3% of respondents state that they are not provided with the most effective technology for their job, but a further 1/3 state that it is adequate but could be improved (33.9%). When taken collectively, this shows that over 2/3rds of respondents feel that they could have more effective technology to undertake their job. Only 11.3% agree that they have the most effective technology, with a large percentage suggesting further uncertainty, responding that they 'sometimes' do (17.7%). When examined in conjunction, these responses indicate concern for the technology provided, with only a small percentage satisfied that the technology is effective enough, and a high proportion feel that it could be improved, or is only sometimes effective.

These responses indicate suggestions that technology could be a mechanism by which service delivery could be improved.

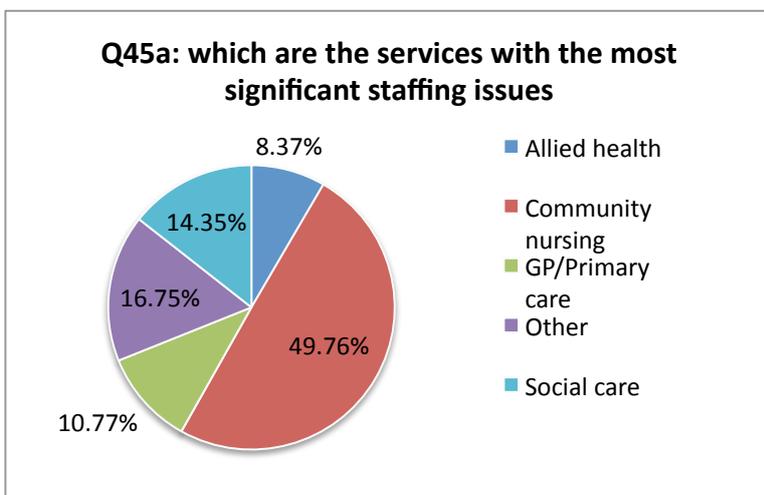
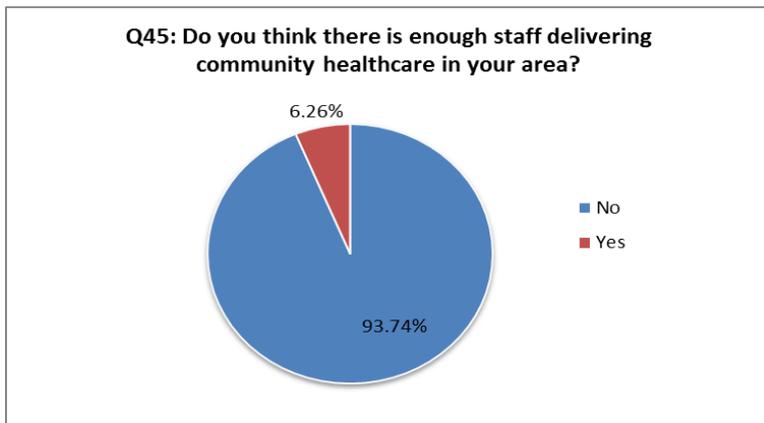




6.6 Staffing and Capacity

When responding to questions about staffing and capacity, respondents were clear that they thought that there was not enough staff delivering community healthcare. There was almost unanimous responses that more staff is needed delivering community healthcare (93.74%). Community nursing being identified as the service with most significant staffing issue (49.76%), followed by 'other' (which had a number of respondents that stated a combination of services that had staffing issues) and social care.

Whilst this suggests a clear concern with staffing levels, it can also be indicative that respondents feel that more clinicians should be transferred from hospital to community healthcare roles. There is also a possibility that respondents suggested their own role as requiring more staffing, but when this question is compared with the numbers of roles, the two sets of responses are not directly concordant. For example, the respondents included 34% of GP/practice professionals, and 18% GPs responding, but this response included on 10.7% suggesting that GPs were most in need of increased staffing. Also, only 6.3% of respondents were from social care, but 14.4% respondents indicated that social care had the most pressing need for increased staffing.



7.0 Conclusion

This report has outlined the training needs analysis of the 'out of hospital' workforce across Thames Valley. It has considered the literature, which suggests that integrated care is being implemented across the health and social care sectors, but with varying levels of integration. There is lack of clarity about the term 'integrated care', with different definitions used throughout the literature. The policy drivers for this integration are consistent and becoming stronger, with a number of key recent reports highlighting the need for more care to be provided in the community by a wider range of skills and professions (Cavendish, 2014; Willis, 2012; 2015). These reports suggest that HCAs are integral to the provision of care and they and nurses in the community need a more defined career pathway.

