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Creating an Interprofessional Workforce

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Health and Social Care Policy and the Interprofessional Agenda

The First Supplement to Creating an Interprofessional Workforce: an Education and Training Framework for Health and Social Care in England

'…..working alone with no regular exchanges of experience for mutual improvement can no longer be considered professionally satisfactory'. Working in a team enables the professions to solve 'complex health problems that cannot be adequately dealt with by one profession alone'. (WHO 1999: 135)

'It is one thing to set up a partnership. It is another to develop the mix of skills, energy and commitment to make the partnership effective' (HDA, 2003: 2)

'Partnerships are not a soft option but hard work; partnerships take time to develop; partnerships must be realistic and aim for what can be achieved, not be set up to fail by being too ambitious; partnerships can, if successful, achieve more than individual agencies working alone'. (Wildridge et al, 2004: 4)

Authors:
Dr Rosie Tope & Dr Eiddwen Thomas

HERC
Associates

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Acronyms

ALB   Arm's Length Body
CAF   Common Assessment Framework
CAIPE   Centre for the Advancement of Interprofessional Education
CIPW   Creating an Interprofessional Workforce
CPA   Care Programme Approach
CSIP   Care Services Improvement Partnership
DfES   Department for Education and Skills
DH   Department of Health
ECM   Every Child Matters
EU   European Union
FAME   Framework for Multi-Agency Environments
HDA   Health Development Agency
ICN   Integrated Care Network
ICS   Integrated Children's System
ISIP   Integrated Service Improvement Programme
LAAs   Local Area Agreements
LINk   Local Involvement Network
LP   Lead professional
LSP   Local Strategic Partnership
LTC   Long term condition
NHSU   NHS University
NLN   National Leadership Network for Health & Social Care
NOS   National Occupational Standards
NSF   National Service Framework
NSPF   National Strategic Partnership Forum
PCT   Primary Care Trusts
PMS   Personal Medical Services
SAP   Single Assessment Process
SfCD   Skills for Care & Development
SfH   Skills for Health
SSCs   Sector Skills Councils
WHO   World Health Organisation
WTD   Working Time Directive

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Chapter 1 - Europe's Policy Agenda

Summary

There are numerous challenges ahead for the people of Europe. With fewer children being born and with an ageing population, it is crucial that high quality integrated models of health and social care are implemented without delay. High quality health and social care implies that it is cost affordable, efficient, innovative and synergistic, uses available resources wisely and ultimately is fit for the purpose intended.

High quality health and social care however, are very expensive commodities hence it is not surprising that the EU, its member states, the WHO and other health related NGOs are working in partnership to develop policies that enable Europeans to live long, healthy and productive lives from cradle to grave, through an intensive public health programme. Recent EU and WHO European Region policy mandates the need for interprofessional, interagency and inter-sectoral practice in health and social care. Policy also mandates a more inclusive partnership with other Directorates, including the environment, transport, agriculture, whose policies impact on the health and well being of Europeans.

The majority of people however will experience periods of ill health at some stage of their lives. Some will have to learn to adapt to, and live with, long term conditions that limit or change their life styles forever. With an ageing population the number of people living with a long-term conditions is predicted to rise, each of whom will require the skills of an interagency interprofessional workforce.

Policy makers and strategists have made it crystal clear that the creation of an interprofessional workforce is critical for the health and welfare of future generations and to ignore their advice would, at the very least, be foolhardy.

Setting the scene

It is tempting from the outset of this paper to write that, almost without exception, every policy paper relating to the health of Europe's population, assumes implicitly and in some cases explicitly, that interprofessional, interagency, inter-sectoral practice is the norm. Indeed analysing recent and current policy it is now hard to defend the continuing reluctance, and dare one say active resistance, of hard-core protagonists, to developing patient led collaborative interprofessional partnerships.

An ageing population in Europe is placing increasing demands on the welfare state. Older people, by definition, are more likely to experience ill health and long-term conditions that impact on their ability to live independent lives. Many will need increasing care and support as they move towards the end of their lives. The support of social care services in enabling people to live as

independently as possible in the community has never been more needed. Poverty and social exclusion exacerbate the problems faced by those with long-term conditions and Member State Governments are developing policies that increasingly integrate models of service delivery, personnel and resources between health and social services when caring for people in the community.

The website http://forum.europa.eu.int/Public/irc/sanco/ehf/library gives a comprehensive yet concise explanation of European legislative process and in order to set the scene for the reader of this paper a summary is outlined below.

EU legislation is ratified through a series of Treaties that determine those statutes that remain the collective competence of the EU and those which pertain to the Governments of individual member states. Reflecting the agreed aims of the EU, the Treaties are applied to specific areas of policy. Usually the European Commission (comprising Member State Commissioners and civil servants) proposes legislation to the Council of Ministers (representing the governments of Member States) and the European Parliament (directly elected by the citizens of Europe). Once agreement has been obtained, European legislation is enforced. Agreement can be unanimous or through a majority vote. European legislation takes priority over individual Member State legislation.

Enforcement can take the form of Directives, Regulations, Decisions or Recommendations and Opinions. The most common type is a Directive in which the goals to be achieved are identified by the EU but individual Member States decide how these are to be achieved. The Directive must, however, be invoked in National laws within a specified period. Less commonly, Regulations are invoked that have 'immediate and direct force of law without adaptation to national circumstances'. Decisions are legally binding but are targeted at specific countries. Recommendations and Opinions are not legally binding.

Interpretation of the laws can pose problems however and when this occurs the European Court of Justice (ECJ) clarifies the position. In the words of the website author 'there is a relative absence of specific legislative activity in the field of health care' hence the relatively frequent intervention of the ECJ. Examples of this include Human Rights, and right of access to healthcare in other member states.

To complicate the issue the WHO European Region has published a 'Declaration on the promotion of patients' rights in Europe', which was endorsed by representatives of 36 Member States at a meeting in Amsterdam (WHO 1994). To inform the publication an in-depth analyses of policies relating to patient rights was completed, the results of which revealed that common themes could be found in the majority of member states. Within the Declaration there is a clear mandate which makes it clear that patients 'should be aware of the practical contributions they can make to the optimal functioning of the health system' and that 'their active participation in the

diagnosis and treatment process is often desirable and sometimes indispensable' (p7).

Divided into six 'rights' categories (confidentiality and privacy, consent, information, care & treatment, application) the WHO Declaration frequently implicitly and occasionally explicitly refers to a patient's right to expect that the health professions will collaborate, co-operate and integrate in planning, delivering and evaluating care.

Within the EU there are a number of health service configurations each of which have evolved in response to the individual Member State policy priorities. Each model has its advantages and is heralded by their owners as 'better or even best', in specific contexts, than other Member States. There has been a much greater emphasis on improving health systems performance in practice and education and training on a pan European basis within the past few years however and evidence of this can be found at: http://europa.eu.int/comm/health/ph_overview/health_forum/health_forum_en.htm

Some Member States, as a result of European Court of Justice rulings, have had to overhaul their health service provision radically but now are 'beginning to see the potential benefits from greater collaboration, in particular where they face shortages of capacity or have identified concrete benefits for cooperating across frontiers'.

The Lisbon European Council (2000) established the 'Open Method of Co-ordination' which 'facilitates exchange of best practice and achieving greater convergence in areas where harmonisation of legislation is not possible. It involves agreeing broad goals, establishing indicators and benchmarks of good practice, developing guidelines for policy, with targets to be achieved, that can be adopted where possible, and establishing a system of monitoring that is organised on the basis of mutual learning'. http://europa.eu.int/comm/health/ph_overview/health_forum/health_forum_en.htm

Here then is concrete evidence that there is a wind of change sweeping across Europe. Patients in every country are being actively encouraged to take ownership of their health and self manage (or at the very least be an equal partner) their care when unwell. All individual member states face the same problems and challenges in that they have an ageing population, who have increasing care needs, and a diminishing workforce to deliver the care needed. A pan European model is emerging that focuses on patient and staff mobility and transferability, with an emphasis on international collaboration, co-operation and integration when planning, delivering and evaluating care.

EU policy

It is fascinating to note that one of the most comprehensive websites found on EU policy relating to health and social care includes a large glossary which does not include 'patient', user', 'client', 'carer', 'teamwork', 'collaboration',

'interprofessional' or any other derivative of this. An 'integrated model' is aligned to health insurance and funding and hence is not relevant. Inter sectoral action however fits the purpose more closely as it is defined as 'action in which the health sector and other relevant sectors of the economy collaborate or interact to pursue health goals'.
http://www.euro.who.int/observatory

A key word search was also made within all publications from the European Network Quality Assurance for Higher Education (ENQA) the expectation being that as ENQA includes monitoring the quality of the education and training of health and social care professions within its deliberations, words such as 'teamwork', 'interprofessional', 'multi-professional', 'interdisciplinary' or 'multidisciplinary' would be frequent occurrences. Astonishingly the search yielded just two mentions of 'teamwork' (neither related to health or social care), three mentions of 'interdisciplinary' (none related to health or social care), four mentions of 'multidisciplinary' (none related to health or social care) with no references made at all to multi-professional or interprofessional activities.

Recognising that 'partnerships are a key means for building capacity for multi-sectoral action' the Verona Initiative produced a Benchmark in the form of practical management tools http://www.who.dk/Verona/main.htm These aim to help new and established multi-sectoral partnerships improve the quality of their relationship and also help them to deliver 'sustainable and integrated health and social and economic development' that complement the WHO Health 21 philosophy, analysed in detail later in this chapter on p11.

EU policy makers by translating health thinking into practice through the adoption of Verona Initiative will, it is believed, enable an emphatic shift in service delivery from narrowly focused acute care to a wider focus on community based health and social welfare (WHO 2000 – European Health Communication Network).

In 2004 a High Level Group within the EC Directorate for Employment & Social Affairs published their views on the future of social policy in an enlarged European Union (EC 2004). While the authors make clear that the report contains the views of the high level group rather than the Directorate General itself none the less through its publication it implies that the EC supports it. The Group was considering the next phase of the EU Social Agenda from 2006-2010 and the implications of the enlargement of the EU by 10 accession countries.
A key concern for the Group is that social policy continues to lag behind economic policy in spite of the Lisbon Strategy that aims to put them on 'an equal footing' (p5). The report aims to identify 'policy orientations in need of development' (p6). The three major challenges are identified as enlargement; an ageing population and globalisation. A number of strategies to address these are identified with, for the purposes of the Creating an Interprofessional Workforce Programme review, one which states 'To improve the contribution of social policy to growth, competitiveness and social cohesion by developing lifelong learning, modernising work organisation and reforming social

protection' (p7). Significantly the Group also recommends that 'employers should invest more in the workforce, in order to increase people's capacity to adapt to new work organisations and circumstances' (p23).

New jobs and new roles are emerging due to changes in society such as an increased concern for the environment; living and working in a multicultural society; an understanding of learning as a life long activity from cradle to grave; diversifying health services and a dawning realisation that health and social care are inextricably linked. Opportunities to forge closer partnerships and networks in order to implement innovative practice are to be encouraged as these 'can lead to productivity gains which are more based on value adding as against labour saving' (p26).

To equip people for new ways of working the Group identifies the need to address two different kinds of skills gaps: basic competences embedded in all qualifications and occupational profiles (p26).

The Group clustered the competences required into three:

1. Personal competences: learning to learn; team working; networking; creativity; entrepreneurship; leadership; defining a project.
2. Technical competences: PC user; Internet user; telecommunications user; environment-friendly behaviour.
3. Theoretical competences: foreign languages; European and global citizenship; scientific developments; understanding cultural diversity.

In Chapter 2, The UK Policy Agenda, the links between this EU work and the UK Agenda for Change (AfC), Knowledge and Skills Framework (KSF) and National Occupational Standards (NOS) are explored.

Calling for the acquisition of broad basic skills and an ability to adapt and learn the Group linked this with the need for life-long learning and personal development opportunities. A subsequent policy recommendation returned to this theme emphasising the need to support the creation of networks of services validating and certifying the outcome of informal learning activities (p49).

While the general remit of the Group does not focus specifically on the interprofessional workforce they imply that in view of the rapid increase in health care expenditure as well as a need for greater efficiency and quality, 'a better coordination of the actors can improve the efficiency of health supply' (p56), the actors in this case including everyone from Government to the interprofessional workforce in practice. In order to meet the social inclusion and social protection agenda the High Level Group recommends that health care is explicitly included in all aspects of the different policy strands (p55).

Further policy recommendations of relevance to the Creating an Interprofessional Workforce Programme include the need to 'promote affordable quality services in particular for long-term care of elderly people

and to ensure equal opportunity with regards to access to services, including through innovative funding' (p62).

In view of the 'New Social Agenda 2006-2010' the High Level Group also 'strongly encourages' a greater emphasis on 'innovation, new forms of employment, working time management, [and] reconciliation of work and family life' (p85) with the aim of improved governance. This of course is reflected in the UK initiative 'Improving Working Lives' which will be discussed in greater detail in Chapter 2.

McKee et al (2004) note that the European Observatory acts 'as a bridge between pure academic research and the needs of policy-makers, and to stimulate the development of strategic responses suited to the real political world in which health sector reform must be implemented' and views the fulfilment of this role as one of their key mandates (2004 pX foreword). The editor is confident that

'European national policy-makers broadly agree on the core objectives that their health care systems should pursue. The list is strikingly straightforward: universal access for all citizens, effective care for better health outcomes, efficient use of resources, high-quality services and responsiveness to patient concerns. It is a formula that resonates across the political spectrum and which, in various, sometimes inventive configurations, has played a role in most recent European national election campaigns' (Series editors introduction no page number).

In February 2003 a High Level Process on Patient Mobility, was established by the health ministers of 14 Member States joined, a few months later, by the health ministers of the accession countries. Areas of immediate concern included the significant increase in health care expenditure in every Member State and the need to improve European's health by focusing on health promotion and illness prevention through evidence based public health policies, strengthening regulations, protocols and guidelines and by improving quality and access to health services.

An on-going challenge is the need to resolve the perceived or actual tension between EU health policies and those of individual Member States. As Mackenbach et al observed 'increasing access to timely and effective health care interventions have done much to reduce mortality in western countries' (1998: 37) however in many countries mental health and chronic diseases still maintain a low priority.

Caring for older people, and meeting the needs of people with long-term conditions effectively, are key issues for all EU Member States. Achieving this will require health care delivery systems to meet new types of demands requiring high cost, highly specialised, technologically driven and multidisciplinary care (Mackenbach et al 1998: 63).

Minimising costs and maximising outcomes within finite resources suggests that seeking solutions that increase efficiency without compromising care has

to be a top priority. This means in many instances, reconfiguring health care services, embracing new technology and optimising the skills of the workforce. Indeed some will argue that the hidden agenda is to address workforce shortages. Ways to achieve this have been identified including strengthening the role of public health, diversifying funding and strengthening the concept of governance.

Thomas et al (2000), in a major study funded by the World Bank, concluded that 'no country has ever achieved sustained development without substantial investment in the education and health of its people' (p67) with their conclusions later supported in subsequent studies by Bloom et al (2001) and the Commission on Macroeconomics and Health (2001) who found, in a study of more than 100 countries, that improvements in a nation's health have a significant positive effect in improving economic performance and hence on Gross Domestic Product.

There are very different approaches to healthcare delivery in the various EU countries, examples being patient autonomy, multi-professional teamwork and confidentiality. Many of the differences are historically and culturally based and before the EU general system Directives that allowed free movement throughout Europe and mutual recognition of the majority of health professions this did not pose a problem (EU 1989 & EC 1992).   In this millennium it does!   Whilst responsibility for qualifications remains with the Internal Market Directorate General many would support its move to the Health and Consumer Protection Directorate General.

McKee et al (2004: 101) perhaps hit the nail on the head when they wrote:

'Nurses and other health professionals in the United Kingdom have developed their roles to an extent that might well be unthinkable in some other countries, taking on many tasks previously carried out by doctors. Multidisciplinary team working is essential in a hard-pressed NHS. In a relatively centralised system where most professionals are salaried or hold contracts involving capitation fees and the like, these developments are less likely to be perceived as a threat than they are in countries where doctors may perceive other health professionals as competing for fees'.

They continue by saying however that 'It would be impossible to standardise the roles of health professionals and senseless to try. Some degree of diversity is inevitable and indeed desirable. At the same time, increasing familiarity will also bring with it a degree of convergence as colleagues share experience and learn from each other' (ibid:101).

These two quotations bring into sharp focus the whole interprofessional debate. Many individuals in every country, including a significant minority within the UK, view the concept of working together, collaborative practice, and all the other derivatives of these, as a dilution of, and a direct threat to, their professional autonomy. While it is true that multidisciplinary team working when it works well helps the 'hard pressed NHS' (ibid) in part, it is certainly true that interprofessional/interagency collaboration helps deliver

best practice to patients and their carers. Rather than threatening professional autonomy it clarifies what constitutes core knowledge and skills and justifies profession specific expertise. Continuing to work in professional silos is destructive for the professions and for the population they purport to serve.

Currently workforce planning, the Working Time Directive and Improving Working Lives are top of the agenda throughout Europe and it is widely believed that these changes will have profound implications for the patterns of hospital services with the enhancement of interprofessional/interagency practice being an essential part of this.

With ten new Member States and other accession countries waiting to join the EU, health and social care in Europe is facing a number of challenges in areas such as communicable disease control. This is evidenced by the recent threat to global health of SARS and the potential for an Avian influenza pandemic. International, interagency, interprofessional surveillance and collaboration is critical if the effects are to be contained.

The health of a nation is not improved solely by the implementation of sound health and social care policies. Health and conversely ill health is affected by decisions and subsequent policies relating to for example, the environment, transport, energy, employment, agriculture and housing. The EU Treaty (Article 152, Amsterdam 1997) emphasises the need for new policies to take account of the impact on health in practice this happens infrequently. While tenuous links exist between for example public health, communicable diseases and environmental health, other EU Directorates and Ministries within individual Member States do not routinely consider the impact of their policies on the wider determinants of health such as the Common Agricultural Policy or Transport Policy.

Failure to adopt an integrated approach means that, by default, interprofessional interagency working where it exists, tends to focus on the ill health of its clients rather than on the wider remit of public health in spite of a recognition that 'clearly considerable scope exists outside the health care sector to prevent ill health at a population level' (McKee et al 2004: 227).

The WHO European Region

The WHO Regional Committee for Europe acts as a permanent collaborative mechanism or 'parliament for health' for the 51 countries of the European Region. The Ministers of Health from each country meet annually to review health programmes and devise new policies. In 1985 the WHO European Region published a seminal document 'Targets for Health for All' that identifies 38 health related targets for the 51 countries to strive for by the Year 2000. Many of these targets contain implicit and in some instances explicit references to the need for increased collaboration in education, training and practice, between the health professions and for the need to network and identify new partners such as social care (WHO 1985).

Every six years the Health for All Targets are evaluated and EU policy is subsequently updated to reflect the findings. The 51st World Health Assembly in 1998, made a Declaration that acknowledged the need 'to give effect to the "Health-for-All Policy for the twenty-first century" through relevant regional and national policies and strategies' (p v). In 1999, although much progress had been made, the WHO European Region, following the World Health Assembly published a further document, from which it is possible to track policy changes throughout the European Region and also in the individual Member States (WHO 1999).

'Health for All Policy Framework for the WHO European Region' (also known as 'Health 21') is the seminal document to which all recent health care initiatives and aspirations in the UK can be linked. It is also of prime importance when supporting the argument for extending and enhancing an interprofessional workforce although it is recognised that not all countries see this as a top priority.

Health 21 is littered with references to the need for collaborative frameworks; integrated approach; co-operation; common approaches; pooling of resources; common values and furthermore it signals the need to strengthen, adapt and reconfigure models of health service delivery based on evidence of best practice and sustainable strategies.

Health 21 highlights the 15 (now 20 year) experience of the WHO European Region 'in together designing, implementing, monitoring and evaluating a joint outcome-focused, targeted and innovative policy in health that integrates efforts to promote healthy lifestyles, a healthy environment, and quality-oriented and cost-effective health care' (p3). The European Region 'embraces some 870 million people living in an area stretching from Greenland in the north and the Mediterranean in the south to the Pacific shores of the Russian Federation' (Foreword).