The report outlined the methods used, describing the *sequential mixed methods* approach adopted. There were three phases of the project: a broad staff survey, focus groups of mixed clinicians, and interviews with key informants from health and social care organisations. The findings suggest that there are concerns about communication, particularly between organisations, and about IT systems incompatibility. Staff in the community were seen as needing to be upskilled, and to have a wider range of generic skills and knowledge (including about long term conditions). There were concerns about staffing levels and capacity, particularly of community nurse and social care teams.

The following sections include a list of recommendations, the limitations to the study, and a range of best practice examples found across the region.

7.1 Recommendations

- More inter-disciplinary training and education opportunities recommended for staff, particularly to include GPs/community medics and social workers with community health clinicians.
- The inclusion of inter-disciplinary modules in pre-qualifying education for professionals, where possible.
- Rotational roles between community and hospital to be encouraged to improve skill mix, and service knowledge across the sector.
- Increase the number and variety of joint community/hospital posts, including medics, to improve flow of skills and knowledge between areas.
- Enhanced scrutiny of improving IT compatibility, so that GPs, community health and social care staff can work from a shared care plan.
- Development of a 'New Who' that undertakes more involved work with vulnerable or frail patients within general practice surgeries. This role to include a cross-professional approach, senior clinical decision-making ability, and access to both health and social care records and referral facilities.
- More co-location of services, particularly health and social care. 'Sharing milk' can be a swift route to help staff understand each other's roles.
- In areas with more organisational boundaries and smaller geographic areas, better communication with neighbouring services about provisions.
- Also in these areas, multi-organisation co-location is recommended, including multi-Trust co-location. For example, community nurses and therapy services from more than one Trust could share at least one office with a number of social workers from a local area. These may helpfully be located near (or in) GP surgeries.
- Specific knowledge and skills development, particularly of diabetes, mental health and COPD for community staff.
- Develop career pathways using the *Care Certificate* and *Advanced Care Certificate* for HCAs to improve staff retention in the community.
- Improve training for administrative and reception staff in some areas to enable them to help direct patients more effectively at the service 'front door'.

- Develop career pathways for community and practice nursing, to enable greater clinical responsibility to reduce hospital admissions.
- Where pockets of staff have gathered and stagnated, for the skill mix to improve by requiring rotational posts and making more stringent demands for CPD.
- Determine the efficacy of implementing the role of 'interface doctor' in the community, with both GP and A & E knowledge and skills.
- Leaders to direct more sustained integrated working at strategic levels, including displaying preferences of collaboration over competition.
- Web information for services to improve to encourage staff to use when showing patients how to improve self-management.
- Universities to determine how to accelerate course design and delivery to create courses that are able to support the pace of change in services.
- A further review of the workforce is recommended in 2-3 years to determine whether there have been changes to workforce knowledge, skills and service delivery.

7.2 Study Limitations

As with any project of this size and scope, there are limitations to the study. Some organisations had very slow internet loading of the survey because of security firewalls. This reduced uptake of the survey, as reported by some respondents.

Because of the disparate scope of the services, there are some pockets of service delivery that were more difficult to connect, such as voluntary and charity services or independent contractors (*i.e.*, care homes and GP practices).

Because of the wide spread of roles, professions and organisations engaged with by the project, there were translational difficulties for all the data collection tools, which were expected. These were managed by seeking professional advice from relevant authorities, and ensuring that the language used was as broad as possible, whilst still retaining a sense of the topic.

Because of the commissioners' overt connections to health, there was less engagement from social care, requiring significant engagement in order to have a relatively smaller uptake. Whilst the attendance and completion (of surveys and focus groups) is smaller, the input was important in providing a broader set of findings. This was managed through the deliberate inclusion of social care leads for some interviews in as many localities as possible, and requests for social care attendance at focus groups.

7.3 Best Practice Examples

Milton Keynes

- Co-location of community nurses attached to GP practices.
- Shared leads for joint services: Council leads on learning disability, community health leads on mental health and Intermediate care is a joint service. This includes a nominated lead from each organisation.
- Critical Response Service: a team providing support for a patient overnight to support reducing A&E admissions
- Jointly appointed geriatrician/gerontologist: ½ Community & ½ Acute Service

- Rapid Assessment and Intervention Team (RAIT): Single-point of access to assist with appropriate service referrals
 - <http://www.cnwl.nhs.uk/service/milton-keynes-rapid-assessment-intervention-team-rait/>

Oxford

- 'Breaking the Cycle': similar to a LEAN event, senior managers making rapid changes to service delivery, with noticeable changes including swift co-location of social care staff in A&E.
 - <http://www.england.nhs.uk/wp-content/uploads/2015/03/breaking-the-cycle-guidance-tips1.pdf>
- Oxfordshire Care Summary: GP info viewable by Acute, and soon Social Care and Community Health
 - <http://www.oxfordshireccg.nhs.uk/your-health/oxfordshire-care-summary/>
- 'Circles of Support': Age UK project to use volunteers to support patients in the community.
 - http://www.circlesnetwork.org.uk/index.asp?slevel=0z114z115&parent_id=115
- Hospital at Home: multi-disciplinary team provision for patients in community, for up to 14 days.
 - http://www.oxfordhealth.nhs.uk/service_description/hospital-at-home/

Buckinghamshire

- BRAVO service: Bucks Reablement & Admission AVOidance, funded through Better Care Fund, brings together health and social care reablement services to create a new, 0800 number, with no restructuring, but with service re-alignment.
 - <https://democracy.buckscc.gov.uk/documents/s56980/Quality%20update%20briefing%20April%202015.pdf>
- Adult Community Healthcare Teams: brings together community health staff into locality based teams, including a 24/7 service.

- Integrated Respiratory Service: integrated community and hospital services, with specialist nurses working across community and hospital, supporting people to stay at home and getting them home as quickly as possible after any necessary hospital stay.
 - <http://www.buckshealthcare.nhs.uk/Downloads/Patient-leaflets-Respiratory/Pulmonary%20rehabilitation%20programme.pdf>

Berkshire

- Intermediate Care: teams comprised of a physio and occupational therapists, with links to social care and community nursing. Six weeks of care, for support during referral to social care until social care support was implemented
 - <http://www.berkshirehealthcare.nhs.uk/ServiceCatInfo.asp?id=16>

South Central Ambulance Service

- Multi-Trust training: SCAS training resuscitation to community health nurses
- Emergency Care Practitioners/Specialist Paramedics and Nurses: paramedics and nurses with enhanced multi-disciplinary skills and knowledge - when they go to a 'call' the discharge rate drops from 47-8% to 75%+, resulting in fewer hospital admissions from ambulance calls.

Thames Valley-wide

- HETV: General practice nurse training scheme
<https://thamesvalley.hee.nhs.uk/2014/05/15/hetv-launches-general-practice-nursing-training-scheme/>

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9.0 Appendices

- i. Project Team
- ii. Detailed Outline of Samples
- iii. Project Timeline
- iv. HETV Interim Board Report
- v. Participant Information Sheets
- vi. Consent Forms
- vii. Topic Guide
- viii. Survey Questions
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Appendix i**Project Team**

Jason Schaub	Project Manager
Fleur Smith	Research Assistant/Administrator
Lesley Bridges, Dr. Gulen Addis	Research Associates
Dr. Lauren Griffiths	Senior Team Lead

With: Katie Butterfield, Damian Haywood, Sian Hayes, Penny Farrelly, Andrea Hughes and Ruth Trout

Appendix ii Detailed Outline of Samples

Total number of participants: 534

Data Collection Method	
Launch event	19
Survey	461
Preliminary Focus Groups	22
Validating Focus Groups	22
Interviews	10
Total	534

Total by role:

Role	
Nurse/midwives	236
Doctors	98
Allied health professionals	81
Social Worker	17
L&D leads/specialists	26
HCA/assistants	44
Other (including health scientists)	32
Total	534

Roles by Data Collection Event/Phase:

Launch	19 Total
Nurse	2
Medic	1 (Clinical Director, GP)
AHP	4
	2 Physiotherapists
	1 Paramedic
	1 Occupational Therapist
Social worker	1 (senior manager)
HCA/Assistants	1
Learning & development specialists	6
Other	4

Preliminary Focus Groups	22 Total
Nurses	15
	Community/district nurse 3
	Specialist heart failure nurse: 1

	Practice development nurses: 4
	Lead nurse: 5
	Supported discharge nurses: 2
Medics	2
	Hospital consultant: 1
	GP commissioner: 1
AHPs	3
	Occupational therapist: 1
	Pharmacist 1
	Radiologist 1
HCA	1
Learning leads	1

Validating Focus Groups	22 Total
Nurse	7
	Practice nurse: 2
	Community/district nurse: 5
GP	1
AHP	5
	Occupational therapist: 2
	Physiotherapist: 2
	Community pharmacist: 1
Health care assistant	2
Learning and development professionals	7