There is a 'formidable potential' for improving the health of 870 million people according to the WHO, who do not mention however the formidable challenge this poses. Improved value for money, improved quality of care, new models of service delivery incorporating new technologies are seen as some of the quantifiable benefits.

The newly developed strategy adopts the concept of Health for All (HFA) as 'a broad social movement through the creation of collaborative networks' (p3). Crucially (from an interprofessional workforce perspective) the authors continue:

'These [collaborative networks] act as vehicles to mobilise many sectors and organisations to work together in permanently organised partnerships of regions, cities, schools, worksites, health institutions and professionals, nongovernmental organisations (NGOs), etc., that join forces to make the HFA idea a reality in their individual areas of work' (WHO 1999: 3).

Four main strategies for action are described, each of which not only support the overall implementation of Health 21 but also explicitly emphasise the need for collaboration at all levels from the EU itself, national policies, research, education and training, and local practice based initiatives. The four strategies are quoted directly from page 4 of Health 21:

1. Multi-sectoral strategies to tackle the determinants of health, taking into account physical, economic, social, cultural, and gender perspectives and ensuring the use of health impact assessments;
2. Health-outcome-driven programmes and investments for health development and clinical care;
3. Integrated family- and community-oriented primary health care, supported by a flexible and responsive hospital system; and
4. A participatory health development process that involves relevant partners for health, at all levels – home, school and worksite, local community and country – and that promotes joint decision-making, implementation and accountability.

Here then is the mandate for implementing inter-sectoral, interagency, interprofessional action for health and it is tempting to say that no further evidence is needed and no time can be wasted in implementing the policy to which every member state has opted in, QED!

The WHO is keen that Non-Government Organisations (NGOs) join 'international, national and local partnerships' (p5) that can bring additional expertise to strengthen efforts towards achieving 'Health for All'.

The WHO also acknowledges that 'thousands of health professionals' have improved the quality of care in their practice through, amongst other ways, 'working more closely with other disciplines to find new ways of meeting the challenges' (p6). Later in Health 21, working more closely with other disciplines is linked with the 'effective integrated health and social policies' [that] are community-oriented, participatory, locally based and needs led, and build on health assets' (p36).

The WHO regrets that training curricula for health professionals remains biased towards treatment interventions and acute hospital care. This bias, they conclude, is unhelpful and referencing in particular older people, 'contributes to the provision of considerable amounts of inappropriate services for older people in the Region (p35). They call for good coordination of health and social services in the community' with the intention of ensuring 'continuity of care, supports people in their home environment as long as possible, and means that care institutions are used only when necessary' (p36). They request that policy makers decide where to target their resources more appropriately in order that money can be used to get to the source of the problems, which they attribute mainly to social causes and increased risk factors (p43).

Equally when they consider services for people who are mentally ill, they call for good quality care in prevention, clinical and social intervention and

rehabilitation, with minority groups and the socially disadvantaged meriting specific mention (p42).

Health 21 also has a large section on communicable diseases in which the importance of collaboration is stressed. Aiming to significantly reduce the incidence of non-communicable diseases by the year 2020 the WHO calls for an integrated approach at national, regional and community levels with the health sector being made specifically responsible for a broad inter-sectoral approach (p58).

In 2006 with the threat of an impending global influenza pandemic and SARS remaining a cause for concern, surely there is an even greater urgency for collaboration across and within the interprofessional workforce.

A great deal of attention is also focused on the increasing number of people living with long term conditions and on the importance of caring for people in the final stage of their lives. Enhancing quality of life in conjunction with maintaining dignity is seen as a key care objective.

Recognising that many people are living already with long term conditions and that treatment and care are fundamental to enhancing their quality of life the WHO concludes that 'strong interaction is needed between emergency, primary, secondary and tertiary care, with efficient processes for referral between the various levels… well planned rehabilitation services' are also deemed essential (p59).

The WHO forecasts that the management of people living, or dying, of cancer 'will increasingly be planned and delivered along integrated care pathways between primary, secondary and tertiary care' (p60). Agreeing outcome based quality indicators is viewed as an essential criterion for success.

Other long term conditions such as diabetes will be managed by 'comprehensive programmes…..with self care and community support as major components'. Self care and family involvement are the keys to success with national programmes expected to have a major impact on the health of people with diabetes (p61).

Each of the examples cited above, in the words of the WHO, 'emphasise the importance of multi-sectoral and interdisciplinary approaches' (p61).

In a later section of Health 21 the WHO concludes that 'comprehensive, pluralistic approaches to the treatment of impairment or disability are more effective than single-track approaches'. They stress that people with disabilities (and their organisations) must be guaranteed a major role in planning and making decisions about national and local community programmes to meet their special needs' (p103-105). Again the importance of inter-sectoral co-ordination and collaboration is viewed as critical for success.

Genetics is another area that is closely scrutinised within Health 21. Recognising that this is a rapidly expanding field, the WHO calls for a 'shared European strategy… based on HFA principles… a collaborative international approach and the sharing of expertise and experience'. Ethics, education, consideration of public preferences, improving quality of services are suggested as key components of a successful strategy (p71) each of which can be achieved only through an interprofessional partnership.

The net is cast more widely still when considering the impact of road traffic accidents, and the number of deaths and injuries caused therein. On this occasion the WHO charges policy makers, the legal professions, the health and transport sectors to learn and work together to reduce the toll (p63).

There are also calls for increased co-operation between the health, environment and economic sectors with the aim of reducing risks to health in the environment (p72). Significantly Health 21 notes that 'many different partners – engineers, architects, urban planners, retailers, people working in NGOs or the health sector, and many others – may influence the creation of a setting' and acknowledges that while 'some constitute natural partnerships, others do not' and the WHO concludes that 'by learning to work together, the partners can make a major, innovative contribution to reaching the common goal of improving people's health' (p97).

HFA values have also been incorporated into ethical codes and guidelines for other professions that can influence the general population including the media. Non-government organisations (NGOs) at all levels are also viewed as 'indispensable agents of change, raising public awareness of health and environmental trends and their consequences and demonstrating alternative and sustainable economic and social systems' (P106).

An entire section (5.5) within Health 21 is dedicated to multi-sectoral responsibility for health with the acknowledgement that promoting and maintaining healthy lifestyles and environments can only be created by mobilising a large number of different sectors. Target 14 (Multi-sectoral Responsibility for Health) is uncompromising in its aim that 'By the year 2020 all sectors should have recognised and accepted their responsibility for health' (p104). Every Member State should establish mechanisms for Health Impact Assessments.

There are, however, certain key tensions that must be resolved before a truly multi-sectoral partnership for health can take effect, one of these being accountability. The health sector is principally, but not solely, responsible for raising the profile of health on the political agenda. It should lead by example however, in formulating integrated policies that include all other sectors, the general public, politicians and industry.

Clear priorities, objectives, targets and progress indicators should be identified from the outset of new initiatives. Where appropriate responsibility as the lead agency should be nominated to other sectors with positive health gains and maximum mutual gains being the guiding factors. The health sector is also charged with finding 'ways of resolving potentially conflicting

objectives between sectors while promoting and protecting the values of HFA, playing the role of advocate in highlighting the likely benefits of action for health by other sectors' (p105).

Governments must also take responsibility, and be accountable for, creating cross-sectoral policies, allocating resources appropriately, which impact positively on the most vulnerable members of its population. Health Impact Assessments (HIA), which are discussed in greater detail on page 24 of this document, are suggested as the most appropriate way forward.

As the WHO notes: 'Care is often episodic and split up among several medical specialists, nurses and other health professionals, rather than being organised around the concept of a multi-professional team providing comprehensive and horizontally integrated care. The vertical integration between primary, secondary and tertiary care is also often weak, and continuity of care between the various levels not ensured in many countries' (p117-118).

Seamless care, focusing on the final health outcome, is the ultimate aim but this will be achieved only through a model of health and social care that is structurally and functionally better integrated.

The pressure on in-patient beds has necessitated managers and commissioners of health services rethinking how and where care is delivered. In the last decade, admission to an acute hospital bed is now avoided wherever possible, the result being that the number of 'unnecessary admissions to hospital have been reduced' in most Western member states who have committed to enabling a person to be cared for in their own homes wherever possible. There is emerging and convincing evidence that for informed patients with long term conditions, their recovery is quicker and they are more satisfied with the care they have received than those who receive cyclic and sporadic care oscillating between home and hospital (Detmer et al 2003, Detmer & Singleton 2004).

Target 15 identifies the need for an integrated health sector. It aims that by the year 2010, Europeans 'should have much better access to family and community-oriented primary health care, supported by a flexible and responsive hospital system'……using multi-professional teams from the health, social and other sectors and involving local communities' (p119).

When diagnosing and treating patients, the WHO advises that all health professionals should be well trained and that rather than fragmented care by 'different medical specialists', this should be 'superseded by integrated health care….'

Once patients are recovering, helping them rehabilitate becomes a priority. The role of profession specific skills such as physiotherapy, speech and language therapy and occupational therapy is acknowledged as key and significantly, the WHO continues, 'primary health care should be the natural focal point for these networks' (p120-121).

Sadly, in spite of the shift in the balance of resources to a community led service in a number of countries, hospitals continue to dominate health care and continue to secure disproportionate funding. This means, in effect, that an integrated interprofessional workforce remains beyond the reach of most community services as, due to a lack of funding, many of the core professions (such as physiotherapists, occupational therapists or dieticians) are rare commodities who remain ensconced in the acute hospital sector caring for people experiencing ill health or trauma.

Self-managed care also assumes a much greater significance, with an acknowledgement that patients where possible, should be enabled to make their own decisions about their care. Health professionals, it is recommended, 'should also act as agents, guides and counsellors for their patients in their relationships with other agencies and with social and other health-related services' (p122). Here then is another reason that an interprofessional workforce is essential. If health professionals are to act as 'agents, guides, or counsellors' for patients, then they must have a good grasp of what contribution to care the other professions make, and they will only grasp this by learning and working together.

The quality of care of people with long-term disabilities, including mental illness, is also scrutinised closely. Keeping people in their own homes and helping them to work wherever possible are the key aims. Where this is not possible 'sheltered accommodation' is the second preferred option and only 'in severe cases should resort be made to nursing-home care' (p123). Whichever model of service delivery is identified as best fit for an individual their care plan 'must be established jointly by the health services, social services, schools, NGOs and, in particular, self-help groups' (p123). The social isolation and financial hardship experienced by those living with a long-term disease and/or disability is also noted and the primary health care sector is charged with working collaboratively with the social care sector to resolve their problems.

Effective referral and feedback systems between primary, secondary and tertiary care and to other agencies outside the health care sector is one of the most 'important skills that all health professionals working in PHC should develop' (p124). Health centres, local schools, NGOs, the business sector, and the local media are all called upon to contribute to collaborative action. International, national, and local agreement is required as to how health outcomes (health promotion, disease prevention, treatment and rehabilitation, patient satisfaction and cost effectiveness) should be measured, evaluated and reported.

Significantly Health 21 states 'the education and training of health professionals must equip them with the skills required to be active participants in this process, providing them with the means to assess the quality and outcome of their clinical work as a necessary step in improving health care delivery' (p127).

The workforce is the most valuable resource in health and social care however in most Member States its current preparation does not adequately prepare it for practice. Professionals are viewed as too specialised, oriented towards disease process rather than health promotion, with their student work experience focusing the secondary and tertiary sectors rather than primary health care.

Health 21 explicitly criticises the lack of opportunities to learn to work in collaboration:

'Furthermore, the education which different health professionals undergo is often completely separate, and they do not come together during their training, so, teamwork is generally not promoted'. Filling the missing gaps it seems is 'vital for population based health' (p128).

Target 18 focuses on developing human resources for health so that the workforce is fit for practice by equipping it with the knowledge and skills needed to deliver the Health for All policy. The WHO raises the question of ethical practice when it calls for 'close collaboration with professional peers [as it] is an important element of professional work and needs to be absorbed more fully into professional ethics'….with the subsequent warning that 'working alone with no regular exchanges of experience for mutual improvement can no longer be considered professionally satisfactory'. Working in a team enables the professions to solve 'complex health problems that cannot be adequately dealt with by one profession alone' (p135).

In a subsequent section of Health 21 the WHO confirms its belief that achieving Target 18 depends in part, on the 'education of public health professionals [that] prepares them to act as enablers, mediators and advocates for health in all sectors, and to work with a broad set of partners in society' (p198).

The WHO while demonstrating their determination for the workforce to learn and work together more effectively, 'inspired by respect for human dignity, professional ethics and solidarity' also acknowledges that 'it is important to recognise that each profession has its special area of competence and that they need to work together on the basis of mutual respect for each other's expertise' (p137). Such a clear statement from the WHO of recognition of profession specific competence and expertise should reassure those who believe their profession is in some way threatened by the concept of an interprofessional workforce. It is not and never will be. Indeed it could be argued that interprofessional practice strengthens professional specificity.

The WHO also expressed its views on co-location, which although they believe is advantageous' is not the sole criteria for working together rather it underpins the concept of 'knowing each other, performing complementary work, constantly exchanging information and meeting at regular intervals to facilitate cooperation' (p137).

As well as analytical, communication and managerial skills, the health and social care professions must utilise problem-solving skills when working as an interprofessional team. In the primary health care arena although special reference is made to the role of physicians and nurses, the contribution of others such as therapists, pharmacists, dentists, social workers and managers is noted. The role that managers play is crucial, with the WHO insisting that they too must be competent in promoting effective teamwork.

Significantly the WHO also mentions that 'professional qualifications are set too high and too rigidly imposed for the tasks to be done – there is scope for staff to perform more tasks and to substitute for other professionals' (p139) with a suggestion that career pathways should incorporate the opportunity for lateral as well as upward moves.

This section is the first real intimation that whilst profession specific expertise is an essential component of best practice in health care, there is also great potential for the professions to delegate some of their non profession specific skills to 'support workers' thus freeing the experts to spend more time practising their higher level skills. The support worker role will be discussed in more detail in Chapter 2- The UK Policy Agenda.

The infrastructure within each Member State should be reviewed with the purpose of identifying a clear mandate for 'population-based public health action'. Ways in which to embrace the expertise of the education sector from infant schools to higher education, economists, social scientists, lawyers, engineers, architects and town planners should be identified. Described as 'new players' they are not 'fully recognised as partners for health today' moreover there is 'a need to overcome the problems posed by single-sector approaches and specific organisational objectives, budgets and activities; one of these problems is the lack of mechanisms to bring partners together in systematic cooperation' (p145-146).

These new networks 'have tremendous potential for facilitating the exchange of knowledge and experience' (p162). With any new partnership however all partners must take responsibility, and hence be accountable, for the health consequences of their policies and actions and assume their share of accountability for health (p153). The WHO expresses a wish that the concept of healthy cities is adopted across the European Region with the health sector taking a leading role as advocates for health by 'encouraging other sectors to join in multi-sectoral activities and share goals and resources' (p155).

To this end the WHO identified the importance of partnerships with major integrated and intergovernmental bodies citing as examples the EU, the World Bank, the Council of Europe, OECD and the United Nations. The successes achieved in relation to population control and nutrition by the World Bank in partnership with the EU were singled out for particular praise as was the initiative on Health Promoting Schools co-ordinated by the EC, the Council of Europe and the WHO Regional Office 'in a practical, long –term and innovative partnership' (p161). The WHO European Region is aiming for

each collaborative to be a permanent international structure with tremendous potential (p163).

The first references to National Environment and Health Action Plans (NEHAP) can be traced to Helsinki in 1994. NEHAP aims to explicitly link actions that improve the population's health with particular reference to environmental issues. More than 40 countries are now committed to this action. NEHAPS, according to the WHO European Region,

> 'have proved to be a successful mechanism for bringing various sectors and partners together and provide a coherent, comprehensive and cost-effective framework for action towards achieving HFA and the Agenda 21 goals'. Its continued success however 'is dependent on collaboration between all actors concerned at national and international levels, e.g. national governments, local authorities, different sectors of the economy and the public' (WHO 1999:162).

Target 21 of Health 21 states that 'by the year 2010 all member states should have and be implementing policies for health for all'……supported by amongst other criteria 'innovative leadership' that can bring together a 'broad range of key partners, public and private, with agreed mandates for policy formulation, implementation, monitoring and evaluation' (p163).

Crucially the WHO argues, 'unless there is a written policy document which can be picked up, read, discussed, and even argued over, the many partners who must be involved will not clearly understand why they should work together for health, or what their particular input might be' (p164). In the absence of such a strategy 'they [the partners] will feel little commitment to putting them into practice'. A further instruction involves the need for adopting 'mechanisms [that] must deal with possible conflicts of interest, recognise the need for negotiation and compromise, and empower vulnerable groups to make their voices heard' (p165).

Reaching consensus is seen as the underpinning framework for policy development that will be achieved only through a 'common understanding of underlying values, goals and objectives, and of the priorities to be assigned to them' (p165). As policy is unfolding continuing negotiation and renegotiation are essential for implementation with 'trade-offs where there appear to be conflicting objectives'. The new policies also mean that new alliances must be formed between the public and private sectors, the voluntary organisations and a greater involvement at all stages by patients and their families. 'All this means learning not only about each other but also from each other' (p167).

Mobilising the workforce towards implementing policies that actively promote and advocate health depends on the success of the health sector in engaging other sectors to join in and also share their aims and resources. Adopted as Target 20, it is achievable if existing partnerships are strengthened, new partnerships are forged, and health professionals respond to those in other sectors by showing a willingness to listen and negotiate (p199).

Towards Unity for Health (TUFH)

Towards Unity for Health (TUFH) is a Non Governmental Organisation (NGO) collaborative of individuals, groups and institutions each of whom is committed to working towards improving and maintaining the health of the community in which they live and work http://www.the-networktufh.org/home/index.asp

In common with other key organisations TUFH aims to address the needs of an ageing population, many of whom are living with long term conditions by implementing new ways of working. To achieve their aim, TUFH signals that increasing levels of interprofessional collaboration within the workforce is essential.
http://www.thenetworktufh.org/publications_resources/positioncontent.asp?id4 &t=Position+Papers

On the TUFH webpage the potential advantages of working collaboratively are listed:
'a greater range of professional skills, more efficient deployment of relevant skills that may or may not be highly specific, more choice for the consumer, avoidance of stereotyping, checks on procedures, mutual education, mutual support, development of high morale, cost effective training and provision of care' (ibid).

TUFH also admits that the barriers to implementing an interprofessional model have been numerous, 'in the past attitudinal, organisational and political problems have become cumulative' (ibid). Encouragingly however when outlining the barriers, the past or passive tense is used, whereas when describing the potential advantages they have adopted an active and progressive prose.

Entrenched and negative attitudes of some individual professionals are still viewed as the major challenge to overcome but of course it can be argued that any innovation that requires change and new ways of thinking, in any field, will be resisted by some. It seems that it is a question of focusing resources on those who 'can and will do' by diverting funding from those who are absolutely determined 'not to do under any circumstances'. The potential blurring of role boundaries is also viewed by many as a threat to professional autonomy. Interestingly the arguments supposedly relating to role boundaries, if analysed, tend to focus on skills competences rather than roles. It comes as a surprise to many that many of the competences that they believe are specific to their own profession, indeed are not, and never have been. Much of everyday workplace activity and certainly much of a patient's care is core competency dependent.

As an NGO, closely affiliated with, but not dependent on, policy makers, TUFH is in an ideal position to drive the interprofessional agenda forward. Its philosophy complements the WHO European Framework and working together Health for All could become a reality rather than a dream.

The WHO is also calling for a complete overhaul of the healthcare workforce training in order to best meet the rapidly increasing number of people living with long term conditions. The WHO regrets that training of the workforce has not kept pace with the changes required in practice. Core competences applied to all members of the workforce are viewed as the best way forward each focusing on a patient centred care model. Core communication skills are keys to collaboration not only with patients and their carers, but also with other health and social care providers (WHO 2005).

Integrated Care

Fragmented models of health and social care however remains a persistent problem, one which causes inefficiency, patient dissatisfaction, impedes quality and accessibility to the services required.

The WHO European Office for Integrated Health Care Services suggests a working definition of integrated care as:

> '…a concept bringing together inputs, delivery, management and Organisation of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency' (Gröne & Garcia-Barbero, 2001).

The WHO Framework differentiates between 'autonomous working', a 'co-ordinated approach' and 'integration'. The expert view of integration is that it is 'a means to improve services in relation to access, quality, user satisfaction and efficiency'. www.euro.who.int/document/ihb/Trendicreflconissue.pdf

Integrated care is adopted as a broad term for technological, managerial and economic aspects of services whereas horizontal integration is viewed as relating to strategies that link similar levels of care through overcoming professional and departmental boundaries. Vertical integration however suggests the strategies which link primary, secondary and tertiary levels of care whilst continuity of care implies the user perspective, in other words the patient's experience of the care package they have received.

Intended for those who need to work together to provide care for people with complex needs and their families, the WHO has published the Framework as a web based exercise suitable they suggest for primary health and social care teams where, providing time for learning is protected, a more collaborative climate will emerge. Examples of where the exercise would be most useful are cited as service provision to children living with disabilities, and older people with mental health problems.

Organisations can use the WHO Framework as a basis for mapping emerging local trends and health care needs of the population and comparing these with the level and quality of integration and collaboration that has been achieved. Identifying strengths and weaknesses is recommended followed by an identification of immediate goals to resolve these.

Even a decade ago policy makers in many countries were trying to overcome the obvious difficulties of fragmented care by implementing a more integrated health and social care model (WHO 1996). In 2006, although progress has been made, much more remains to be done.

The five 'laws' of integration first described in 1999 by Walter Leutz, are cited as a possible mantra for organisations working towards integration. Familiar to many, Leutz's 'laws' are worth repeating here:

Leutz's first law

'You can integrate some of the services all of the time, all of the services some of the time, but you can't integrate all of the services all of the time'.

This is a strong message about the need to target (expensive) integrated approaches towards people with complex needs – he argues that it would be hopelessly inefficient not to discriminate in this way.

Leutz's second law

'Integration costs before it pays'.

This is a timely reminder that long term success is likely to depend on wise, pump-priming investment of time for planning and resources for training and development of an interprofessional workforce.

Leutz's third law

'Your integration is my fragmentation'

This may well explain why many people resist new approaches. It suggests that as much attention needs to be given to what may be lost through integration as to what is likely to be gained.

Leutz's fourth law

'You can't integrate a square peg and a round hole'.

A timely reminder that certain things may remain permanent challenges, for example charging for social care when health care is free at the point of delivery in some countries. Such matters have to be managed carefully in practice.

Leutz's fifth law

'S/he who integrates calls the tune'.

This looks like a comment on relative organisational and professional power. However, Leutz principally argues that ways should be found for users and carers to determine the shape of services and their integration.

Health Impact Assessment

A WHO consensus paper defined Health Impact Assessment (HIA) as 'a combination of procedures, methods, and tools by which a policy, programme or plan may be judged as to its potential effects on the health of the population and the distribution of those effects within the population' WHO 1999 (Gothenburg consensus paper, European Centre for Health Policy).

HIA is a systematic assessment of the interrelated personal, social, cultural, economic, and environmental factors that influence both individual and population health status. Categories, known as determinants of health, are measured against policy changes, thus offering the best opportunity for improving the health of a population on an inter-sectoral basis. The ECHP is beginning to use HIA as an integral part of its public health programme and have developed a toolkit that could be used to assess the possible health impacts of policies and proposals (see ECHP, 2001).

Unlike the Environmental Impact Assessment (EIA), where legal statutes exist, HIA is not currently a mandatory requirement. However statutory requirements for employment, housing and transport, and their cost implications are being used increasingly in the overall HIA. Experts warn however that HIA should be viewed only as one, rather than the, way of embedding public health in policy development (Breeze & Hall 2001, Letho & Ritsatakis 2001, Hubel & Hedin 2003).

In 2003 a survey of the HIA and government policy making in European countries was coordinated by the Welsh Assembly Government (Wales, UK) & the European Network of Health Promotion Agencies, Brussels in co-operation with the European Commission, DG Health & Consumer Protection Public Health Policy Unit (Luxembourg) and the World Health Organisation (WAG, 2003). Of the 22 European countries that took part, all but one admitted that health was a relevant theme across policies and programmes developed in other policy areas. However, even though seven governments appeared to be using HIA, the findings suggest that its use 'appears to be driven by opportunism as opposed to a systematic approach' (p4). Its use also varies across policy areas and reported as 'good in some policy areas but poor in others' (p4). The report concluded that, although some governments have allocated some resources to support the development and use of HIA, there is a need to increase awareness and understanding of its role within and between countries. It is this that ultimately will ensure integrated and inter-sectoral policy and activity, which focus on the determinants of health.

According to Wismar (2004), sceptics question the effectiveness of HIA because of the inherent difficulties of evaluating its effect on the health of the nation. Indeed Wismar suggests that an evaluation would need to span a decade or more to gather useful information. Definitive answers however, are needed before that. Quigley &Taylor (2003) suggest that the effectiveness of HIA could be assessed by measuring its influence on the decision-making processes when writing policy.

Interprofessional practice- based learning

In 1999 a multi-professional group of experts from a number of European countries met in Geneva to consider the rapidly increasing number of elderly people in Europe, their increasing health and social needs and the consequent challenges faced by health and social care providers. The experts argue that investing appropriate resources towards maintaining elderly people in their own homes, wherever possible, 'yields gains in both health and well-being outcomes as well as financial benefits' (WHO 1999:4).

Significantly however they observed that 'unfortunately, many health care providers lack the overall competencies to provide older persons with such inter-professional care' (ibid: 4). In common with many other WHO publications, the need to make a major philosophical shift towards embracing inter-sectoral, interagency care is called for. The experts believe that without such a shift in emphasis, elderly people, and their families, will not receive the quality of care that is their human right. They recommend that those involved in consumables should also be engaged in the network because as they argue, if elderly people cannot afford to buy food which is healthy for them, or heat their homes adequately inevitably they will become more vulnerable to ill health.

The expert group stressed the need to ensure that formal learning experiences of the workforce, whether in educational institutions or in the workplace must be geared to the changes in health service delivery, the implication being that what people learn is not always appropriate or timely. They also argue that competent practitioners will only emerge as a result of being taught by competent teachers, the most competent being the patient and their carers (p5).

One of their key recommendations for health care providers is 'to ensure that an interprofessional team approach is taken to the delivery of community based Health Care for Older Persons and that the contribution of each of its members is recognised as being equally important' (p6).

By implication they also override any concerns about the validity of interprofessional learning when they recommend that education providers 'grant academic qualifications recognised by the European Credit Transfer System, to health care providers on satisfactory completion of an educational programme for community-based health care for older persons, wherever appropriate' (p6)

In partnership with health institutions, education providers should 'establish the professional profile of each type of health care provider in the community-based health care team in order to facilitate the creation of teams, efficient interprofessional collaboration, clarity the respective contribution of each team member and promote accountability' (p7).

Their list of recommendations is numerous, wide ranging, and targeted at all levels from international organisations such as the WHO down to local

education and health care providers. They urge the WHO European Member States, not only to accept the full recommendations in the Report but also to adopt policies and strategies that underpin models of education and practice that delivers the best health outcomes for elderly people.

The group calculated that there are more than five million nurses and collectively the other health professions (medical doctors, allied health professions, psychologists and pharmacists) comprise a further 2.5million workforce.

In addition to the health and social care professions involved in caring for elderly people, the group identifies other key stakeholders who they recommend have a vested interest in becoming partners in care. These include legal advisors, elected government officers, insurance specialists.

Crucially the experts focus on the actual and potential contribution the various professions can make to the care of older people and comment: 'This contribution can be maximised when such professionals work in teams. There is evidence, however, that when they do exist, interprofessional teams often do not function efficiently' (p9). They conclude this section of the Report with the conclusion that 'an interprofessional approach would make a significant contribution to the well-being of older persons' (p10).

An interprofessional team implementing community based health care services for elderly people should result in the following positive outcomes:

- organised quality home-care
- short hospitalisation in case of acute health/social crisis
- organised day care
- collaboration with other older age care services. (p13)

This model of health and social care delivery is a process that, the group believes, 'stimulates partnership between members of the interprofessional health care team with the older person and informal carers including families'. They continue 'this interprofessional team concept is essential. The health team members should respect and acknowledge the contribution of each other and work towards a common goal' (p13). A quality team however requires a quality leader, regular meetings attended by all members, joint assessment, a regular review of patient records which should include 'shared care plans'; joint decisions following consultation with the patient (or their carers) and task delegation to individual team members (p14) with the outcome being that 'care must be structured, organised and systematically provided to each older person in a variety of ways with care [that] is interprofessional and multidisciplinary and will require inter-sectoral networking (P16).

So what can be concluded from this overview of EU policy and what are the implications for the UK? Attention has already been drawn to the numerous challenges ahead for the people of Europe, the most important being that there be an urgent need to demonstrate a real commitment to implementing

comprehensive frameworks which enable people to live long, healthy and productive lives. An effective interagency interprofessional workforce is now acknowledged by policy makers and strategists as critical for the health and welfare of future generations.

Chapter 2 will explore how the United Kingdom has responded to emerging EU policy and the strategies the UK is adopting to ensure the right frameworks are place. Questions will be asked about the frameworks, whether these are working well, whether they can be improved and most importantly whether models of good practice are challenging current policy and if so how this can be resolved.

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Chapter 2 - The UK Policy Agenda

Summary

In Chapter 2, in light of the Government's new initiatives and models of service delivery in interagency interprofessional care we have concluded that as social care is an essential partner, social care policy must be included. We have also included Department for Education and Skills policies in the section devoted to children and young people.

We have deliberately excluded Higher Education policy as we wished to focus on clinical practice rather than educational practice and to ensure that the whole workforce is considered. We have however included the Statutory Bodies who have profession specific responsibilities.

From our analysis it is clear that for decades the UK government has given directives for an interprofessional, interagency workforce however this has not been implemented widely in practice until recently.

Background

In our previous paper we examined whether there is a European agenda for creating an interprofessional workforce and if so which EU and WHO policies point the way forward. We were able to demonstrate that not only does policy mandate interprofessional, interagency and inter-sectoral practice in health and social care but also the need to forge partnerships with the environment, transport, agriculture Directorates, whose policies also impact on the health and well being of Europeans. We concluded that 'policy makers and strategists have made it crystal clear that the creation of an interprofessional workforce is critical for the health and welfare of future generations and to ignore their advice would, at the very least, be foolhardy' (Tope & Thomas 2006). Starting from this premise, in this Chapter we intend to examine whether, and if so with what degree of success, the UK Government has implemented these EU and WHO policies.

It could justifiably be argued that in spite of progress being frustratingly slow UK policy is showing other member states the way forward, in interprofessional, interagency, inter-sectoral education and practice. Indeed for more than eighty years experts have been advising the Government of the need for interprofessional teams to work in partnership with patients and their carers (see for example HMSO, 1920).

In 1959 the Younghusband Report focused on the role of social workers in health care, remarking that it was essential for healthcare teams to collaborate with social workers for the benefit of patients and their families (HMSO, 1959). There was a flurry of activity during the late 1960s, 1970s and 1980s, with report after report being submitted to the Government, each of which emphasised the need for increased interprofessional collaboration in

education and practice across the health and social care arena (see for example HMSO 1968a, 1968b, 1969, 1971, 1972a, 1972b, 1973, 1974a, 1974b, 1975, 1976a, 1976b, 1977, 1978, 1979a, 1979b, 1979c, 1979d, 1980, 1981, 1985, 1986a, 1986b, 1987a, 1987b, 1989a, 1989b, 1992). Significantly many of these Reports were published as a Government Command, so the rhetorical question must be asked why did everyone, with the exception of a few, ignore what they were being commanded to do?

From the late 1980s there were more explicit commands for professionals and agencies to work together in targeted areas (for example DH 1988, 1991, 1993, 1995a, 1995b, each of which focuses on safeguarding children) and we suggest, it may be this switch in emphasis away from the needs of the workforce towards the needs of the patient or client and family, or in this case the vulnerable child that has at last galvanised everyone into action. Suddenly patients' voices were being heard and they were saying that what they wanted and needed was some 'joined up thinking' between all those involved in their care.

By the middle of the last decade nearly every DH publication called for the health and social care workforce to overcome their reticence and put the needs of the patient, and their families first. The White Paper *'The National Health Service: A Service with Ambitions'* emphasised the point that sharing 'relevant' information is absolutely essential 'if multi-professional and inter-agency care is to function effectively' (DH 1996a). In the same year the DH extended its directives of working across boundaries again mentioning the need to share information between agencies implying that this should be done on a 'need to know basis' (DH 1996b, 1996c).

'The New NHS: Modern, Dependable' (DH 1997) outlined how integrated care, partnerships and collaborative working across Health Authorities, local authorities, voluntary organisations and the private sector would replace the internal market. The needs of patients were seen as central to the changes highlighted in this White Paper. The Government introduced the concept of developing a joint university and NHS planning culture that emphasised 'partnership' and 'collaborative working'.

At the end of 1997 and the beginning of 1998 the Government published three White Papers on its proposals for the National Health Service in England, Scotland and Wales: Cm 3807 *'The New NHS'* (DH, 1997); Cm 3811 *'Designed to Care'* (The Scottish Office, 1997); and Cm 3841 *'Putting Patients First'* (NHS Wales, 1998) respectively. In England a consultation document *'A First Class Service'* (DH, 1998a) detailing the proposals within *'The New NHS'* was published in the summer of 1998, followed by a discussion document *'Partnership in Action'*, later that year (DH, 1998b). In the same year Wales undertook an independent consultation in *'Quality Care and Clinical Excellence'* (Welsh Office, 1998a), and *'Partnership for Improvement'* (Welsh Office, 1998b).

The publication by NHS Executive (1999) *'Clinical Governance: Quality in the New NHS'* emphasises partnership and team working, a shift away from

previous practices where professionals worked in isolation. *'Making a Difference'* (DH, 1999a) and *'The NHS Plan'* (DH, 2000a) promoted multi-disciplinary and interprofessional working across areas of health and social care and emphasised that the approach to the educational preparation of future health professionals should be integrated and patient centred.

A consultation document *'A Health Service of all the Talents: Developing the NHS Workforce'* recommended a complete overhaul of workforce planning (DH, 2000b). New models of service delivery were identified, each of which depended on individual professions being prepared to move out of their silos and work across professional and organisational boundaries. To ensure that the workforce is fully equipped for their new roles, and acquire the skills these would require, a complete overhaul of their education and training would be necessary and there is an explicit acknowledgement that it is vital to engage the Regulatory Bodies and the trade unions.

The Government's modernisation programme is having a profound impact on not only the NHS but also agencies such as local government and social services. Policy changes outlining increased interagency, interprofessional care can be identified within The Local Government Act 1999; The White Paper *'Modernising Social Services'* (DH, 1998d); The White Paper *'Modernising Mental Health Services'* (DH, 1998e); The Green Paper *'Our Healthier Nation'* (DH, 1998c); *'Modernising Health and Social Services: National Priorities Guidance 2000/2001, 2002/2003'* (DH, 1999b); *'The Health Act 1999'* and its accompanying discussion document *'Partnership in Action'* (DH, 1998b); *'The Crime and Disorder Act 1998'*; and the *'Quality Protects'* initiative by DfES. Each of these focuses on the need to extend strategic alliances.

Moreover, the National Institute for Health and Clinical Excellence (NICE) is an independent organisation that publishes guidance in public health, health technologies and clinical practice. The Health Development Agency merged with NICE in 2005. NICE guidelines implicitly recognise a flexible workforce and also promote and reinforce partnership working (http://www.nice.org.uk/).

A major issue that arises time and time again in Government publications is the continuing reluctance to use terminology that leaves the reader in doubt that there is a mandate to implement policy. Even in White Papers, which by definition are commands, words such as 'may', 'might' or 'could' rather than 'must' or 'should' are used. This in effect, gives the reader an opportunity to opt out if a particular directive does not suit. Particularly good examples of this relate to *'The Disability Discrimination Act'* (1995) and *'The Human Rights Act'* (1998). The White Paper '*Our Healthier Nation'* (DH, 1998c) observes for example 'we need to encourage different professional groups to learn together and to think about how we plan our workforce to meet the challenges we face'. If only the word 'must' had been inserted rather than the much less emphatic 'think about' planning the workforce, much more progress would have been made towards delivering a service that patients want and need. In the same year another White Paper *'Modernising Social Services'* suggested

that for best practice, an interagency 'one stop shop' would be needed (DH 1998d).

Overview of Government initiatives and reviews that promote and endorse interagency and interprofessional working

Initiatives that relate to specific client groups are described in more detail in Section 3 (see page 28).

Health Act flexibilities

The Government has introduced numerous initiatives to promote and support interagency and interprofessional working. Section 28A and 28BB of the National Health Service Act (1977) enabled money transfers and joint finances between the NHS and local authorities. Section 31 of the Health Act 1999 introduced three new mechanisms, or 'flexibilities' to encourage inter-agency and interprofessional cooperation. These included:

- Pooled budgets which enable service providers to bring together resources into a joint budget;
- Integrated provision where services are based in one setting rather than many; and
- Lead commissioning where one authority, either healthcare or social services can commission services on behalf of the other

These flexibilities, which became operational in April 2000, relax some statutory duties and obligations in an attempt to reduce the barriers to collaborative working between health and local authority staff. More information regarding the evaluation of the flexibilities is reported in Chapter 3.

The National Service Frameworks (NSFs)

The publication of National Service Frameworks (NSFs) by the government outlines their long-term strategies to improve specific areas of care. National standards and goals are set by multi-professional teams including service users, carers and agents and agencies related to the area of care. The rolling programme of NSF publications was launched in 1998 and to date seven frameworks have been published in the following care areas: mental health; coronary heart disease; older people; diabetes; children and maternity services; renal services; and long term neurological conditions. In June 2006 the DH announced plans for a further NSF: 'Improving Care for patients with Chronic Obstructive Pulmonary Disease' (DH, 2006a).

In the NSF for mental health there is a call for 'a comprehensive package of services' for individuals, which should be 'a multi-agency endeavour' (DH 1999c: 44). It identifies the need to integrate the systems of assessment, care planning, implementation and evaluation developed independently by individuals working in social services and the health service. It also recommends that services involved in mental health care need to develop policies to enable the sharing of information.

Similarly, in the NSF for coronary heart disease (DH, 2000c) there is reference to 'collaboration' of the numerous individuals involved in this area of care. In order to achieve the goals set out in the NSF for diabetes, services need to be 'integrated' and include 'health and social care professionals across a multidisciplinary diabetes health care team, including primary care and social care as well as specialist services' (DH, 2001a: 14).

In 2001, with the publication of the NSF for older people, a single assessment process was advocated along with a recommendation that older people receive 'appropriate and timely packages of care… regardless of health and social services boundaries' (DH, 2001b). The NSF has identified four core principles for those caring for older people. These are: to respect the individual; deliver joined up care; ensure that everyone is able to access specialist care when they need it and to promote healthy and active living. The NSF also places a strong emphasis on the need to integrate care for older people through closer co-operation across boundaries and through the development of agreed pathways.

In the Children's NSF the government advocated the development of 'Children's Trusts' where the planning, commissioning and delivery of health, education and social care services, along with other relevant agencies would be coordinated and integrated. It also highlighted the need for co-location of services, a common core of training for the workforce, the use of a lead professional, integrated commissioning, a common assessment process, pooled resources, the sharing of information and robust inter-agency governance arrangements (DH, 2004a). The Children's NSF perhaps has the most far reaching consequences of all in that it prescribes an interagency interprofessional model encompassing health, education and care for all children and young people. Implementation of this NSF has been rapid and the evidence of its effectiveness is just beginning to emerge.