Survey	461 Total
Nurse/Midwives/School nurse	211
	Nurse: 186 (Including community/district nurse and emergency care practitioner)
	Health visitor/school nurse: 15
	Midwife/community midwife: 10
Medics	94
	General Practitioner: 83
	Medic (other than GP, including paediatric and psychiatrist): 11
AHPs	68
	Occupational therapist: 29
	Physiotherapist: 25
	Dietician: 1
	Pharmacist: 2
	Podiatrist: 1
	Speech and language therapist: 4
	Paramedic: 4
	Clinical psychologist: 2
Social Workers	15 (including managers)
HCA/Assistants	40

	Care assistant: 22
	Health care/Social work assistant: 6
	SW Assistants: 3
	Physio technician: 2
	Rehab assistant: 1
	Care worker: 2
	Therapy assistant: 1
	Emergency nurse assistant: 1
	Medicine management technician: 1
	Senior administrator: 1
Education Leads	7
	Including: clinical development lead, clinical practice educator, learning environment lead, deans, learning and development manager, LTC manager
Others	26
	Practice manager: 4
	Service manager: 1
	Clinical lead: 1
	Business Manager: 1
	Resource Centre Manager: 1
	Business and operational development: 1
	Lead referral coordinator: 1
	Community services manager: 1
	Integrated locality team manager: 1
	Undisclosed: 14

Interviews	10 Total
Healthcare Learning and Development Leads	5
Social Care Leads	2
Integrated Care Leads	2
Director of Nursing	1

Appendix iii Project Timeline

Month	Activity
October	Stakeholder meetings Contact gathering Literature Search
November	Literature Search Launch (18 th November) Methods Design
December	Stakeholder Engagement Literature Search Survey Design
January	Stakeholder Engagement Contact List compiling Literature Review Ethics
February	Stakeholder Engagement Literature Review Preliminary Focus Groups Ethics Pilot Survey
March	Stakeholder Engagement Ethics Survey Opened
April	Stakeholder Engagement Ethics Validating Focus Groups Final call for survey
May	Interviews Data Analysis Write-up

Appendix iv HETV Interim Board Report – 02/03/2015

1. Purpose

To provide a high level summary for Health Education Thames Valley (HETV) of the development and progress of the Thames Valley 'Out of Hospital' workforce training needs analysis.

2. Background

This project originated with the Oxford Academic Health Science Network (Oxford AHSN) and HETV. The organisations are seeking further clarity about the training needs of the community and primary care workforce, as they move towards providing more integrated care. It is anticipated that the findings from this project will be used to inform organisational decisions and strategies for the development of a future workforce that is truly fit-for-purpose with the ability to provide integrated, person-centred care closer to home. As the landscape of care changes over the next few years, it will be increasingly important to make sure there is the right workforce, trained to embrace a role/s that ensures patient care remains robust during the reformation of clinical services; bringing care closer to home.

Co-ordinating services and professionals involved in providing care to patients is difficult and the patient experience may be fragmented with a sense of 'falling through the gap' (DH, 2013). In addition to this setting, the population is aging and presents with more complex needs than historically (Oliver, Foot & Humphries, 2014). The integration of care for patients in the community is approaching, yet this integration has significant challenges including differing structures, processes, commissioning and professional expectations. An important method of delivering this change is through the training and education of the workforce delivering care in the community (CfWI, 2013).

This project is using a mixed methods approach including three phases (the timeline is outlined in appendix 1): a broad staff questionnaire of community/primary care workforce; validating focus groups of frontline clinicians; semi-structured interviews with key informants (service improvement or integrated care leads).

This report summarises the project work to date, and outlines the further stages as planned.

3. Key issues and actions

3.1 Project Design & Stakeholder engagement

To date there have been 15+ meetings with external stakeholders across the region. A launch event took place with representatives invited from the relevant organisations. Ethics is granted for the first two phases, with a further final approval in process. The questionnaire is designed and refined following findings from initial focus groups. The questions for both interviews and focus groups are drafted, pending further input from the questionnaire.

3.2 Contact lists

There has been significant work in gathering good, 'live', contact details of relevant key informants from across the region to assist with disseminating the questionnaire in Phase 2, a key strategy to improve questionnaire completion rates. With a scope of this size, across this many organisations, ensuring organisational and management engagement is key to collecting enough data to generate useful findings.

3.3 Data collection

There have been several parts to the data collection that have taken place already. The launch event took place, which included focus group discussions. Three initial focus groups took place (Buckinghamshire, Berkshire, Oxfordshire), these findings have been used to design the questionnaire. The questionnaire was launched on 2 March and will close on 30 April.