The renal NSF (DH, 2004b; 2005a) promoted 'renal services health communities' which enable all stakeholders, including service users, to take ownership. It was highlighted that such communities would promote 'work across traditional service boundaries and models of care' to provide seamless care (DH, 2004b: 11). Closer working between health and social services was echoed in the NSF for long-term neurological conditions along with the need for a 'holistic, integrated, interdisciplinary approach to care planning, review and service delivery involving a range of agencies' (DH, 2005b: 13).

The Wanless Report

In 2001 Derek Wanless was appointed by the Chancellor of the Exchequer to undertake a long-term view of the future health of the UK. His brief was to examine emerging trends and identify the resources required to ensure that the NHS remained a 'publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay' (HM Treasury 2001: 1).

Wanless appreciated the enormity of the task and the uncertainties around predicting the future of the NHS when he observed: 'I am conscious that trying to look ahead over such a long time is fraught with difficulties. The uncertainties are huge yet it is evident that many of the decisions being taken in the short term about, for example, the development of people, investment in new information technologies or in buildings could significantly constrain the health service's ability to respond appropriately and with flexibility to circumstances as they arise' (HM Treasury, 2001: 2).

Published in 12 chapters, the Wanless Review focuses on five disease areas: cancer; coronary heart disease; mental health; diabetes and renal disease. These five areas complement the National Service Framework's (NSFs). Wanless challenges traditional hierarchical thinking by examining the historical and international context of the NHS and then measuring these against what in his view are the public's expectations of the health service. He was absolutely clear that 'in the future the public will expect the NHS to provide… quicker more flexible access to treatment; longer, good quality relationships with health professionals… and they want to be better informed' (p89). He refers to the benefits of 'whole systems' modelling, where there is greater interaction between health and social care (ibid: 93).

Chapter 11 of the review focuses on workforce issues with Wanless starting from the premise that 'having the right number of people with the right skills will be critical to delivering a high quality health service' (ibid: 183). Workforce issues, he concluded 'are key to the review of the long term trends affecting the health service' (ibid: 184). He predicted that there would be substantial changes in the roles and responsibilities of the different professions with the role of social care becoming increasingly important.

The workforce is 'marked by strong demarcation of roles and responsibilities between different staff groups often backed up by legislation or regulation' (ibid: 184). None the less Wanless predicted an 'expansion in the health care assistant (HCA) workforce… which may pull existing or potential staff away from the social care workforce (ibid: 194). Improved productivity and outcomes formed a large part of Wanless' deliberations. This he believed could be achieved only through greatly improved communications and changing the skill mix. Noting the limited time available for direct patient contact, he urged the workforce to identify ways that would ensure that not only would patients be viewed as 'co-workers' in their care but that for overall continuity of care the workforce should learn to work together. Linked in with the concept of increasing self care, where people are able to do so, improved working partnerships will enable more time to be devoted to caring for those with long term conditions and complex health needs.

Wanless refers to 'health care practitioners' who he envisages as 'registered health care professionals able to span a number of current professional boundaries' (ibid: 199); 'health care technicians' as 'health care workers with a range of skills' and also 'care co-ordinators' who are 'health or social care workers supporting patients with chronic and major conditions, across institutional boundaries' (ibid: 200). Significantly, adding to the ground swell

of opinion that interprofessional, interagency working is the only way forward, Wanless concludes his exploration of the workforce issues by commenting 'although the number of health care professionals is important for the capacity of the system, arguably the way the workforce is used is even more important' (ibid: 204).

The Kennedy Report

In 2001 perhaps the most significant and far-reaching Inquiry into the way the systems can fail to protect the community it purports to serve was published (DH, 2001c). Commissioned by the then Secretary of State in 1998 the Inquiry took three years to complete. Generally referred to as the Kennedy Report, it focuses on the poor quality of children's heart surgery and its consequent high mortality rates at Bristol Royal Infirmary between 1984 and 1995.   The Report acts as a wake up call for all and was subsequently described by the Government as 'a turning point in the history of the NHS' (ibid: 13). The Inquiry was wide ranging and far reaching, with the then Secretary of State, Alan Milburn observing in his foreword that 'the Report provides a powerful analysis of the flaws and failures of the organisation and culture, not only at the BRI in the years in question, but of the wider NHS at that time'. Kennedy and his team made 198 recommendations, most of which were accepted unreservedly by the Government and were implemented as quickly as possible.

A number of these recommendations can only be achieved through truly interprofessional, interagency practise an example being No19 which states 'Healthcare professionals responsible for the care of any particular patient must communicate effectively with each other. The aim must be to avoid giving the patient conflicting advice and information' (ibid: 439).

The Government's response to this is also worth quoting in full: 'We agree. Our communications initiative will ensure patients are at the centre of care and the focus of team working and interprofessional care.   Health care professionals will develop these skills through joint learning and working at all levels of the NHS (DH 2002a: 138).

Recommendations 57, 58, 59, 60 and 61 of the Government's response to the Kennedy Report continue in similar vein with references being made to the need for 'shared learning across professional boundaries' (57) a call for core competences in non-clinical aspects of care to be learned 'as part of a common learning approach across professions' (58) with a particular emphasis being made on communications skills which the Government accepts as 'a core feature of professional training' (59) which would be addressed in a new initiative encompassing all NHS staff. To reinforce the importance placed on communication skills, Recommendations 60 and 61 are explicit 'communication skills must also include the ability to engage with and respect the views of fellow healthcare professionals' (60) with the acknowledgement that 'the education, training and continuing professional development of all healthcare professionals should include joint courses between the professions' (61)

Recommendation 62 summarises the above very succinctly: 'There should be more opportunities than at present for multi-professional teams to learn, train and develop together'.

The drive for interprofessional practice continues apace throughout the document with Kennedy recommending that a Council for the Regulation of Healthcare Professionals be established with the overall responsibility of co-ordinating the professional bodies and 'integrating the various systems of regulation' (71 & 72).

The Government had anticipated this as not only did they agree but in their response they added that the consultation document *'Modernising Regulation in the Health Professions'* (DH, 2001d) had been published in advance of the Kennedy Report and that legislation had subsequently been implemented which would make the Council accountable to parliament.

Significantly Kennedy called for the organisations that regulate each individual profession *'to behave in a consistent and broadly similar manner'* (73). It was made clear that the independence of each regulatory body should be respected in order that each could fulfil its statutory functions.

Primary Care Trusts

In England the 302 Primary Care Trusts (PCTs) once established, were envisaged as being 'better placed to address integrated care pathways and long term service agreements. They build on the experience of Community Trusts in providing community-based services and services provided in conjunction with Social Services and also establish more integrated working between general practice and community health services'. Interagency rehabilitation and recovery services for patients were cited as examples of what might be achieved (DH 1999d).

The Government envisaged that PCTs would be able to plan and deliver services for patients in collaboration with social care and with Local Authorities. Intermediate care, once beyond the scope of primary health care teams, would be delivered to patients in their own homes, who might otherwise need admission to an acute hospital. Intermediate care was seen as better for patients' (many of whom had complex health and social needs) and their families, would reduce pressure on beds in the acute sector, and provide better value for money.

PCTs were given responsibility for: 'Assuming joint accountability for clinical governance of services which are delivered on a multi-sector, multi-agency basis'. Part of the PCT remit was to develop multi-disciplinary education and training programmes which support the continuing professional development of practice staff (DH 1999d).

The need to work together throughout the PCT is spelt out clearly in the publication *'Competency Framework for PCT Leadership'* (DH, 2002b). The Government acknowledged that PCT leadership is a complex task that is

dependent on the relationship between three key players. These are the Board Chair, the Board Chief Executive and the lead clinician who is Chair of the Professional Executive Committee (PEC). Described as 'Leadership by Triumvirate', the three are expected 'to pool their talents… working together to meet the common goals, and separately, to make their unique contribution'.

In *'Shifting the Balance of Power within the NHS'*, (DH 2001e) the shared goals of the three members of the triumvirate are described as: 'to improve the health of the local community; to secure the provision of a full range of services; and to integrate health and social care'.

In the autumn of 2006 the number of PCTs in England will be reduced from 302 to 152 'as part of the Government's drive to create a patient-led NHS'. (see details on DH Primary Care Trusts website)

The impact of this reorganisation and reconfiguration on the workforce is already evident. Interagency, interprofessional co-located teams who have been using Common Assessment Frameworks, implementing joint protocols and standards, and providing data that proves the effectiveness of their collaboration in terms of better patient outcomes, are now being disbanded and relocated or made redundant!

Care Trusts

The government announced in the 'NHS Plan' (DH, 2000a: 70) that Care Trusts were to be developed 'to bring health and social services into one organisation'. Described as 'important vehicles for modernising both social and health care which will enable staff to shape a new organisation around patient and user needs' (DH 2001e: 39), Care Trusts were introduced in 2002 to 'enable the commissioning and provision of services to be as integrated as possible… [and] build on existing joint working' (DH, 2003a: 4)

It was acknowledged that although some Care Trusts may focus, initially, on services for older people or those with mental health problems, there are no limitations on the client groups it could serve (DH, 2003a)

Care Trusts are the next step in evolution from the PCTs with an even closer integration between the health and social care services. Working across the organisational boundaries by adopting a single strategic approach and working together from a shared location is offering a golden opportunity for integrated care pathways and joint assessment frameworks.

For further information see Care Trusts on the DH website

Recent initiatives

One of the most recent initiatives includes the publication of *'Standards for Better Health'* (DH, 2005c). The Health and Social Care (Community Health and Standards) Act (2003) Section 46 sets out the legislative basis for the Healthcare Standards and the requirements expected of all healthcare

organisations in relation to the quality and safety of services. The standards, set out in seven domains, are to be used by the Healthcare Commission as part of the performance assessment. Although the standards are related to the provision of NHS health care, it is acknowledged that services should be developed 'in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care' (DH, 2005c; 8). It is intended that a whole system approach to health service provision will be adopted. A key element in this 'will be the adoption of a common framework for all matters related to performance and a common language so that terms such as 'standards' have a clearly understood, shared meaning' (ibid: Para 10). The standards must be adopted by all NHS providers 'no matter what the setting' and also by the voluntary and private sectors where they provide care to NHS patients.

The seven domains within the standards framework are identified as outcomes and comprise: safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health. The 'patient focus' domain expects that, health care providers work in partnership with patients and their carers and relatives.

The Government makes it clear that these are considered universal standards and that they are mandatory, 'health care organisations must comply with them from the date of publication of this document'.

Although the standards are designed for health care providers, where other agencies are involved in care packages, they too must 'read and interpret' the standards 'to allow for the statutory duties of partnership on all NHS bodies and Local Authorities established under the Health Act 1999 and the Health and Social Care (Community Health and Standards) Act 2003', (DH, 2005c: 9).

This requirement is made abundantly clear in core standard C6, which states 'Health care organisations must cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met' (ibid: 11).

Another initiative, *'Options for Excellence'* is the term that has been used to describe a government review of the social care workforce. The review, a joint initiative by the Department of Health and the Department for Education and Skills was launched in July 2005 and is due for completion by late 2006. Its aim is to develop a workforce to deliver user-led services and to ensure that the well being of vulnerable people are safeguarded.

As part of the review a number of working groups have been established to explore: how the number of social care workers can be increased; whether new roles can be developed; how the quality and training of social care workers can be improved; the career opportunities in social care; and how to improve service standards. The review also focuses on cross-professional working and contributes to the Department of Health Green Paper and the DfES Children's Workforce Strategy.

'The NHS Improvement Plan' (DH 2004c) is another initiative that sets the agenda for delivering better services over a four year period to 2008 and has some key messages for the workforce. These include the commitment to increase the number of people working in health care year on year however people will be expected to 'work differently with a move to competence based roles. It promotes integrated workforce plans, within the NHS and also at the NHS/Social Care/Independent and Voluntary Sector interface. It also envisages a significant shift from national to local decision making so that the local workforce capacity can be maximised.

A further and highly significant shift towards interprofessional, interagency working has resulted from the mandatory reduction of junior doctor's working hours to 48, due to be implemented no later than 2009. The DH recognises that this alone 'will require major workforce redesign' (DH 2004d: 2) and in response has set up the Working Time Directive 2009 Project that is discussed in more detail in Chapter 3.

The workforce

Historically the health professions have been regulated by a number of independent bodies that operate within specific statutes and legislative procedures. These bodies are supported by independent professional organisations such as the Royal Colleges. In 2006 while remaining autonomous, these independent bodies are now broadening their horizons and learning to work collaboratively. Moreover there is concrete evidence that some, such as the General Dental Council (GDC), have extended their register to include other members of the dental team. The GDC is no longer the exclusive preserve of dental surgeons as, for example, qualified dental nurses, dental hygienists and dental technicians will also be registered with this Council. A similar model has been adopted by the Royal Pharmaceutical Society (RPSGB) that plans to register pharmacy technicians.

As the New Ways of Working initiative gathers momentum and the professional boundaries blur there will be an even greater need for the regulatory bodies to work collaboratively. Registered nurses, physiotherapists, podiatrists and midwives for example are now able to prescribe a limited number of medicines once individuals are deemed competent to do so. In August 2006 the DH announced that it is likely that optometrists will at some stage be able to prescribe ophthalmic related medication. These developments mean that there must be interprofessional collaboration at the highest level with the General Medical Council (GMC), the Nursing & Midwifery Council (NMC), the Health professions Council (HPC) and the RPSGB working together.

The establishment of the Council for Healthcare Regulatory Excellence in 2003 is therefore appropriate and timely.

The Council for Healthcare Regulatory Excellence (CHRE)

Following the enactment of the NHS Reform and Healthcare Professions Act 2002, The Council for the Regulation of Healthcare Professionals was established in 2003. It subsequently became the Council for Healthcare Regulatory Excellence (CHRE) the rationale being that the new name better reflected its remit. It is a 'statutory overarching body, covering all of the United Kingdom and separate from Government'. It promotes best practice and consistency in the regulation of healthcare professionals (see CHRE website).

There are 19 Council Members of whom nine are lay members. It is an umbrella organisation that covers nine separate regulatory bodies namely:

1. General Chiropractic Council (GCC) regulates chiropractors
2. General Dental Council (GDC) regulates dentists, dental hygienists and dental therapists
3. General Medical Council (GMC) regulates doctors
4. General Optical Council (GOC) regulates dispensing opticians and optometrists
5. General Osteopathic Council (GOsC) regulates osteopaths
6. Health Professions Council (HPC) (previously the Council for Professions Supplementary to Medicine) regulates 13 professions (arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers and speech and language therapists.
7. Nursing and Midwifery Council (NMC) (previously the UKCC) regulates nurses, midwives and specialist community public health nurses
8. Pharmaceutical Society of Northern Ireland (PSNI) regulates pharmacists
9. Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists'

One of CHREs statutory responsibilities is to 'promote co-operation between regulators and other organisations' (CHRE, 2005: 4).

One section of their 2004/05 Annual Report is devoted to Regulation at Work and there is clear recognition that 'different traditions and history and, crucially, different legislative frameworks affect what the regulatory bodies are able to do'

The Report also identifies four key challenges for the future:

1. Responding to the increased mobility of healthcare professionals in the European Union or worldwide
2. Adapting to new workforce trends
3. Responding to outside changes
4. Building on good practice

In 2001 several regulatory bodies were seeking evidence of skills in collaborative working as part of their undergraduate programmes, including the UKCC, GMC, the Council for Professions Supplementary to Medicine (CPSM), and the Central Council for Education and Training in Social Work (CCETSW) (UKCC, 2001). Representatives from each of these bodies and from Universities UK worked in partnership to review the evidence on inter-professional education. They noted that National Occupational Standards were already written in a language common to the health and social care professions. However to date, they observed 'there has been a piecemeal approach to the development of interprofessional education. Many of the examples we discovered would be more aptly described as shared learning, with students sitting in a classroom together but not necessarily learning with and from each other' (ibid: 31).

The following is a selection of some of the UK statutory bodies to illustrate how they are embracing the concept of interagency and interprofessional working.

The Health Professions Council (HPC)

Set up by the Health Professions Order (2001), amended in January 2006, The Health Professions Council has replaced the old Council for Professions Supplementary to Medicine.

As an independent statutory regulatory council it sets the standards for the training, conduct and performance of thirteen healthcare professions. It has mandated that from 1 July 2006, all health professionals on their Register, circa 170,000 of them, must undertake Continuing Professional Development (CPD) but there is no explicit reference to learning with other health or social care professions. A potentially significant statement however is that the HPC expects individuals to provide evidence that the CPD event 'has contributed to the quality of their practice and demonstrates that it benefited the service user', moreover 'the standards apply not only to those in clinical practice, but also to those working in research, management or education' (see NHS Networks website)

One of the Education & Training Standards laid down by the HPC in 2004 relates to curriculum standards where it is stated: 'Where there is inter-professional learning the profession specific skills and knowledge of each professional group must be adequately addressed' (HPC, 2005: para 4.7). Standard 5 the practice placement standards, also implies the need for interprofessional practice as in Students and practice placement educators must be fully prepared for placement which will include information about and understanding of: 'communication and lines of responsibility' (ibid: para 5.7.5).

The HPC has also published a short paper that focuses on 'generic standards of proficiency' in which their expectations of a health professional are spelt out.   Whilst the first standard refers to professional autonomy and accountability, the second focuses on professional relationships, which for the purpose of this paper are worth quoting verbatim:

Registrants should:

> ➢ Know the professional and personal scope of their practice and be able to make referrals (1.b.1)
> ➢ Be able to work, where appropriate, in partnership with other professionals, support staff, patients, clients and users, and their relatives and carers understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team understand the need to engage patients, clients, users and carers in planning and evaluating care (1.b.2)
> ➢ Be able to contribute effectively to work undertaken as part of a multi – disciplinary team (1.b.3)
> ➢ Be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, patients, clients, users, their relatives and carers (1.b.4)
> ➢ Understand the need for effective communication throughout the care of the patient, client or user' (1.b.5)

Nursing and Midwifery Council (NMC)

The NMC under the Nursing & Midwifery Order 2001 was established in 2002. It replaced the UKCC and the four National Boards. Its remit under the Order is to maintain a Register of qualified nurses and midwives (Article 5.1) and to establish standards it considers necessary for safe and effective practice (Article 5.2a).

The NMC helpfully clarifies how the Order and its subsequent rules and standards impact on the professions:

'Rules are established through legislation and they provide the legal strategic framework from which the NMC develops standards. The standards support the rules being put into practice. The standards are mandatory and gain their authority from the legislation, in this case the Order and the rules' (NMC, 2004a: 8).

By 1999 the UKCC was actively encouraging nurses, midwives and health visitors to learn with and from other healthcare professions (UKCC, 1999: Recommendation 32). This could be achieved by education providers including interprofessional education in pre-registration curricula, education commissioners including an explicit criterion for interprofessional teaching and learning and increasing the use for shared resources in practice placements. The UKCC was prepared to lead joint initiatives with other relevant regulators.

Every nurse and midwife is held accountable for their practise through the NMC *'Code of Professional Conduct'* (NMC, 2004b). A short succinct Code, it is explicit and mandatory with a clear emphasis on responsibility for individual actions or omissions. Co-operation with other team members, risk management, maintaining knowledge and competence are listed within the

Code with the suffix 'these are the shared values of all the United Kingdom healthcare regulatory bodies' (ibid: 3) leaving nurses and midwives in no doubt that other health professions must aspire to the same expectations.

Partnership between patients or clients and the team that cares for them is also emphasised (NMC, 2004b: Para 2.1) with the further mandate 'you must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients' (Para 4.3). Keeping records is viewed as a team communication tool (Para 4.4) and the Code acknowledges that while 'it is impractical to obtain consent every time you need to share information with others' (Para 5.1) nurses and midwives must 'guard against breaches of confidentiality by protecting information from improper disclosure at all times' (Para 5.1). In essence this means that sharing information with others, whether they are nurses, midwives or members of any other profession, must be justifiable in the best interests of the patient.

There is one further reference in the Code to collaborative working with other team members 'in order to promote health care environments that are conducive to safe, therapeutic and ethical practice' (Para 8.1).

The UKCC first published the PREP Handbook in 2001 and this is reviewed and updated by the NMC as new rules are implemented and evidence of best practise emerges. The NMC while acknowledging that continuing professional development (CPD) is 'not a guarantee of competence, [it] is a key component of clinical governance' (NMC, 2006: 3).

PREP is a flexible framework that enables the practitioner to decide the CPD which best meets their professional needs… 'There is no such thing as approved PREP (CPD) learning activity' (ibid: 8). This flexibility thus enables practitioners to pursue interprofessional, interagency learning and still meet the PREP standard.

The NMC produces standards of proficiency for the various professionals they represent. In the Standards of proficiency for pre registration nurse education (NMC, 2004c), one of the standards expected is that every nurse can 'demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team' (ibid: 5) with another being that the nurse can 'Work in a team with other nurses, and with medical and paramedical staff and social workers related to the care of the particular type of patient with whom they are likely to come into contact when registered at this level of the nurses' part of the register' (ibid: 6).

One of the guiding principles for the standards of proficiency relates to the management of care one aspect of which 'involves the capacity to work effectively within the nursing and wider multidisciplinary team, to accept leadership roles within such teams, and to demonstrate overall competence in care and case management' (ibid: 14).

In common with nurses, midwives are expected not only to 'work collaboratively with other practitioners and agencies' but also to 'demonstrate effective working across professional boundaries and develop professional networks' (NMC, 2004a: 7).

In the public health arena the standards relate to working in an environment that is service user centred, includes their carers and families, and evidence collaborative working with others in the health and social care workforce 'in the planning, delivery and evaluation of public health activities and programmes'. There is also the clear expectation that these activities will be evident 'in a variety of settings, including homes, schools, workplaces and local areas' (NMC, 2004d: 6).

Significantly the NMC emphasises that the standards 'are not separate and insular professional aspirations. They are instead directly linked to the wider goals of achieving clinical effectiveness within healthcare teams and agencies, with the ultimate aim of achieving high quality healthcare'. The NMC expresses the belief that this is 'one of the fundamental underpinnings of clinical governance' (ibid: 7).

The phrase 'collaborative working' is used frequently in this set of standards and the NMC spells out in the glossary what in their view this entails: 'it includes working with others working in health and social care; those working in social security, benefits, education, housing and the environment; those working in advice, guidance and counselling services; employers and employees in a range of different sectors; voluntary agencies; community networks and legal and judicial agencies' (ibid: 21). Collaborative working and its impact on the health and well being of the population will be explored in detail in Chapter 3.

When reviewing the document entitled *'Supporting nurse and midwives through lifelong learning'* (NMC, 2002), our expectation was that there would be some reference to learning and working with other members of the health and social care workforce but this proved not to be the case.

The General Medical Council (GMC)

In 1999 the GMC observed that 'healthcare is increasingly provided by multi-disciplinary teams' and gave explicit acknowledgement that 'such collaboration brings benefits to patient care'. They warned however that if communication is poor, between the team members, problems can arise. A systematic approach to prevent this was suggested, in order to 'facilitate collaboration and communication… improve the quality of the team's work… and that teams are… clear about their objectives' (GMC, 1999: Para 21).

The GMC repeated their observation of the increase in multi-disciplinary team working two years later but emphasised that 'working in a team does not change your personal accountability for your professional conduct and the care you provide' (GMC, 2001: Para 36). Although written by the GMC this statement is pertinent to all every health professional and could easily be

adopted verbatim by each Regulatory Body. The GMC recommends that team leaders, in this instance doctors, must amongst a number of other directives, 'communicate effectively with colleagues within and outside the team'

A seminal document was published by the GMC in 2003. In *'Tomorrow's Doctors'* it is made clear in Para 28f, that graduates 'must be aware of current developments and guiding principles in the NHS, for example [of] the importance of working as a team within a multi-professional environment'. A subsequent paragraph urges medical schools to 'provide opportunities for students to work and learn with other health and social care professionals. This will help students understand the importance of teamwork in providing care' (GMC, 2003: Para 47).

Earlier this year the GMC Education Committee released a position statement which notes that 'the study of medicine also involves substantial direct and intimate contact with patients making serious demands of students together with the need to work collaboratively together with a range of health care professionals and others' (GMC, 2006a: Para 7). The Committee returned to the theme in Para 8a with its reference to 'one of the skills that is fundamental to the skills of clinical medicine is described as: 'the ability to communicate clearly, sensitively and effectively with patients… and with colleagues from health and a range of other professions who may be involved in the patients care' (GMC, 2006a: 2).

Published by the GMC and the PMETB the current consultation document *'Quality Assurance of the Foundation Programme'* when referring to the quality assurance process envisages that the 'Team of Visitors' whose remit is to quality assure undergraduate medical training, will include not only doctors but 'other health professionals, lay members and patients' (GMC, 2006b: Para 32b).

The selection criteria for appointment as a Visitor for the Quality Assurance of the Framework Programme (QAFP) includes 'a knowledge and understanding of assessment systems and of developing and delivering interprofessional learning' (GMC, 2006b: 56).

GMC guidance on continuing professional development also makes it clear that a doctor is expected, amongst other things, to 'explore the benefits of learning across professional disciplines and boundaries' (GMC 2004: Para 19b). There is also the expectation that organisations (unspecified) will provide guidance on topics such as 'how to benefit from the knowledge and experience of colleagues within a specialty, from other disciplines, professions and agencies, and from patients' (ibid: Para 27e) which is reinforced further in Annex A of the document which states that good medical practice includes 'shared learning across professional boundaries' (ibid: Para 2d). It also devotes a short and succinct section to working with colleagues in which it states that doctors must keep up to date with: The roles and expertise of other health and social-care professionals and effective team-working, management and, if necessary, leadership skills…' (ibid: Annex A Para 4).

The General Dental Council (GDC)

Recently the GDC has published a number of key documents, which focus on the team approach to oral and dental health. The opening web page informs the general public about the concept of dental teams, who they are, what they do, and how the team works collaboratively to help individuals retain oral and dental fitness

In their publication *'Developing the dental team: Curricula Frameworks for Registrable Qualifications for Professionals Complementary to Dentistry'*, the opening sentence affirms the GDCs belief that 'good dental care is delivered by a team of dental professionals' (GDC, 2004: 6). The GDC also confesses that 'the vital roles of the PCDs [Professionals Complementary to Dentistry] have too often been under recognised and their training and career development neglected' (ibid: 6). With the introduction of a new PCD register not only must dental hygienists and dental therapists register but also dental nurses, dental technicians, clinical dental technicians and orthodontic therapists. The benefits are seen as enabling greater flexibility across the team to allow each team member to make the best use of their skills. The history of developing the dental team can be traced back to a document published by the GDC in 1998: *'Professionals Complementary to Dentistry: A Consultation Paper'* which received support for its proposals.

One of the key principles in *'Developing the Dental Team'* listed as: 'learning opportunities and experiences should enable students of the professions complementary to dentistry to work and train as part of the dental team' (GDC, 2004: 9). To achieve this there is the expectation that each curriculum will offer the opportunity for student PCDs to learn and work with the other members of the dental team. Common curriculum subjects are identified with core communication skills viewed as an 'essential part… as they facilitate effective team working and underpin the provision of high quality care' (ibid: Para 44)

Further reference is made to the importance of core communication skills with the dental team when ethical and safety issues are addressed: 'This [core communication) helps to develop attitudes of empathy and insight… and provides the opportunity for discussion of contemporary ethical issues…' (ibid: Para 51). Suggestions are made for 'integrated teaching of legal and ethical issues with other topics such as pain, stress and anxiety, social class, poverty, and the needs of children and the elderly' (ibid).

In their publication *'Standards for dental professionals'* the GDC outlines the standards of every member of the dental team each of whom is deemed as having individual responsibility. The standards include one that states 'co-operating with other members of the dental team and other healthcare colleagues in the interests of patients' (GDC, 2005: 4). In the patients best interests communicating effectively by sharing knowledge and skills within the dental team is seen as key with the additional mandate 'make the interests of patients your first priority' and 'follow our guidance 'principles of dental team working' (Ibid: Para 4.3). This is followed by the warning that each practitioner

must be able to justify their actions and if they are unable to do so satisfactorily, their registration with the GDC will be at risk (ibid: 5).

The GDC, in their publication *'Principles of dental team working'* state that 'good dental care is delivered by a dental team. The quality of teamwork is closely linked to the quality of care the team provides' (GDC, 2006: 3). The GDC includes receptionists and practice managers as essential team members. Teamwork means working together to provide good-quality dental care (ibid: Para 1.1). Para 1.3 makes reference to 'the wider healthcare team' an acknowledgement of the fact that dental teams cannot work in isolation from other professions. In the GDCs opinion 'a good team will have: good leadership; clear, shared aims, and work together to achieve them; and different roles and responsibilities, and understand those roles and responsibilities' (ibid: Para 5.1).

The General Social Care Council (previously CCETSW)

Social Cares commitment to interagency working has been evident for a number of years. Benchmark statements for Social Work acknowledge that 'contemporary social work commonly takes place in an inter-agency context, and social workers habitually work collaboratively with others towards inter-disciplinary and cross-professional objectives' (QAA 2000: 11)

In their Code of Practice social workers must be able to demonstrate that they are 'working and respecting the roles and expertise of workers from other agencies and working in partnership with them' (GSCC 2002: 6:7). However, in the National Occupational Standards for social work the concept of partnership is embedded rather than used explicitly. Although one of the key roles relates to 'plan, carry out, review and evaluate social work practice, with individuals, families, carers, groups, communities and other professionals' inter-agency working is not mentioned specifically (see TOPSS England, 2005).

It appears that social services in each of the four home countries adopt a similar approach to partnership working with England stating that 'all social workers will learn and be assessed on partnership working' (DH 2003b: 8). In Wales, based on the NOS and the QAA Benchmark Statement, 'partnership' in terms of shared skills and knowledge is implicit throughout (NAW, 2003). Scotland mentioned partnership specifically throughout their Framework in terms of underpinning knowledge, transferable skills and competence. They give as examples the need to work in partnership with service users, carers, partner organisations and colleagues in other organisations. The whole of Standard 6 involves working in partnership to help individuals achieve and maintain greater independence (Scottish Executive, 2003). In Northern Ireland partnership is mentioned both in relation to pre registration and post qualification. Knowledge of inter-professional working and the requirement to work in partnership with colleagues, provider organisations and with service users is evident throughout their Framework (DHSSPS and NISCC, 2003).

The GSCC has welcomed the DH decision to undertake a public consultation proposing change to the regulations for healthcare professions. The DH decision complements the recently completed GSCC public consultation in which they sought views about the need for regulating the care workforce. On 17 July 2006 the GSCC wrote: 'We are already working closely with other regulators in all relevant sectors, in healthcare and beyond. Working together is an essential step in the delivery of a comprehensive regulatory regime for all professional groups and the public has the right to expect high standards of competence, conduct and care' (GSCC, 2006a)

The following week, the GSCC announced that they would be recommending the registration of domiciliary and residential care workers (25 July 2006). A seminal statement in this announcement is as follows: 'The recommendations are founded on the clear principle that registration seeks to build a well-trained, trusted and accountable, workforce which delivers high quality services. They also support moves to achieve greater integration and harmonisation between workforce regulators and service users to achieve a shared understanding of inter-professional values and standards' (GSCC, 2006b)

Interprofessional education and training

In 2002/03, within the NHS in England, £3 billion was made available for the learning and development of healthcare staff from a central Multi-Professional Education and Training budget (MPET) (DH, 2003c). The local NHS Workforce Development Confederations (WDCs) contracted higher education institutions (HEIs) to deliver pre-registration training for the majority of the healthcare professions with the exclusion of medicine and dentistry. Monies from MPET paid for student bursaries and placement costs as well as the continuing professional development of staff.

The WDCs were made responsible for the planning of practice placements and monitoring their quality in line with nationally determined standards. Recognising the importance of interprofessional learning as one of the means by which the workforce can be developed to deliver enhanced patient-centred care, WDCs had to ensure that all practice-learning environments:

- are suitable to facilitate multidisciplinary learning;
- are available in sufficient numbers to accommodate the students;
- have appointed experienced and qualified professional staff to manage, supervise and assess the students; and
- are responsive to student evaluation and feedback.

In April 2004, WDCs were fully integrated into Strategic Health Authorities (SHAs), many of which planned to become a Workforce and HR Directorate of their SHA.

National Occupational Standards (NOS)

It is now government policy to promote the use of occupational standards as the accepted model for competency frameworks across all sectors. The Department for Education and Skills license National Training Organisations to develop NOS for their sector. As knowledge, skills and application competency frameworks, they are broad based and having originally been equated to NVQs, they have now been extended and include higher-level qualifications. NOS build the bridge that link organisational and individual needs. NOS are developed through stakeholder engagement and consensus. Reinforced by the QAA Benchmark Statements NOS can be used in a number of ways including the development of interagency, inter-professional care pathways; clarifying professional boundaries, highlighting shared competences where boundaries can be blurred safely.

Agenda for Change (AfC)

In November 2004 Agenda for Change (AfC) was launched. Designed to modernise the NHS pay system, it has been agreed by the four health departments within the UK, the NHS Confederation, the Unions and the Professional Bodies. AfC refers throughout to the collective NHS workforce and its goal of achieving 'a quality workforce with the right numbers of staff, with the right skills and diversity, and organised in the right way' (AfC 2004: 3), however, the medical and dental professions are excluded from Agenda for Change. Significantly, AfC intends to 'assist new ways of working… to best meet the needs of patients' (ibid). New ways of working includes implementing new roles, a number of which involve working across professional boundaries and organisations.

For some Trusts there is the opportunity within AfC to reward bonuses to teams (Para 8.2). This implies that if a team works well together and the outcomes for patients improve accordingly, they could apply for a bonus.

Within the Partnership agreement a number of success criteria are identified (see Annex E) one of which is 'Better teamwork/ breaking down barriers – the creation of additional posts involving new roles, leading to shorter care pathways and fewer adverse incidents due to poor teamwork (such as appointment cancellations)' with another being the 'Greater innovation in deployment of staff - extended availability of services for patients, more sharing tasks between team members and more staff in wider roles'. Measuring these includes evidence of 'improved team working' (p62). For more information see the DH Agenda for Change website.

The NHS Knowledge and Skills Framework (KSF)

The KSF will be used as the measure for the annual development review of all staff. An individual's level of knowledge and skills applicable to their role in the workplace will be a key indicator of their achievements. The outcome of the annual review will be a personal development plan. Primarily intended to

enhance and extend the role played by the individual in practice, it also encourages career progression.

Crucially the KSF is 'NHS wide, applicable all staff… supports the delivery of NHS plans and links with professional regulatory standards' (Para 7.3). For more information see the DH Knowledge and Skills Framework website

The regulation of the non-medical health professions (The Foster Report)

In July 2006 the DH published their long awaited response to 'The regulation of the non-medical healthcare professions' (DH, 2006b) Commissioned originally as part of the Governments response to the Shipman Report its remit was to consider the measures necessary to:

- strengthen procedures for ensuring that the performance or conduct of
- non-medical health professionals and other healthcare staff does not pose a threat to patient safety or the effective functioning of services, particularly focusing on the effective and fair operation of fitness to practise procedures;
- ensure the operation of effective systems of continuing professional development and appraisal for non-medical healthcare staff and make progress towards regular revalidation where this is appropriate;
- ensure the effective regulation of healthcare staff working in new roles within the healthcare sector and of other staff in regular contact with patients (DH, 2006b: 3).

Foster and his colleagues were asked to 'recommend any changes needed to the role, structure, functions and number of regulators of non-medical healthcare professionals' (ibid: 3).

In 2004 a public consultation was conducted by the DH in England, Wales and Northern Ireland with a similar exercise completed in Scotland by the Scottish Executive Health Department. Most people wanted statutory regulation for the majority of support staff, although further debate about the implications of this was called for.

The Health Professions Council (HPC) was for most respondents, the appropriate body to regulate the support workers however nurses and the professional bodies preferred the NMC to regulate Healthcare Assistants (HCAs). An additional consideration was that the professional bodies want to regulate support workers specific to their own professions.

The ramifications of all this are far reaching in that there is emerging evidence that many HCAs are being reclassified as support workers, without additional training or a change in role, and many support workers have the key role of supporting patients and their families, adopting an interprofessional, interagency model rather than a specific profession. The implications of this are discussed in Chapter 3.

Similar findings were reported from the consultation in Scotland. Respondents from all four countries supported the concept of single statutory registration thus enabling transferability of the workforce across the UK.

The Government intended originally to publish the Foster Report towards the end of 2005 and in their own words warned that the eventual report would be 'likely to have important consequences for the regulators and their Registrants and to affect our programme of work for next year'. The Foster Report was embargoed until July 2006 when it was published in part. The full impact of the Foster Report therefore is yet to be realised. One of the opening statements however gets straight to the point: 'It is however essential that all the different healthcare professions, which work together so closely, are regulated in consistent ways which are planned together as an integrated whole' (DH, 2006b: 3). It has been decided that the Knowledge and Skills Framework (KSF) 'should be the basis of revalidation' (ibid: 6).

A consistent approach is called for based on the recognition that increasingly professional boundaries are being blurred, and that new roles and ways of working are being implemented on an almost daily basis. With the different models of service delivery professionals are working in more diverse ways in more diverse settings. To implement the new ways of working, any remaining barriers between the professions will need to be dismantled. The Report warns however that whilst new ways of working can break down barriers it can also 'produce ever greater specialisation'.

The Report notes that for many years healthcare professionals have been extending their roles to include skills previously practiced exclusively by others. It concludes that extended practice does not necessarily require further regulation in its own right. It cites examples however of new roles that are producing greater specialisation such as Anaesthesia, Emergency Care, Endoscopy, Medical Care and Surgical Care Practitioners. Foster and his colleagues recommend that if healthcare providers agree these new roles are fit for purpose they will need statutory regulation (ibid: 8). This is a very important decision as far as the interprofessional workforce is concerned as the above 'practitioners' are not mutually inclusive to any specific profession. The implications for the workforce, in future, will be explored in more depth in Chapter 3.

'There are substantial areas in which common standards would be desirable' (p9) and the DH has charged CHRE with this responsibility. For the time being the DH has refrained from restructuring the regulatory bodies their rationale being that closer 'collaboration and harmonisation' will avoid the need. Further persuasive arguments for reducing the number of regulators includes reducing the burden for Higher Education Institutions which currently has to respond to, and liaise with, a number of statutory bodies each of which have different demands and expectations.

The DH however, although in the interim maintaining a status quo, added a caveat 'we will review the position after five years, in 2011 (ibid: 10)'. This implies that unless there is clear evidence that the regulatory bodies, whilst

remaining autonomous, are working collaboratively, there is the potential for their autonomy to be removed.

Service users and carers

Since 1997, the Government has stressed the need for organisations and government departments to co-operate more closely in the delivery of public services, placing the service user, or citizen, at the centre.

Service users have played a crucial role in driving policy forward for some years now. Recent examples include: The Bristol Royal Infirmary Inquiry (DH, 2001c); The Victoria Climbié Inquiry (DH, 2003d); and the Shipman Inquiry (2005).

In September 2004, the government launched a Strategic Agreement *'Making Partnerships Work for Patients, Carers and Service Users'* (DH, 2004) and a National Strategic Partnership Forum was established. The Forum is made up of key stakeholders whose brief is to support national and local health and social care partnerships at a strategic level.

'Creating a Patient-Led NHS' (DH, 2005d), outlines the Government's vision of a health service that is designed to meet patient expectations and needs. A number of ways of achieving this are identified but as the Government acknowledges 'the system itself, and the way people work in the system, can often get in the way. There can be barriers and blockages, professional and organisational boundaries, vested interests and perverse incentives' (ibid: 7). A radical over haul of the service is needed before it can be pronounced 'truly patient-led'. A new framework of standards, skills, organisations, systems and incentives will be required. A safe, integrated local service that can respond rapidly and is convenient for patients and their families is the model envisaged (ibid: 13).