4. Next steps

- Validating focus groups (x9, April)
 - Buckinghamshire, Berkshire, Oxfordshire, Milton Keynes
- Interviews with key informants
 - One at each Trust & local authority
- Data analysis
- Report write-up
- Complete report – expected 31 May

5. Conclusion

This project is needed in order to help inform workforce redesign and to determine the training needs of the workforce. It is a complex and large needs analysis of a disparate and complicated workforce. Engaging with this number of organisations, across this area, has been challenging, but there has been willingness to take part. The project includes three phases: questionnaire, focus groups, interviews. The reporting timescale is a challenge, but the project is on track to complete on time.

6. Recommendations

1. Encourage relevant managers to disseminate questionnaire
2. Encourage relevant clinicians to complete questionnaire
3. Release relevant clinicians to take part in focus groups
4. Encourage relevant key informants to be interviewed

Project Timeline

Oct/Nov/Dec/Jan	February	March	April	May
Stakeholder meetings & engagement Contact gathering Contact list compiling	Stakeholder engagement	Stakeholder engagement	Stakeholder engagement	
Literature search & review	Lit Review			Draft final report – 31 May
Launch - 18 November	Initial Focus Groups (x3)		Validating Focus Groups (x9) Interviews (x12-15)	
Methods design Ethics approval	Ethics		Ethics	
Survey design	Finalise questionnaire design	Survey open – 2 March Survey 2 nd call – 24 March	Survey 3 rd call – 14 April Survey close 30 April	Data Analysis

References

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Appendix v Focus Group and Interview Topic Guide

Opening discussion topic:

Drawing on your experience in managing patients with long-term conditions and/or multiple complex needs. How effective is the current clinical management of patients receiving community healthcare?

- a. Personal/professional issues/problems?
- b. Communication?
- c. Knowledge and skills?
- d. Access to information/information sharing

Questions:

1. What is going well in the current construction of the community healthcare?
2. Are there gaps in service delivery to patients in the community healthcare arena?
 - a. Where are issues that cause the most consistent challenges?
 - b. What are less pressing/less common issues?
3. How could the existing provision be improved?
 - a. Education (more, better, different)?
 - b. Improved communication?
 - c. Improved/altered leadership?
 - d. Staff with more experience?
 - e. Major structural changes?
4. What education and/or training is currently available to support you in the delivery of community health care?
 - a. Is current education/training sufficient to address the issues you identify?
 - i. If not, why not?
5. What specific education or training could help you to deliver community healthcare more effectively to bridge the gap between hospital and community?
 - a. Leadership/coaching training

- b. Communication
 - c. Knowledge and skills, specifically?
 - d. Training for administrative/support staff
6. Is there any way that you can think of how to construct the training to help it be more effective?
- a. Multi-disciplinary?
 - b. Multi-Trust (through collaborations)?
7. Is there anything else that you can think of?
8. As a closing - what's one word that describes your thoughts of the community healthcare services?

Appendix vi Focus Group and Interview Participant Information Sheet



Thames Valley Out Of Hospital Workforce Training Needs Analysis Information Sheet for Participants

Purpose:

This project seeks to explore the training needs of the out of hospital (community) health care workforce. During this period of change and structural reform, clinicians training needs will change, requiring Trusts to make changes to the current set of training. This project hopes to inform the way that training is designed for the workforce for the next few years to manage this change.

Participation and Data:

- Taking part for this phase involves being part of a facilitated, audio-recorded focus group of up to 8 clinicians. These clinicians will be from across the community healthcare workforce (including GPs, community nurses, occupational and physio-therapists, and social workers).
- It is not expected that you will have any direct benefits, but taking part will hopefully shape the training for the workforce in the next few years. It is also not expected that you will experience any distress as a result of taking part. There is no requirement from your employer that you take part, and you will not be disadvantaged if you choose not to take part.
- You have a right to withdraw at any time without prejudice and without providing a reason. Your data will not be able to be extracted if you request to withdraw after data analysis has begun (approximately 28 February).
- The data will only be used for this project, which concludes in May 2015.
- The data will be used in the construction of a project report, as well as possible journal articles and conference papers.
- The data will be stored securely, will not be shared with anyone, and your personal details will be stored separately from the data. The data will be held on file for up to 3 years to assist with the production of academic papers.
- The project team is committed to ensuring that your confidentiality is protected. All personal details will be removed when including data in the project report. This will include names, roles and names of organisations, unless these are specific to the context of the point being made.
- If there is any information that comes from the focus group that relates to safeguarding or criminal/unethical behaviour, confidentiality may be breached to a relevant authority. You will be informed, if possible, before this happens.

Project Details:

There are two funding sources for this project: Oxford Academic Health Science Network and Health Education Thames Valley. It is being undertaken by Buckinghamshire New University's Faculty of Society and Health.