Aiming to improve community health and social care services for everyone, in 2005 the DH undertook a public consultation the findings of which were published subsequently in *'Your health, your care, your say'* (DH 2005e). The recommendations made by the general public (albeit a very small, selective sample) and health care professionals were taken into account in the resulting White Paper *'Our health, our health, our care'* that was published in 2006 (DH, 2006c)

Using the five principles of 'giving people a choice, making life easier, giving people a say, promoting independence and dignity, and supporting people (such as family, friends and neighbours, who provide care) The public were asked to consider the following questions:

- 'How can we help you take care of yourself?
- How, when and where do you want to get help when you need you need it?
- What do you need to help you manage your care and make decisions'?

A key finding from this consultation was that although people generally hold the health and social care professions in high regard, 'people feel that the system is not really designed around them'. Each service or agency works too autonomously and there is no real sense of working together in the patient's best interests. Described as falling between the gaps, older people and those living with long term conditions find it particularly hard to receive integrated care packages which best meets their needs and aspirations. Maintaining independence, staying at home rather than being admitted to hospital, and being the key partner in decision making wherever possible are fundamental to best practice.

In the consequent White Paper *'Our health, our care, our say'* (DH 2006c), the government sets out a clear vision for the development of integrated services, which offer personalised care where people are empowered to exercise personal choice and control over services. Service providers are expected to respond accordingly. To sustain an integrated service, Personal Health and Social Care Plans are being developed, underpinned by integrated health and social care records. People living with complex long-term conditions have been promised a joint health and social care team to co-ordinate and deliver their care.

The DH itself has made a commitment to adopt 'a more integrated approach to its leadership role' by ensuring that the departments work more cohesively (DH, 2006c: Para 2.97). Eventually the outcome of this should be integrated policy. A significant development has been the appointment a Social Care representative onto the DH Board. Another way in which the DH is planning to achieve greater integration is through the development and implementation of Local Area Agreements (LAAs) by the end of 2007.

The LAAs are three-year agreements setting out the local priorities for certain policies and are made up of outcomes, indicators and targets. The overall aim is to deliver a better quality of life for people by improving performance of local services. A paper published by ODPM in 2005, *'Local Strategic Partnerships: Shaping their Future'* emphasised the need for local leaders to take a sustainable multi-disciplinary and integrated approach to social, economic and environmental issues henceforth to be known as 'Sustainable Community Strategies'. Driven by these Sustainable Community strategies each LAA must agree their priorities with central government as well as between the local partners.

The LAAs are designed to 'simplify funding streams, targets and reporting arrangements to enable local partners to deliver better public services' the aim being to 'add value by bringing diverse partnerships together' (ODPM, 2005: Para 2.69).

The experience of the first 20 pilot sites is reported as showing 'that they have the potential to facilitate integrated service planning and delivery across all those who provide services in a locality' (ibid: Para 2.72). The Department for Communities and Local Government (formerly the Office of

the Deputy Prime Minister) has published a toolkit based on the lessons learnt from these (see DCLG, 2006).

Children and young people

Following the inquiry into the death of Maria Colwell in 1974 when it was reported that there was a lack of coordination between services relating to children, Area Child Protection Committees (ACPCs) were developed. These were non-statutory and multi-agency bodies that brought together professionals from government departments, charities and organisations working in the field of child protection. ACPCs were given the role of coordinating the agencies involved in ensuring the safety of children at risk. In cases where child abuse was suspected or confirmed to be the cause of death, ACPCs would have to investigate whether child protection procedures had been followed (known as a 'Part Eight Review')

The Children Act 1989, which was implemented in England and Wales in 1991, in Scotland in 1995 and in Northern Ireland in 1996, placed emphasis on statutory and voluntary agencies to work in partnership with those who were responsible for children and young people. The Act empowered local authorities to request assistance from other professions, authorities or agencies when caring for children at risk of abuse and exploitation, and they were not able to decline unless such assistance was incompatible with their own statutory duties and obligations.

The report by Lord Laming in 2003 following the inquiry into the death of Victoria Climbié found that health, social services and police failed to notice twelve opportunities which could have saved her life and all services failed to intervene early enough. It was reported that there was: 'poor co-ordination; a failure to share information; the absence of anyone with a strong sense of accountability; and frontline workers trying to cope with staff vacancies, poor management and a lack of effective training' (DH, 2003d: 5).

Multi-agency training was strongly recommended by Laming. He stated that 'each of the training bodies covering the services provided by doctors, nurses, teachers, police officers, officers working in housing departments, and social workers [are] to demonstrate that effective joint working between each of these professional groups features in their national training programmes' (DH, 2003d: Recommendation 14).

During the inquiry the legislative framework for safeguarding and promoting the welfare of children as laid down in the Children Act 1989 was examined to see if there were defects in the law. Legislation was considered to be sound hence the difficulties reported throughout the inquiry were as a result of how the law was interpreted, implemented and resourced.

The report went on to stress the importance of collaborative working in preventing child abuse, reiterating the policy imperative in *'Working Together'*. Moreover, in response to the Victoria Climbié Inquiry, Alan Milburn, then

Secretary of State for Health, introduced the concept of Children's Trusts as a means to create 'more seamless local services for children'.

In September 2003 a government green paper, *'Every Child Matters'* (DfES 2003) was published. The government proposed that by 2006 social services, child health and education should be amalgamated, that most areas should have a Children's Trust and that ACPCs should be replaced by Local Safeguarding Children Boards (LSCBs). LSCBs were established in April 2006 and are made up of Strategic Health Authorities, Primary Care Trusts, NHS & Foundation Trusts, district councils, police, probation staff, Connexions, Cafcass, secure training centres and prison establishments. LSCBs operate within statutory guidance and regulations.

Within *'Every Child Matters'* it was reported that fragmentation of responsibilities for services related to children can result in children 'slipping through the net' as crucial information and concerns were not shared between the agencies. Children were frequently subjected to duplicate assessments by different professionals, each of whom is in contact with the child and their family, but not necessarily with each other. This duplication of services besides putting a child at an increased risk of being lost in the system has a cost implication in terms of time and resources.

A coordinated support package delivered by an interprofessional interagency co-located workforce has real benefits realisation for both the child and their family as well as for the health and care services. Since some families and children will need support from a range of different professionals, the Government recognised that there was a need to 'establish new cultures in the workplace so that individual professionals work horizontally across professional boundaries rather than vertically in professional hierarchies' (DfES, 2003: 86). They continued by stating that 'everyone working with children needs to be trained to do their own job well. They also need to know how their role fits with that of others. They need the skills to work positively with, and draw on the expertise of, other professionals and support staff' (ibid).

In the absence of an integrated model of care, there is a likelihood that children will be referred on to other agencies, with DfES noting that there is particular risk of this happening when it is a 'difficult case'. They concluded that 'planning services… can enable a better response to support the child and better value for money. Joint commissioning can enable the creation of services that deliver multiple dividends such as Children's Centres and extended schools' (DfES, 2005f: 6).

The proposals in *'Every child matters'* led to the development of the Children Bill 2004 as a means to implement some of the proposals. However, the amalgamation of social services, child health and education was no longer deemed to be mandatory and Councils were given another two years to set up children's trusts in their locality.

The process for establishing Children's Trusts will be finalised after the evaluation of the current pathfinder (pilot) Trusts in a selected group of localities is completed. In anticipation of this several comprehensive toolkits has already been prepared (see DH, 2005f; 2005g; 2006d; 2006e).

The Children Bill 2004 has since become the Children Act 2004. All agencies involved with children, now have a duty to make arrangements to safeguard children from harm and promote their welfare. Moreover, in the latest edition of *'Working Together to Safeguard Children'* (DfES, 2006: 3) it is recommended that 'safeguarding and promoting the welfare of children – and in particular protecting them from significant harm - depends upon effective joint working between agencies and professionals that have different roles and expertise'. In order to promote and achieve joint working, the report regards coordination by the LSCBs and 'a strong lead' from authority members and chief officers in all agencies as essential. It is recommended that all agencies and professionals need to: share information to contribute towards a comprehensive assessment of a child's needs and circumstances; contribute towards safeguarding and promoting the welfare of children; review outcomes for children against specific targets and plans; and work collaboratively with children, young people and parents wherever possible.

Section 10 of the Children Act outlines the statutory requirement of Local Authorities (referred to as Children's Services Authorities in the Children Act 2004). It is the duty of Local Authorities to promote cooperation between agencies to improve and maintain the well being of children within their area. The Children Act defines wellbeing as five positive outcomes: physical, mental health and emotional wellbeing; protection from harm and neglect; education, training and recreation; the contribution made by them to society; and social and economic wellbeing.

DfES recommends that local integrated partnerships should include children and young people along with their families, carers, and services such as housing, leisure and recreation; organisations such as childcare, culture and sport; Connexions; the probation board and youth offending team (YOT); health service providers; schools, colleges, work-based learning providers and Learning and Skills Councils; voluntary and community sector agencies; agencies involved in delivering statutory services to children; the police authority and the immigration services.

The government produced five documents to support the provisions in *'Every Child Matters'* and *'The Children Act 2004'* specifying the duties of agencies involved in safeguarding and promoting the welfare of children and young people and improving their wellbeing. The five publications are as follows:

1. *'Statutory Guidance on Inter- Agency Cooperation to Improve the Wellbeing of Children: Children's Trusts'* (DfES, 2005a), provides a strategic framework for the operation of all children's services within localities and describes the duties placed on local authorities and their key partners to work collaboratively. Local authorities and 'relevant partners' have to work

cooperatively to design and deliver integrated services to meet the needs of children and young people thus improving their wellbeing.

Within this document the DfES acknowledge that some local authorities have already or are in the process of implementing cooperative working, however, there is 'often [a] need to challenge long-standing practice and cut across long-established professional and organisational boundaries' (DfES, 2005a: 4).

Even though it is stated in the document that local authorities must take the lead in arranging and promoting cooperation between agents and agencies that provide services for children within their area, it also dictates that the 'relevant partners must cooperate with the authority in its making of those arrangements'. Relevant partners include the local health services, Connexions Partnerships, Youth Offending Teams, voluntary and community sectors, childcare organisations as well as children, young people and their families and carers.

It is also stated that 'making arrangements is not just about agreeing a set of processes'. Instead it requires 'the continuous joint working needed to make cooperation a reality', at a strategic level through to front-line teams (DfES, 2005a: 5).

Statutory arrangements were put in place from September 2005 for 'Joint Area Reviews' (JARs). Consequently, each locality in England undergoes a regular joint inspection of all services for children and young people to ensure their welfare is protected and promoted.

2. *'Statutory guidance on making arrangements to Safeguard and Promote the Welfare of Children under section 11 of the Children Act 2004'* (DfES, 2005b) specifies what agencies and organisations need to achieve in order to safeguard and promote the welfare of children. Amongst the duties identified, 'effective inter-agency working' and 'effective information sharing' are acknowledged as necessary to promote and safeguard the welfare of children.

3. *'Guidance on the Children and Young People's Plan'* (DfES, 2005c) specifies how local authorities, working in partnership with other agencies and organisations, need to produce a 'single, strategic, overarching plan for all services affecting children and young people' (ibid: 4). The plan needs to include how services will achieve the five outcomes for children and young people.

4. *'The role and responsibilities of the Director of Children's Services and Lead Member for Children's Services'* (DfES, 2005d) provides guidance on the leadership and governance for children's services. The onus of 'building and sustaining effective partnerships with and between those local and out-of area bodies, including the private, voluntary and community sectors' is placed on the appointed Director of Children's Services within each locality (ibid: 8).

5. *'Local Safeguarding Children Boards'* (cited in DfES, 2006) describes the roles and functions of LSCB. Again emphasis is placed on interagency working.

'The Common Core of Skills and Knowledge for the Children's Workforce' (DfES, 2005e) is a seminal document for the interprofessional, interagency workforce. Although classified as non-statutory guidance, the Government makes it clear that it expects all those who work with children and young people to adhere to the guidance.

Crucially the guidance states: 'Looking ahead, as part of its strategy to build a world-class children's workforce, the Government is committed to the creation of a single qualifications framework to support career pathways. Over time, all qualifications for work with children, young people and families, and the occupational standards that underpin them, will include an appropriately differentiated Common Core' (DfES 2005e: 5).

A large number of agencies have signed up to this common core including those from the health and social care sectors, education, the police and justice systems, the Sector Skills Council, various unions and the voluntary sector. It is interesting to note however that none of the Regulatory Bodies are included.

Described as a set of common values, there are six themes in the Common Core:

- Effective communication and engagement with children, young people and families
- Child and young person development
- Safeguarding and promoting the welfare of the child
- Supporting transitions
- Multi-agency working
- Sharing information

To strengthen the impact of the Common Core DfES lists a number of Acts and Statutes to which the Common Core relates: Health and Safety at Work Act 1974; The Children Act 1989; The UN Convention on the Rights of the Child 1989; The Disability Discrimination Act 1995; The Crime and Disorder Act 1998; The Data Protection Act 1998; The Human Rights Act 1998; The Freedom of Information Act 2000; Learning and Skills Act 2000; The Special Educational Needs (SEN) Code of Practice 2001; The Special Educational Needs and Disability Act 2001; The Education Act 2002; The Children Act 2004.

'Working Together' provides guidance to agencies and professionals regarding how to work together to safeguard and promote the welfare of children. The first edition was published in 1988 (DHSS, 1988) and was revised in 1991 (Home Office et al, 1991) and 1999 (DH and DfEE, 1999). The latest edition was published earlier this year (DfES, 2006).

Although addressed to everyone who work with children, young people and their families in health, education services, social services, the police and probation service it states that it is the responsibility of social services to coordinate the assessment of children's needs and of the parents' capacity to promote the child's welfare and safety. In circumstances where the child's welfare and safety is considered to be at risk, it is social services that are responsible for coordinating an inter-agency plan to safeguard the child.

The current edition specifies the arrangements by which professionals and agencies need to follow in order to work collaboratively to safeguard and promote the welfare of children. The document also includes guidance on how professionals and agencies can share information effectively.

In the statutory guidance section DfES devotes a whole chapter to effective training for effective multi and interagency working. They regard interagency training as an effective way of promoting a shared understanding of the roles and responsibilities of different professionals. It can also contribute to effective working relationships. During training, individuals should be exposed to situations where they will develop an ethos, which values collaborative working.

DfES make employers responsible for developing, maintaining and resourcing a competent workforce each of whom is able to recognise and respond to any safeguarding concerns. Local Authorities, through the LSCBs, retain responsibility for checking and evaluating that the employers are indeed fulfilling their statutory duties. DfES also insists that 'operational managers and those with statutory responsibility for services participate in the relevant training and development'.

DfES specifies those who, in their view, must take part in interagency training if better outcomes are to be achieved for children, by developing and fostering a shared sense of responsibility for promoting children's welfare. They include members of the workforce from health and social care, education, housing, leisure services, police and probation services. DfES is also convinced that 'training on safeguarding and promoting the welfare of children can only be fully effective if it is embedded within a wider framework of commitment to inter and multi-agency working, underpinned by shared goals, planning processes, and values' (DfES, 2006: 71).

To support this, they continue, a training needs analysis should be completed and a training strategy identified. The strategy should be based on policy, standards, procedures and practice guidelines. Senior managers must lead by example and give a clear mandate for interagency working.

New initiatives to promote and support collaboration

'The Children's Fund' was introduced in England between November 2000 and April 2003 to support collaboration between agents and agencies providing preventative services for children and young people at risk of social exclusion. Partnerships include individuals from statutory and voluntary sectors as well as representatives from local community groups and cater for children and young people between the ages of five and thirteen years. The Children's Fund responds to local needs and operates under the guiding principles of partnership, prevention and children and young people participation.

As part of the Every Child Matters programme there are three new initiatives each of which changes the focus of children's services from a reactive to proactive service. Directors of Children's Services are responsible for their implementation by December 2008. They are:

1. Common Assessment Framework (CAF) for children and young people
'The CAF is a nationally standardised approach to help practitioners, in any agency, assess and decide how to meet the unmet needs of a child' (DfES 2005e: 24). The framework enables a collaborative assessment of children's needs and facilitates a process where agents and agencies work together the intended outcomes being earlier intervention, a reduction in bureaucracy, and a single assessment process. Safeguards are built in to the CAF so when children or young people have 'urgent or complex needs, requiring specialist assessment and intervention, the common assessment information will feed into the specialist assessment process' (DfES 2005e: 24).

2. The lead professional
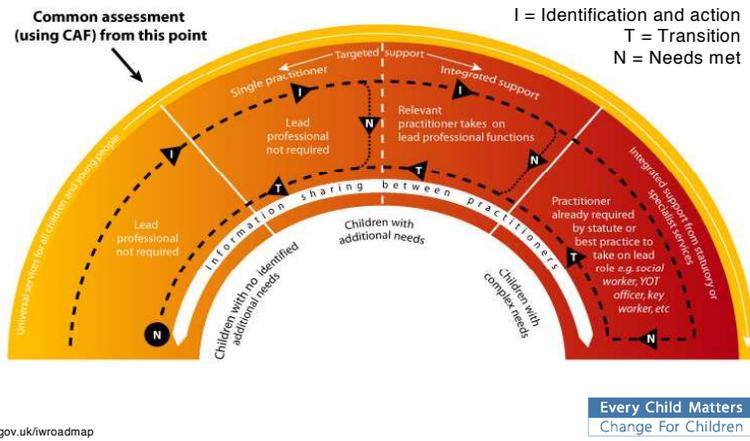A person is identified to coordinate the multidisciplinary actions identified during the assessment process.

3. Information sharing
A process to help practitioners share information to meet the needs of children and young people.

Continuum of needs and services

Information sharing, CAF and lead professional support across the continuum:

Source: Every Child Matters (2006)

The Children and Young People's Plan (England) Regulations 2005 and enforced in September 2005 (Statutory Instrument 2005 No. 2149) is an initiative introduced in response to the Children Act 2004. It required evidence by 1 April 2006 of how local partners were working collaboratively. Each locality has to produce 'a strategic, overarching, single plan' (DfES, 2005f: 22) which includes all services for children and young people. The Children and Young People's Plan is described as a 'focus of joint planning for local authorities and their partners' and acts as 'the vehicle for them to work together' (ibid: 2).

Vulnerable adults/special needs

In 2000 the DH published *'No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse'* (DH, 2000d) as the government recognised that arrangements for dealing with incidents of adult abuse needed to be improved. It is stated that 'agencies should work together in partnership (as advocated in the Health Act 1999) to ensure that appropriate policies, procedures and practices are in place and implemented locally (DH, 2000d: 7) The document provides a framework for partnership working and a structure to develop inter-agency policies, protocols and procedures to ensure that vulnerable adults receive the services and support they require.

In 2001 the White Paper *'Valuing People: A New Strategy for Learning Disability for the 21st Century'* was published (DH 2001f Cm 5086). This was the first White Paper to focus on learning disabilities for thirty years. The proposals in the White Paper are based on four key principles: civil rights; independence; choice; and inclusion. It promotes person centred care and support which should be provided through a single, multi-agency process.

The policy framework described in the publication *'Keys to partnership: working together to make a difference in people's lives'* (DH, 2002c) provides suggestions on building partnerships in services for adults with learning disabilities. It is noted that 'partnerships have to be worked at'. The document enables organisations to evaluate their current partnership arrangements and to identify the actions required to further develop and enhance them.

Mental Health

The White Paper *'Modernising mental health services'* (DH, 1998e) identified 10 key drivers to improve care for people with mental health problems. One of these drivers is that the care should be well co-ordinated between all staff and agencies. With its focus on safeguarding vulnerable people the subsequent White Paper *'Reforming the Mental Health Act'*, built on this theme of co-ordinated interagency care (DH, 2000e). The whole ethos of care seems built around the concept of teamwork in mental health.   Each document refers to early intervention teams; the crisis resolution teams; community mental health teams; out reach teams; primary health care teams (DH, 2001g).

The NSF for Mental Health (DH, 2001h) identified poor workforce planning as a contributory factor to less than satisfactory mental health services. Poor workforce planning can be attributed to factors such as: a lack of robust data on numbers, types of staff, skills mix and needs; 'a lack of a local strategies across the statutory authorities and the non-statutory sector; lack of effective links to the service planning and delivery process and a lack of enthusiasm to implement flexible working across professions and disciplines' (see DH, 2001h).

The Workforce Advisory Team (WAT) for mental health services made it quite clear that 'a user centred approach should be central to the delivery of care and treatment' (DH, 2001h: 5) and that they, and their carers should be engaged throughout the whole process of workforce planning, education and training and the recruitment process and 'to provide more opportunities for shared learning across different sectors and professional groups; a need to bring the private and voluntary sector more closely into this agenda and to encourage the non-professional affiliated staff to undertake education and training…' (ibid: Para 4.39)

One of the ways to redress the balance, WAT recommended, is to implement a 'multi-agency, multi-professional workforce plan'. They expected SHAs, Trusts, PCTs and Local Authorities to contribute to this plan which should embed the Health Improvement Programme and Joint Investment Plans. Redesigning services reflecting future service models was also called for.

In one accompanying paper WAT listed each agency and its remit for moving the workforce agenda forward.   In relation to the now defunct Workforce Development Confederations (WDCs), their role in implementation amongst other things was 'to take the lead in developing integrated workforce planning across sectors; to negotiate and manage the education and training contracts

including promotion of multi-professional team training and learning' (DH 2001h: 9)

A mapping exercise in education and training for mental health was reported in another paper by WAT. One of their conclusions was that, while there was strong support in the workplace for inter-professional training (DH, 2001h: Para B.1.2), 'accreditation of multi-disciplinary training is difficult because there is no common value for CPD across professional groups' (ibid: Para 12.6). It was also recognised that 'although a challenge, trainers need to work inter-professionally and encourage inter-faculty communication' (ibid: Para B.1.13). A further critical finding was that the tension between educational theory and practice contributes to the low opinion practitioners have of some educationalists' (ibid: Para B.1.14). Para B.25 observes that 'although many programmes claim to be multi-disciplinary, there were few examples of shared learning between the MH professions'. Social services were keen to provide joint training initiatives with health care and were frustrated that progress was so slow (ibid: Para B.3.2).

The Mental Health policy implementation guide 'Support Time & Recovery (STR) Workers (DH, 2003e: 3) should be 'seen as a single point along a continuum' and while it does not quite reflect the recommendations made in the WAT final report, this merely reflects the emerging thinking in caring for people with mental health problems. The DH warns that where conflicting thoughts appear between the WAT report and this current guidance, the workforce should accept the guidance 'as the authoritative resource' (ibid: 3).

The policy implementation guidance recommends that STRs should work 'with a group of service users across sectors, as part of a team approach, [as] it would provide them with not only variety and experience but also unique insight about how the sectors work and interact' (ibid: 11). The guidance warns that 'STR workers are not there to merely act as assistants for example. Being part of the non-professional affiliated workforce does not mean they do not have a professional attitude or have skills which should be valued less than professionally qualified staff' (ibid: 12).

This, we suggest, gives a clear indication of where Government policy is leading. Not only is the inter-professional interagency team here to stay, but there is evidence that it will continue to expand and restructure as new ways of working and new models of service delivery evolve.

Older People

The Labour party manifesto in 2001 recognised that integrating services was an essential part of caring and supporting older people: 'Pensioners... need simple, accessible services that treat them with dignity and promote independence. We will build on Care Direct to provide a better integration of health, housing, benefits and social care for older people. This will be an integrated 'third age service' to help older people and those who care for them'.

Published in the same year, the NSF for older people sets 'new national standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital' (see DH, 2001b)

Reinforcing the NHS Plan directives, the NSF is a ten-year programme that demands a model of 'integrated policy and practice development'. A Reference group comprising of older people and their carers, health and social services staff and managers and other partner agencies agreed eight Standards. The Standards, each of which stresses the need for interprofessional, interagency care are currently being monitored 'through a series of milestones and performance measures'.

The Standards can be accessed by clicking on the links below.

- Standard One - Rooting out age discrimination
- Standard Two - Person-centred care
- Standard Three - Intermediate care
- Standard Four - General hospital care
- Standard Five - Stroke
- Standard Six - Falls
- Standard Seven - Mental health in older people
- Standard Eight - The promotion of health and active life in older age

Standard Two: Person-centred care, in particular, has significant implications for integrated working and it states: 'The aim of this standard is to ensure that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries'.

This is being achieved 'through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services'.

The NSF for Older People emphasises the importance of listening to what older people and their carers, have to say. The health and social care sectors have made great progress within the past few years in consulting user groups and incorporating their views when planning improvements in service planning and delivery. The Single Assessment Process, designed to cut bureaucracy and duplication was implemented in 2004.   There has also been great progress in the provision of end of life care. Older people by definition are moving towards the end of their lives and many have complex needs which demand an integrated package of care, delivered wherever possible in their own homes, from a variety of health and social care professionals. There has been substantial investment into end of life care, enabling the integrated services to plan an innovative and quality service.

The publication of *'Integrated Services for Older People: Building a Whole System Approach in England'* (DH, 2002d) gives guidance on redesigning services to develop a whole system approach around the needs of the older

person. It also describes how the Department for Work and Pensions the DH and the Office of the Deputy Prime Minister have been working in collaboration to explore how older people can access the local services they need through a 'single gateway'.

When a group of individuals were asked to identify the most important characteristics of whole system working, one of the features was 'Users experience services as seamless and the boundaries between organisations are not apparent to them' (ibid).

The report completed by Wanless *'Securing Good Care for Older People: Taking a long term view'* (King's Fund, 2006) places an emphasis on the benefits of partnership working. Wanless raises fundamental questions that seriously challenge the very essence of health and social care such as can we afford, as a nation, to sustain the level and complexity of care needed by older people? In the coming decades the problem will intensify as 'the baby boomer generation' retires. Central to the debate is the role of social care. Once this has been decided, Wanless concludes, decisions can be made about the range and size of services, the workforce skill mix required to meet the desired outcomes, the financial resources required and the environmental considerations such as housing and technology to sustain care.

Wanless challenges the fact that whilst older people express a desire to remain in their own homes, towards the end of their lives, more and more people are admitted for care to residential or nursing homes.

Significantly for the Creating an Interprofessional Workforce programme, Wanless concludes that 'there is a growing body of evidence relating to the gains from better joint working between the health and social care systems. The government has promoted a series of measures to improve partnership working, but their use is far from widespread (ibid: 6). He also notes that 'the interface [between health and social care] has become a flashpoint for arguments about inequities in the system'. Having noted that many people more than 50 years old are unlikely to be able to pay for their care in old age he also takes into account the data that 'demonstrates that disability is correlated with lower income and assets, so that those who are most likely to need long term care are also least likely to be able to pay for it' (ibid: 7).

Long term conditions and self care

There are approximately seventeen and a half million people in the UK living with a long-term health condition (DH, 2005h). In their publication *'Independence, Well-being and Choice: Our vision for the future of social care for adults in England'* the DH called proactive, collaborative, seamless and person centred care. It sets out seven key roles for the Director of Social Services which include: 'promoting local access and ownership and driving forward partnership working to deliver a responsive, whole-system approach to social care' (DH, 2005i: 44).

There is acknowledgement within the document that there are examples of best practice in partnership working between agencies in the UK but more work is needed to 'remove barriers to reaching an understanding of shared objectives and priorities' (ibid: 48). Integrated services will not be a reality until there is 'agreement on the necessity for joined-up working' (ibid).

In 2004, *'The NHS Improvement Plan'* called for the recruitment of 3,000 community matrons by 2008 to care for individuals with long-term conditions. The DH published a competency framework for the community matron role in 2005 and one of the nine domains of competence is 'Interagency and partnership working' (DH, 2005j).

In 2005, the DH published *'Supporting People with Long Term Conditions'* (DH, 2005h) which outlined a new NHS and social care model as a framework to care for individuals living with long-term conditions. The model was regarded as an aid to 'ensure effective joint working between all those involved in delivering care – including secondary care, ambulance trusts, social care and voluntary and community organisations – so patients experience a seamless journey through the health and social care systems' (ibid: 8).

The DH published another document in 2006 entitled *'Supporting people with long term conditions to self care: A guide to developing local strategies and good practice'* (DH, 2006f). This supported the view that a successful self-care strategy requires and investment in 'people and resources to support partnership-building across health and social care communities' (ibid: 11). In order to design and achieve a patient-led service, there is a need for agents, agencies, organisations and people with long-term conditions and their carers to work together and share resources. It is essential to ensure that 'there are no artificial boundaries between agencies and organisations, so that individuals experience a seamless care pathway' (ibid: 14).

Carers

The role and value of the carer has recently been afforded much greater attention. In the first UK National Strategy for Carers the Government demands that all organisations involved with caring must now focus on not just the client, patient or user but also the carer if only because in their absence there 'would be a considerable cost to the tax payer' (DH, 1999e: 11). Carers are recognised as a distinct but 'diverse group with diverse needs' (ibid: 12). The Government acknowledges that 'too often in the past, bureaucratic restrictions have made it difficult to target help at carers themselves'. (ibid)

The rationale for involving carers is multi-factorial. Carers need good information and their views must be sought when planning and providing services or training programmes. Authorities are now expected to invite carers to contribute as equal partners with health and social services to identifying, developing and evaluating all stages of local health improvement programmes (ibid: 45).

Everything points towards working together in practice to meet the Governments objective of 'supporting carers in carrying out their caring responsibilities' and what is more with the statutory services and service providers working in a different and more flexible way which empowers patients and their carers as equal partners in order 'to provide the best possible care' (ibid: 45).

Collaborating with service users and carers, the Strategy continues, involves an ongoing and active partnership based on developing relationships, new models of service delivery where 'initiative and decision making rests with users and/or carers rather than with the professionals' (LMCA, undated: 15).

Since the NSF for Older People was published in 2001 initiatives such as Patient Forums have enabled users and their carers to play a central role in the development of services that will be of benefit to them. User satisfaction surveys are now standard procedure for NHS Trusts.

More recently, the *'Carers (Equal Opportunities Act 2004)'* has been published. The background information for this Act acknowledges that there are at least '5.2 million people (nearly 10% of the population) in England and Wales identified themselves in the 2001 Census as providing unpaid care to support family members, friends, neighbours or others because of long-term physical or mental ill-health, disability or old age'. More than a million carers are providing care for more than 50 hours per week. Ways of keeping this unpaid army of carers healthy has become a central consideration for the Government, which acknowledges that many people with long term and degenerative conditions rely almost entirely on the care given to them by family and friends. The Act specifically excludes carers who provide care by contract or who work within the voluntary services.

Chapter 15 of the Act focuses on the Governments duty to inform carers of their right for their circumstances to be assessed. The Act also commands that for an assessment to give an accurate picture there must be 'co-operation between authorities' thus 'facilitating joint working by providing a formal basis for co-operation' to include 'local authorities, housing authorities, local education authority (in the case of the patient being a child or young person), any Special Health Authority, Local Health Board, Primary Care Trust, National Health Service Trust or NHS foundation trust'.

Wanless, in Securing Good Care for Older People (King's Fund, 2006) notes the heavy dependency of older people on informal carers (a disproportionate number of whom are elderly themselves). In 2000 there were 5.8 million informal carers, usually family members. In 2006 the numbers have increased as the population ages. Most carers, unless they can afford to employ additional carers privately, carry the burden of 24-hour care every day of the year. This has a significant negative impact on their personal health and wellbeing. Wanless concludes that greater carer support is needed to relieve some of the pressures' (King's Fund, 2006: 7).

Conclusion

In this second Chapter we have reviewed UK policy, with a particular focus on England, in relation to the interprofessional and interagency workforce in health and social care and its impact on a variety of user groups. There is unequivocal evidence that UK policy promotes and supports interprofessional, interagency working. There is evidence however that some policy relating to changing boundaries is slowing progress and impact as embryonic teams are dismantled and reconfigured in new partnerships. The implications of this will be explored in detail in paper 3 along with an analysis of how government initiatives are being implemented in practice.

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Chapter 3 - Policy into Practise: Are we realising the vision?

Summary

This is the final Chapter of three in which we have identified European and UK policies, supported by World Health Organisation directives, each of which drives forward the agenda for interprofessional, interagency practise. This Chapter focuses on how successful the implementation of these policies has been to date and in our view are the key factors for maintaining the momentum.

We have found plenty of evidence that enables us to conclude that interprofessional, interagency working is now commonplace and that it is now firmly embedded in the new ways of working that have been redesigned across the health and social care arena. The pace of change is phenomenal and providing this is sustained, service users will reap the benefits of truly integrated care from cradle to grave.

Introduction

In Chapters 1 and 2 we outlined the European and UK Policy directives, which specify the need to implement interprofessional, interagency care. This third and final Chapter explores whether implementation is happening both strategically and at grassroots, and if so how effectively.

We have taken an overview of national developments and have identified the models that appear to be working well. We have not attempted to report on all the interprofessional interagency initiatives that we have identified. In common with Chapter 2, we have focused on interprofessional interagency working in practice rather than education and training. We stress however that education and training for the entire workforce remain the key underpinning principles that are fundamental for best practice.

To reflect the format we adopted in the second volume we have explored national developments and the new strategic bodies and then focused on the different user groups, including some of the individual National Service Frameworks (NSFs). Our rationale for focusing on the different user groups is that this is where different models of interprofessional, interagency practice are likely to be most evident.

It is worth stating from the outset that Government reform in health and social care continues apace. This lends credence to the necessity and desirability of the nation's health and well being achieved in part through the adoption of a user centred self-care model, supported when appropriate by an interprofessional, interagency workforce. Quite clearly the Government has turned its attention to a wider and more diverse audience in the form of Social Enterprise.

First muted by the Department of Trade and Industry in 2002, social enterprise focuses primarily on social objectives rather than profit. The NHS network introduction to this hot topic observes that 'Government policy is to encourage a greater diversity of providers in health and care, with a particular emphasis on social enterprises. This aims to increase capacity and innovation, while also encouraging a more integrated approach to health and care services' (NHS Networks, 2005). The Department of Health (DH) has just announced the first Social Enterprise partnership. An organisation has been identified to deliver the 'Expert patient programme', which provides courses for individuals living with long-term conditions to equip them with the skills and knowledge to manage their own illnesses.

As Social Enterprise partnerships are collaborative frameworks designed to integrate approaches that meet the health needs of local communities, they adopt the recommendations made in 'Health for All Policy Framework' otherwise known as 'Health 21' (WHO, 1999). Health 21 was discussed in detail in Chapter 2.

As already illustrated in Volume 2, legal frameworks, such as the Health Act Flexibilities are in place to support partnership working. According to Miller and Kurunmäki (2004) the innovative practices encouraged in the Health Act 1999 carries a degree of risk, which has to be identified and managed. They reported that the government is encouraging 'risk taking' as long as it is 'well managed'.

Miller and Kurunmäki (2004) reported on research conducted in five sites where the Health Act 1999 'flexibilities' were being introduced. They stated that although informal cooperation was evident between professionals and agencies at the local level, the more advanced form of partnership working such as pooled budgets had not, as yet, been introduced. There was also lack of progress in getting mechanisms in place to monitor and ensure governance. They conclude that risk management and performance measurement tools had not yet been developed. One reason for this lack of progress was attributed to the fact that partners had to feel they could trust each other.

In the same year, Hudson et al (2004) reported on an eighteen-month evaluation of the number, types and outcomes of the 32 partnerships that had registered an interest to use flexibilities in 2000. They reported that at the start of their evaluation, the most common partnership combination was between a health authority, NHS trust and local authority social services department. Partnerships had been organised primarily for: older people; people with sensory impairments; adults with learning disabilities; adults with physical disabilities; adults with mental health problems; children with complex needs; and children and adolescents with mental health problems. However, when reviewed eighteen months later, the range of partner organisations had widened to include user and carer groups, the voluntary sector, transport and leisure departments, police and probation services as well as private sector providers. This illustrates how services are evolving continuously.

The authors findings suggest that using flexibilities to create partnerships enhances the experience of service users; improves the efficiency of scarce resources by reducing duplication; improves communication between agencies which increases the likelihood of providing a seamless services to clients, achieved, in part, by co-locating health and social care staff and promotes equitable redistribution of services according to need (Hudson et al, 2004).

Partnerships in care

The Health Development Agency (HDA) was an NHS Special Health Authority that had the remit of supporting and enhancing health in England, with a particular emphasis on reducing health inequalities. In 2005 the HDA was merged with the National Institute for Clinical Excellence (NICE) following a DH review into 'arms length bodies' (see p12). A number of relevant papers were published by the HDA, one of which is entitled *'The Working Partnership'* (HDA, 2003). This paper makes a number of crucial observations for the successful creation of an interprofessional workforce. Primarily it observes that 'partnerships come in all shapes, sizes and structures. There are no unique models for successful partnerships. Different kinds of partnerships are effective under different conditions, according to local needs and circumstances, but there are factors common to all successful partnerships' (HDA 2003: 5). It also emphasises the need for service planners and providers 'to work alongside the people who use them, to put together new and better solutions to difficult problems' (ibid, 4) hence making it crystal clear that without service user engagement from the planning stages of any new initiative, it becomes meaningless.

In 2006 no one can really deny that the focus is on partnership, but what does partnership in care actually mean? Authors have highlighted the difficulties in defining partnership working because of the different terminology adopted. 'Collaboration, co-ordination, co-operation, joint working, interagency working, networking' are all used to describe partnership working (Wildridge et al, 2004).

Regardless of the terminology adopted it is quite clear that 'the benefits of working across organisational boundaries to develop joint programmes to improve health, community safety, sustainable development and regeneration have been recognised for some time' (HDA, 2003: 4).

The World Health Organisation (WHO) categorises partnerships as a vertical and horizontal integration and continuity of care whilst Glendinning (2003) helpfully describes three levels: macro-level which are strategic taking place at a national level; meso-level where partnerships are implemented at a local service level; and thirdly where a team combination is convened specifically for individual service users. Current evidence suggests that it is a three level integrated partnership model that is evolving in England.

The earliest partnerships seem to have been forged at the individual service user level followed by innovations at a local service level. As we have

identified in Chapter 2, strategies that support the concept of partnership and interprofessional interagency working have been published for a number of years. It is only comparatively recently however that the Government has made a sustained effort to implement partnership working at a macro level. The most obvious and relevant example of the Government's determination to drive the agenda forward is the creation in 2005 of the DH/NHS South West 'Creating an Interprofessional Workforce' Programme.

It has been noted that although 'central government has an important role in driving change… partnerships also need the flexibility to reflect local circumstances and resources. It is easy to underestimate the challenges of working together.   Partnerships must also devise effective cross organisational arrangements that can cope with multiple lines of accountability to produce genuine collaborative working.   They also need to regenerate meaningful yet realistic targets for change, and to demonstrate achievements and improvements' (HDA 2003: 7).

Cynics will suggest that partnership working points towards the Government's determination to cut costs and that if more funding was invested in health and social care, then new ways of working would be unnecessary. There may be an element of truth in this but there are several factors that generally refute this criticism. The single most important reason for implementing partnership working is that users need it and want it and what is more they are saying so! There is also an increasing awareness and albeit a reluctant acceptance, by the general public, that the spiralling cost of health and social care is no longer sustainable. As an ageing population, as we grow older and frailer, inevitably we will need increased health care interventions which will have to be delivered by a smaller workforce. New ways of working in partnership with others is no longer an option it is a necessity.