This project is called '*Thames Valley out of hospital workforce training needs analysis*'

Feel free to contact the project team for more information at any point, even after the conclusion of the project:

Jason Schaub, project manager	jason.schaub@bucks.ac.uk
Lauren Griffiths, senior team lead	lauren.griffiths@bucks.ac.uk
Lesley Bridges, research associate	lesley.bridges@bucks.ac.uk
Fleur Smith, research assistant	fleur.smith@bucks.ac.uk
Gulen Addis, research associate	gulen.addis@bucks.ac.uk

Appendix vii Focus Group and Interview Participant Consent Form



Consent Form for

Thames Valley Out Of Hospital Workforce Training Needs Analysis

Please tick the appropriate boxes:

I have read and understood the project information sheet.....

I have been given the opportunity to ask questions about the project.....

I agree to take part in the project. Taking part in the project will include taking part in a single focus group, lasting approximately 2 hours, which will be audio-recorded.....

I understand that my taking part is voluntary; I can withdraw from the study at any time and I will not be asked questions about why I no longer want to take part.....

Select only one of the next two options:

I would like my name used where I have said or written as part of this study will be used in reports, publications and other research outputs so that anything I have contributed to this project can be recognised.....

I do not want my name used in this project.....

I understand my personal details such as phone number or address will not be revealed to people outside of this project.....

I understand that my words may be quoted in publications, reports, web pages, and other research outputs but my name will not be used unless I requested it above.....

I understand that other researchers will have access to these data only if they agree to preserve the confidentiality of these data.....

I understand that other researchers may use my words in publications, reports, web pages and other research outputs.....

I agree to assign the copyright I hold in any materials related to this project to Jason Schaub.

On this basis I am happy to participate in the TV Out of hospital workforce training needs analysis

Name of Participant Signature..... Date.....

Name of Researcher..... Signature..... Date.....

If you have any queries or concerns, please contact:

Jason Schaub, project manager - jason.schaub@bucks.ac.uk

Fleur Smith, research assistant - fleur.smith@bucks.ac.uk

tel: 01494 522 141

One copy to be kept by the participant, one to be kept by the researcher

Appendix viii**Survey Questions****1. Which organisation do you currently work for?**

Buckinghamshire Healthcare NHS Trust
Buckinghamshire County Council
Aylesbury Vale Clinical Commissioning Group
Chiltern Clinical Commissioning Group
Milton Keynes Hospital NHS Foundation Trust
Milton Keynes Community Health Services
Milton Keynes Clinical Commissioning Group
Milton Keynes Council
Berkshire Healthcare NHS Foundation Trust
Berkshire West Clinical Commissioning Group
Royal Berkshire NHS Foundation Trust
West Berkshire Council
Bracknell and Ascot Clinical Commissioning Group
Bracknell Forest Council
North and West Reading Clinical Commissioning Group
South Reading Clinical Commissioning Group
Reading Borough Council
Slough Clinical Commissioning Group
Slough Borough Council
Frimley Health NHS Foundation Trust (Heatherwood and Wexham Park Hospitals)
Windsor, Ascot & Maidenhead Clinical Commissioning Group
The Royal Borough of Windsor and Maidenhead Council
Oxford Health NHS Foundation Trust
Oxfordshire Clinical Commissioning Group
Oxford University Hospitals NHS Trust
Oxfordshire County Council
Health Education Thames Valley
Southern Health NHS Foundation Trust
South Central Ambulance Service NHS Foundation Trust
Wokingham Clinical Commissioning Group
Wokingham Borough Council
Other, please specify
Private and Voluntary Organisation, please specify

2. Which of the following is your area?

Berkshire: Bracknell Forest
Berkshire: Reading
Berkshire: Slough
Berkshire: West
Berkshire: Windsor & Maidenhead
Berkshire: Wokingham
Buckinghamshire
Oxfordshire
Milton Keynes
Other, please specify

3. What is your professional area?

Community health
GP Practice/Primary care
Acute healthcare
Social care
Other, please specify

4. What is your job role/job title?

General Practitioner

Medic (other than GP)
Nurse
Occupational Therapist
Physiotherapist
Social Worker
Care assistant
Other, please specify

5. Which of the following is your current job band?

Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
My role does not use healthcare banding

6. How many years have you worked in your current role?

Less than 1 year
1-2 years
3-5 years
6-10 years
10 years or more

7. Is community based integrated care working effectively in your region/locality?

Yes/No

8. If integrated care is not effective in your region, which of the following do you think most inhibits effective care integration?

Organisational culture
Hierarchical structures
Poor communication
Technology
Lack of resources
Other, please specify

9. Which of the following is the best role to co-ordinate and implement community based integrated care packages?

GP
Nurse
Occupational Therapist
Social Work
Other, please specify

10. Which of the following is the biggest reason that other systems have struggled to provide integrated care? Please select all those that apply:

Resourcing
Employment models
Hierarchy and status
Poor understanding
Obstructive behaviours

Lack of support
Bureaucracy
Technology
Poor communication
Other, please specify

11. To what extent do you agree with the following statement: I think that health and social care services work together effectively in my region.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

12. How could community health and social care services be encouraged to work together more effectively?

Multi-disciplinary teams
Co-located teams (comprised of council and NHS employees)
Multi-disciplinary training
Compatible IT systems
Other, please specify

13. Which of the following best describes the links between mental health and your service?

Very Poor	Poor	Average	Good	Very Good	Unsure
-----------	------	---------	------	-----------	--------

14. Which of the following best describes your regional inter-agency working between social care services and healthcare?

Very Poor	Poor	Average	Good	Very Good	Unsure
-----------	------	---------	------	-----------	--------

15. To what extent do you agree with the following statement: I think that in my area, we have effective clinical transitions between acute to community care.

Very Poor	Poor	Average	Good	Very Good	Unsure
-----------	------	---------	------	-----------	--------

16. What are the ways that services can make integrated care more attractive to patients and clinicians?

17. How effective is the current leadership supporting implementing integrated care in your service?

Very Poor	Poor	Average	Good	Very Good	Unsure
-----------	------	---------	------	-----------	--------

18. How can services use leadership and management to encourage more integrated care?

Very Poor	Poor	Average	Good	Very Good	Unsure
-----------	------	---------	------	-----------	--------

19. To what extent do you agree with the following statement: The amount of inter-professional clinical communication is good enough in my region.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

20. To what extent do you agree with the following statement: The quality of inter-professional clinical communication is good enough in my region.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

21. To what extent do you agree with the following statement: The information sharing between professional groups is effective.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

22. How can the services improve communication between acute, community and social care services?

- Multi-disciplinary teams
- Co-located teams (comprised of council and NHS employees)
- Multi-disciplinary training
- Compatible IT systems
- Other, please specify

23. How well does your organisation identify staff training needs?

Very Poor	Poor	Average	Good	Very Good	Unsure
-----------	------	---------	------	-----------	--------

24. Of these areas, which is the most important in improving the delivery of integrated care services?

- Communication
- Leadership/management
- Generic clinical skills
- Other, please specify

25. Do you believe that mandatory training should be included for integrated care for all clinical staff (acute, community, social care)?

Yes/No

25.a. Can you identify the type of training that should be mandatory?

26. Are there any challenges with integrated care training?

Yes/No

26.a. If yes, please explain:

27. Which of the following factors do you consider to be most important for integrated care training?

- Multiprofessional/interdisciplinary
- Better understanding of risk management
- Better understanding of roles
- Other

28. Do you think the training you currently receive is adequate to provide integrated care effectively?

Yes/No

28.a. Can you provide details to explain your answer?

29. To what extent do you agree with the following statement: The frequency of training I receive is adequate.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

30. Which format used in integrated care training is most effective?

- Face to face

Online
Classroom
Mentorship
Other, please specify

31. Is there additional training that you could benefit from receiving, in order to provide more effective integrated care?
Yes/No
Other, please specify
32. How do we enable staff to gain sufficient experience to deliver higher risk care in the community?
Mentorship
Coaching
Rotational post
Accredited training
Learning
Other, please specify
33. Would finance, budgets and benefits training help you use resources more effectively?
Yes/No
34. Which service is most appropriate to facilitate the training for integrated care in your area?
Trust L&D (Learning and Development)
Inter-agency group
Clinical bodies (Medical councils etc.)
National bodies (Skills for Care, etc.)
Other, please specify
35. Would patient safety training for administrators improve communication and understanding patient needs?
Yes/No/Maybe/Don't Know
36. Is good practice disseminated well within your organisation?
Yes/No/Maybe/Don't Know
37. Which of these roles is most important to keep patients well and in the community?
GP
Other community medic
Nurse
Social worker
Health advisors
AHPs
Other
38. Can you give some examples of effective models of integrated care across the nation?
39. Can you identify some local examples of integrated care good practice? (Please identify up to three)
40. Which service most needs to change in order to provide more integrated care?
GP practices
Community/district nursing

Acute health
 Social care
 Allied health provision
 Care assistant provision
 Other

41. Would dissemination of good practice be useful to promote integrated care?

Yes/No/Maybe/Don't Know

41.a. What would be a good way to disseminate integrated care best practice?

Events
 Newsletters
 Publications
 Training
 Team meetings
 Other, please specify

42. How well do you think your service uses technology to deliver care?

Very Poor	Poor	Average	Good	Very Good	Unsure
-----------	------	---------	------	-----------	--------

43. Do you feel that you are provided with the most effective technology to undertake your job?

Yes/Yes, but could be improved/Sometimes/No/Don't Know

44. Could the use of more/different technology improve your work?

Yes/No

44.a. In what ways? Please explain:

45. Do you think there is enough staff delivering community healthcare in your area?

Yes/No

45.a. If no, which are the services with the most significant staffing issues?

GP/Primary care
 Community nursing
 Social care
 Allied health
 Other, please specify

46. If there are staffing issues, how does this impact on patient care?

47. How do you feel these staffing issues could be resolved?

48. If you are willing, please provide your email address (there is no requirement for you to do so):

Appendix ix Analysis Frequency Table

Theme	Group 1	Group 2	Group 3	Group 4	Total	In Survey
Capacity issues	x	x	x	x	4	x
Communication	x	x	x	x	4	x
Lack of time	x	x	x	x	4	x
Training & education	x	x	x	x	4	x
Diabetes	x	x	x	x	4	x
Systems/IT	x	x	x	x	4	x
Team/ work together/ Collocating	x	x	x	x	4	x
Barriers between staff	x	x	x	X	4	x
Changes. Past/Now/Future.	x	x	x	x	4	x
Referrals	x	x	x	x	4	x
Staff: issues & low staff	x	x	x	x	4	x
Service/Trust (issues)	x	x	x		3	x
Admin: forms, paperwork, notes	x		x	x	3	x
Meetings	x		x	x	3	x
Elderly patients/longer life		x	x	x	3	x
Patients		x	x	x	3	x
Differences		x	x	x	3	x
Funding/money/finance/ commissioning		x	x	x	3	x
Roles	x	x		x	3	x
GPs		x	x	x	3	x
Leaders		x	x	x	3	x
De-skilled/Skills		x	x	x	3	x
GP receptionists		x		x	2	
Public		x		x	2	x
Culture (change)			x	x	2	x
Workload (combine staff)		x		x	2	x
Self-management/care		x		x	2	x
Resources		x		x	2	x
Discharging	x			x	2	x
Social worker	x			x	2	x
HCA role		x			1	x
Gaps			x		1	x
Bed pressure (combined with discharging)				x	1	x

Group 1 includes the initial 3 focus groups

Group 2 includes ½ of validating focus groups

Group 3 includes ½ of validating focus groups

Group 4 includes interviews

Appendix x Introduction Letter



Health Education Thames Valley

Thames Valley House
4630 Kingsgate
Oxford Business Park South
Oxford
OX4 2SU

06 June 2015

Dear Colleague,

Health Education Thames Valley in partnership with Oxford Academic Health Science Network have commissioned Buckinghamshire New University to undertake a training needs analysis of the out of hospital workforce across Thames Valley. It is anticipated that the findings from this project will be used to inform organisational decisions and strategies for the development of a future workforce that is truly fit-for-purpose with the ability to provide integrated, person centred care, closer to home. As the landscape of care changes over the next few years, it will be increasingly important to make sure there is the right workforce, trained to embrace a role/s that ensures patient care remains robust during the reformation of clinical services; bringing care closer to home.

In order to undertake this project, the team will need to make contact with Workforce Directors/Leads to gain the necessary clearance to ensure they have access to the workforce data. It will also be necessary for the team to have access to a range of staff in departments/clinical environments and managers to disseminate the survey and undertake interviews and focus groups with staff. **We would be most grateful if you would facilitate this at a local level and identify a local organisational contact who the project team can liaise directly with.**

The project will be in three parts: a staff-wide survey (of the out of hospital workforce); a series of focus groups with front-line staff (selected from each area); and interviews with some managers and training leads. The project is aiming to complete by end of May 2015, which is an ambitious target for such a large undertaking.

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We encourage you to give every assistance to the project team, who are identified below, and to ensure you have appropriate representatives from your organisation to attend the launch event on 18 November (details which are forthcoming from the project team). The aim of the launch is to provide an outline of the project, and to assist in the formulation of the analysis tool to ensure an appropriate return on input.

I would be grateful if you could email details of your local organisational contact to Jason Schaub at jason.schaub@bucks.ac.uk and should you have any questions please do not hesitate to contact one of the Project Team – details listed below.

Yours sincerely



John Clark
Director of Education & Quality
Health Education England – South



Dr Dan Lasserson
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Project Team:

Jason Schaub, Project Manager – jason.schaub@bucks.ac.uk

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