A rhetorical question must therefore be asked of whether realising the vision of a user led interprofessional, interagency workforce has been implemented by default and if this proves to be true, does this matter? In Chapters 1 and 2 we have been able to demonstrate clearly that the WHO, European and UK policy has been driving this agenda forward for a number of years. All the evidence we identified points to the implementation of partnership working, in every public service, as a direct response to the clear directives given by the WHO and the European Union (EU). Ministers and civil servants from departments such as health, social care, education, transport, and the environment have to address the partnership agenda.
We have identified a number of strategic partnerships in the UK which replicate the proposals of the EU Treaty Article 152 (1997) which emphasised the need for services to encapsulate a variety of agencies and organisations relating to, for example, the environment, transport, energy, employment, agriculture and housing.

To make sure that no one misunderstands the Government's intentions, it has published a report called *'No excuses, embrace partnership now'* (DH, 2005a). The report identifies a so-called third sector the aim being to:

- 'promote a sound commercial relationship between public sector commissioners of health and social care services, and the third sector as providers of those services
- help to remove barriers to entry for all providers of health and social care services, and
- promote equality of access for all types of third sector organisations, compared with providers from other sectors, in the public provision of public sector health and social care services'

Each of these aims appears to confirm that the ability to work in partnership is now the critical component for the sustainability and perhaps even more importantly survival of the future NHS. The DH estimates that there are more than 26,000 existing third sector health and social care providers and there is no doubt that in principle they are needed.

As the number and diversity of service providers increase the commissioners are expected to demonstrate that they are 'thinking outside the box' by commissioning more effective, innovative and dynamic services which embrace the Third sector.

The Third sector commissioning task force concludes 'a partnership approach, based on mutual trust and understanding between organisations concerned, with commissioning and delivering services that people want and value will be achieved by improved communication and changed behaviour' (DH, 2005a: i). To make a real difference to the nation's health and well being implementing the reform agenda should be a key priority for every organisation.

In July 2006 the government published a consultation document entitled *'A stronger local voice'* in which it confirms its commitment to engaging a wider and more diverse user voice through the introduction of Local Involvement Networks (LINks). The Government recommends that these should be mandatory as it wants 'people to become active partners in their healthcare and wish to create a system where people are no longer passive recipients of NHS and social care services' (DH 2006a: 3).

Each LINk will be contiguous with the local authorities that have social service responsibilities and their boundaries will reflect the new Primary Care Trust (PCT) boundaries. Building on the original patient forums, the new LINks will enable an increasing number of people to share their views about their health care, as equal partners with the workforce who deliver their care. A local response to local needs will, it is hoped, make the commissioning process more accountable and transparent. Currently every trust, including PCTs and Foundation Trusts has a patient forum however the rationale for changing the way user views are sought is that this current model does not reflect the recent changes in health and social care policy. The Government is aiming for 'open and transparent communication' between service users and the care providers.

In common with Social Enterprise partnerships LINks reflects the recommendations made in 'Health for All Policy Framework' otherwise known as 'Health 21' (WHO, 1999).

National initiatives driving the interprofessional, interagency agenda forward

Numerous national and local initiatives have been established to drive forward the interprofessional and interagency agenda. It is not possible to report on all of these in this volume but we provide examples of national initiatives with a brief explanation of how and why they were developed along with their aims and functions. The list of initiatives below is presented alphabetically and not in any order of priority.

Care Services Improvement Partnership (CSIP)

CSIP is part of the care services directive at the DH. Launched in 2005, CSIP is a collaborative of existing and new partners who work with the statutory, voluntary and private sectors. Marketing itself as 'Partnerships for Positive Change' CSIP provides 'support through eight regional development centres, each hosted by a statutory organisation in their patch' in which they combine 'the right mix of experience and knowledge to deliver work and outcomes agreed' with their partners (CSIP 2006: 4). Networking across nationally and across the regions is a key task being addressed by CSIP with the intention being to highlight and exchange information about the efficient use of resources and evidence of best practice in service delivery.

CSIPs main aim is 'to support positive changes in services and the wellbeing of:
- People with mental health problems
- People with learning disabilities
- People with physical disabilities
- Older people with health and care needs
- Children and families and
- People with health and social care needs in the criminal justice system'
- (CSIP, 2005)

There is evidence that strategic bodies are starting to work in partnership to improve the quality of services offered to individuals. As an example, CSIP and SCIE have signed an agreement to work together on issues concerning social care. The collaboration will involve sharing resources and expertise to improve the support offered to those who use the service and their families and carers.

Centre for the Advancement of Interprofessional Education (CAIPE)

CAIPE was founded more than twenty years ago by a small group of committed individuals from the health and social care professions who believed that effective collaboration between the health and social care

professions would be enhanced by interprofessional education. It is an independent expert organisation that aims to foster and improve interprofessional collaboration and to promote, develop and research interprofessional education and training. CAIPE has been instrumental in leading and supporting a cultural change by raising the interprofessional profile and enjoys international standing and respect.

CAIPE continues to champion interprofessional education and practice in health and social care and more recently has extended its interest to include other agencies such as education and the community. Amongst its achievements to date, CAIPE: has an established database; has a website which provides an information network; holds conferences and seminars; and publishes bulletins and occasional papers. It works in partnership with other agencies.

Creating an Interprofessional Workforce Programme

Funded by the DH, and hosted by the South West Peninsula Strategic Health Authority (now NHS South West), Creating an Interprofessional Workforce (CIPW) is a three-year national programme launched in July 2004. CIPW aims to produce a strategic framework to bridge the gap between workforce redesign and education to develop an education and training framework to enhance intra- and inter-professional working in health and social care.

Through the APPRECIATE initiative CIPW provides an opportunity for individuals to share their experiences of interprofessional working and education on their website.

The COMPACT

Supporting a number of strategic developments, and underpinning policy is what is acknowledged as a mutually advantageous agreement known as 'The Compact'. Convened in 1998 and building on the Health Action Zone initiative, the thinking behind the Compact is that it will enable the 'Government and the community and voluntary sectors to work better together for the communities they serve'. Codes of good practice have been agreed and adopted by the partners. Key to success is the engagement of the community and voluntary sectors emphasising the right that everyone has to be treated with respect and dignity, where discrimination of any kind is unacceptable and where everyone regardless of race, colour or creed is empowered to reach their full potential. Each COMPACT agreement must focus on local needs and address local issues and concerns. More information on the 'Codes of Good Practice' can be viewed on the COMPACT website.

Described as the beginning of a journey the concept of COMPACT partnership working as a flexible and dynamic entity has moved forward in leaps and bounds. Some locations, recognising the potential and value of joint working decided very quickly to extend their original remit of partnership working by including the NHS.

Signed by all partners, COMPACT agreements are expected to provide clear standards and set out a framework that clarifies the way partners will be working together, developing good practice through increased understanding, and reducing the amount of duplication. Success depends on each partner identifying their distinct but complementary roles, identifying shared roles and responsibilities and then agreeing the ground rules that enable implementation. Ground rules focus on issues such as funding, interagency communication and information, community empowerment, BME communities and vulnerable members of the local populace such as those who are living with disabilities.

In September 2006 more than 360 COMPACT agreements are listed on the English website. Each are dated individually varying from 2002 to 2006 (see COMPACT regions). A random analysis of a few of these agreements highlights the need for a regular review and update as inevitably the earlier ones do not reflect recent policy. None the less the few examined demonstrate a commitment to the interagency interprofessional agenda and are at various stages of implementation. This again is in line with recommendations made in the 'Health for All Policy Framework' or 'Health 21' (WHO, 1999), and discussed in Chapter 2, where it was suggested that collaborative frameworks and integrated approaches were required to met the health needs of local communities.

DH arm's length bodies

The DHs arm's length bodies (ALBs) operate in an advisory and regulatory capacity for the health and social care services. On 30 October 2003, the former Secretary of State for Health, John Reid, announced a review of the ALBs with the aim of making the ALB sector fit for purpose by reducing their numbers by 50%, reducing the number of posts by a quarter thus saving half a billion pounds. The rationale for such changes included the vision to: forge links between ALBs in health and social care so that the organisations work closer together; reduce bureaucracy for the health and social care system thus increasing the efficiency of systems; devolve power to frontline staff; and relocate ALBs so that they were not concentrated in London and the South East.

In the proposals published in *'Reconfiguring the Department of Health's Arms Length Bodies'* (DH, 2004a) it was recommended that the number of ALBs was reduced from 38 to 20. Many of the original ALBs were amalgamated and some were disbanded. New bodies were also convened.

Framework for Multi-Agency Environments (FAME)

The Department for Communities and Local Government (DCLG) has launched the Framework for Multi-Agency Environments (FAME) to support multi-agency working and information sharing. A theoretical framework and a series of tools, such as the Demonstrator, are available with online support for agents, agencies, departments and organisations across the UK. The FAME

team are already working across a range of multi-agency environments within health care, for example, children's services and services for vulnerable adults.

Integrated Care Network

The Integrated Care Network (ICN), established in October 2003 by the DH became part of the CSIP when it was launched in April 2005. It is a national initiative offering advice on partnership and integration to a wide variety of individuals, such as, politicians, senior managers within organisations, academics. Its members belong to Health, Social Care and the Independent and Voluntary sectors.

The ICN has been charged by the government to maintain the Section 31 budget notification database and is the first point of contact for work around the Health Act Flexibilities and the development of Care Trusts.

Another remit of the ICN is to ensure that policy and practice inform each other and it achieves this by facilitating communication between front line organisations and government. It has become to be regarded as a source of knowledge, expertise and ideas regarding partnership development and working and has published several guidance documents. It is also used as a 'sounding board' when long-term strategic guidance is required.

In its guide to integrated working, the ICN acknowledges that variations and diversity in integration is inevitable and describe it as an 'idiosyncratic process'. Indeed they advise the readers to view organisational and professional relationships as a continuum with fragmentation at one end and integration at the other and even admit that some practice may be ahead of policy and strategy.

For an overview of integrated care pathways, a good link is provided by the electronic library for health, see www.nelh.nhs.uk/carepathways/

Integrated Children's System (ICS)

In response to findings of research, inquiries and inspections over the past years, the Welsh Assembly Government and the DH developed a conceptual framework known as the Integrated Children's System (ICS). The framework facilitates joint working and information sharing between agencies that provide services for children and a common approach to assessment, planning, care delivery and evaluation. The process collates the previously used Assessment Framework with the Looking after Children System and came into force for new referrals in January 2006. All authorities are to have a fully operational framework in place by January 2007.

Numerous adverse incidents in the past have been blamed on the failure of staff to access, record, analyse and understand the significance of facts and events surrounding children's lives. Consequently, the ICS requires an

electronic case record system where staff can record, analyse and collate data (DfES, 2005).

Inter Agency Group (IAG)

The Inter Agency Group (IAG) was set up with the aim of bringing together a range of voluntary and statutory organisations to analyse and respond to government policy and initiatives. Interagency forums have been set up to deal with various groups within the community, for example, services for children and young people, adult social care (ADSS, 2005).

Local Strategic Partnerships

A Local Strategic Partnership (LSPs) is a non-statutory, multi-agency body, within a local authority. LSPs are charged with bringing together different parts of the public, private, community and voluntary sectors to deliver Local Area Agreements (LAAs), policies created by the Office of the Deputy Prime Minister. The vision is for the each Local Authority and PCT to deliver health and social care in partnership to meet the needs of each local community and respond to local circumstances. Widespread consultation with user groups underpins LAAs.

National Leadership Network for Health & Social Care (NLN)

The NLN is the successor to the NHS Modernisation Board. There are approximately 150 members including 'patients and user groups, clinicians and professionals, managers, regulators and inspectors, voluntary and commercial sector partners and other Government Departments with a critical stake in the wider health agenda'. Its brief is to 'promote shared values across the whole NHS and social care system'. Over a five year period the NLN collaborating with government ministers intends to 'deliver lasting improvements in health and social care' for all. This will be achieved by removing barriers to progress, improving communication and 'offering early advice on emerging policy'.

National Strategic Partnership Forum (NSPF)

One of the National Strategic Partnership Forum main briefs is to review the 'Making Partnerships Work Strategic Agreement between the DH, NHS, Social Care and the Voluntary Care Sector' and to help them 'work effectively together to deliver responsive, high quality health and adult social care services for patients, service users and carers'. They are also seeking feedback from a wide range of stakeholders about the practical issues of working in partnership.

NHS Employers

NHS Employers, which is part of the NHS Confederation, is an independent organisation providing employers in the NHS in England with guidance and assistance on issues relating to employment and the workforce. It was set up

in November 2004 to support, promote, represent and negotiate on behalf of employers. Consequently NHS Employers are charged with running a number of programmes that support and promote new and redesigned roles and services as well as interagency, multidisciplinary working. One of their latest projects involved engaging 42 sites and rolling out a programme to support the development of new and redesigned roles and services to improve services for children. One of their objectives for this programme was 'to support integrated and coordinated service delivery'.

NHS Healthcare Workforce

Made up of the NHS National Workforce Projects and the Workforce Review Team, the Healthcare workforce portal provides access to workforce planning tools, information and guidance.

NHS Integrated Service Improvement Programme (ISIP)

The NHS Integrated Service Improvement Programme (ISIP) provides guidance and tools to encourage and enable collaborative working across health and social care. ISIP works with local communities to help them deliver services that are fit for the purpose of meeting the needs the locality with service users at the centre. Their work with different communities enables them to identify and share best practice.

Sustainable communities

Sustainable community strategies were developed as the result of the Egan Review, which emphasised the need for local leaders to adopt a more integrated, interagency approach to social, economic and environmental issues (ODPM, 2005).

UK Sector Skills Councils

There are 25 independent, employer led, Sector Skills Councils (SSCs) across the UK. Their remit is to help reduce skills gaps and shortages by extending the skills of the workforce and enhancing the opportunities for learning through the development of National Occupational Standards (NOS).

Two of the SSCs have a particular relevance to health and social care. These are Skills for Health and Skills for Care & Development.

- **Skills for Health**

Skills for Health (SfH) was identified as the SSC for health in May of 2004. Although hosted by a trust and part of the NHS, SfH covers independent and voluntary employers as well as the NHS.

Skills for Health facilitate the development, maintenance and use of workforce competences and NOS. Further information about these can be found on the Skills for Health website.

A key task for SfH is to 'help modernise qualifications within the health sector and optimise transferability within and across sectors' the implication being that many of the competences are core and related to competence based roles and hence transferable across the professions and across sectors. More than two million people are employed by the NHS workforce, some of whom have academic qualifications, others vocational qualifications, whilst others have no formal qualifications but have a wealth of work experience in a variety of health care settings. SfH through the development of NOS is enabling every individual if they so choose, to learn new skills and advance their career. Described as a 'common currency' the competences offer people the opportunity to change jobs without having to repeat learning programmes. For more details, see the Awards and Qualifications section on the Skills for Health website.

- **Skills for Care & Development (SfCD)**

SfCD is the second SSC that has a significant impact on the health and social care workforce. SfCD has the remit of developing NOS for the social care workforce in the following categories: 'children's homes; care homes; domiciliary care and support services; day centres and services; social work; fostering agencies and services; foster carers; adoption services; nursery and early years work; childminding; voluntary youth services; Connexions; day nurseries; voluntary and charitable care. For more information see the Sector Skills Development Agency website.

New ways of working

The need to change and modernise the workforce was identified in the *'The NHS Plan'* (DH, 2000). The government recognised that new and redesigned roles and services were required to meet the diverse needs of those who use services. The implementation of the proposed changes was to be delivered through numerous agencies, one of which was the NHS Modernisation Agency. It was stated: 'We will create a new Modernisation Agency to help local clinicians and managers redesign local services around the needs and convenience of patients…The Agency will work with all Trusts to support continuous service improvement' (ibid: 60). Since this the Modernisation Agency has been superseded by the NHS Institute for Innovation and Improvement.

The NHS Institute has produced guidance for developing new and redesigning roles and services. Examples of the guidance for developing collaboration between professionals include: *'Achieving timely 'simple' discharge from hospital: A toolkit for the multi-disciplinary team'* (DH, 2004b); and *'Improving Orthopaedic Services: A Guide for Clinicians, Managers and Service Commissioners'* (DH, 2002).

The NHS Institute for Innovation and Improvement has a *'Service Transformation Team'* to help establishments to instigate and manage change. They have the remit of fast tracking new and verifiable innovations and improvements; improving health outcomes and raising standards; and to

support the shift from hospital to community care. They have published *'Improvement Leaders' Guides'* which provide tools and details of techniques that can be used to improve services. Details of both these can be found on the NHS Institute for Innovation and Improvement website.

The NHS Institute for Improvement and Innovation having set up a primary care/long term conditions priority programme has been measuring how far these new ways of working, with their emphasis on shifting care into the community, have been implemented in five local health and social care communities. It is also looking for ways to accelerate similar changes across the NHS. Testing began in April 2006 with the initial results expected later this month (September 2006). This will be followed with the delivery of a programme of tools and guidance in March 2007.

There is evidence that new ways of working are being introduced throughout England at grassroots level. Examples where this involves interprofessional working are summarised below.

Hospital at Night and the 2009 Working Time Directive (WTD)

The current 'Hospital at Night' project is changing the way out-of-hours medical cover is provided in hospitals and will reduce the working hours of medical staff in order to comply with the WTD (for further information see the DH website) which is due for enforcement in 2009 (NHS MA, undated). The model proposes that the most effective means of providing clinical care at night is to have multidisciplinary teams on duty. Identifying new ways of working by redesigning existing roles is a top priority. Each team must possess the skills and competences to meet patient needs but specialist expertise can also be contacted and called-in as required. The Hospital at Night model also advocates a multi-specialty handover.

Personal Medical Services (PMS)

With the abolishment of the previous primary care contracting arrangements and the introduction of the PMS contract, service contracts are no longer between the PCT and individual GPs but with the practice. This has afforded professionals within the practice to work collaboratively to improve services that will meet the needs of individuals within their locality.
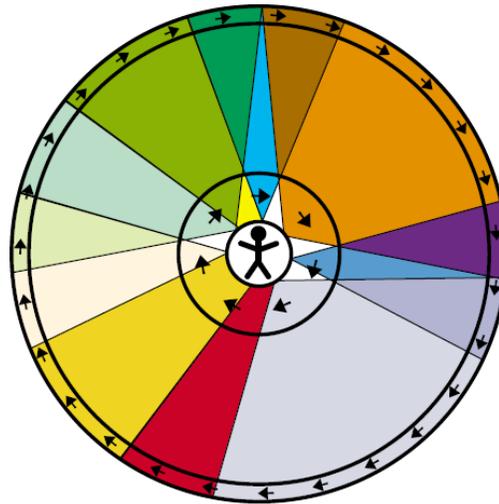
Support workers

Perhaps the most significant development of all has been the introduction of 'support workers' a generic phrase that embraces a diversity of new roles across and between the whole health and social care arena. In 2006 support workers are being employed in increasingly large numbers in a diversity of roles in a diversity of places. Support workers are working with client groups from cradle to grave. Their new roles are designed to bridge traditional professional and interagency boundaries. Their job descriptions and titles are determined by the various organisations and professional groups that employ them.

Although in relatively small numbers some of the support workers are highly qualified professionals working as specialist practitioners. Many have completed further training in order to extend their knowledge and skills in order to fill the shortfall in medics resulting from the WTD. Examples of these new support workers include emergency care practitioners, medical care or surgical care practitioners. Working within strict protocols these practitioners have proved competent to practise clinical interventions previously considered the remit of a medic. The implications of role redesign for the rest of the workforce are obvious. As professionals are up-skilled in increasing numbers some of their previous activities are being back filled by non-registrant support workers, many of whom were previously health or social care assistants.

The NHS Modernisation Agency in their documentation *'Developing support worker roles in rehabilitation and intermediate care services'* presented a model proposed by Shield (cited in NHS MA, 2003). The model illustrates how and where interprofessional support workers can fit within interagency services based around the needs of clients.

Key

Client/Carer at the centre

Coloured segments represent professions/agencies and overlapping roles

Hub around client/carer represents interprofessional support workers

Tyre around rim of wheel represents interprofessional team leader/manager

The evolving 'wheel' of client-centred rehabilitation – the client-centred multi-professional team with interprofessional support workers. From: Shield (cited in NHS MA, 2003).
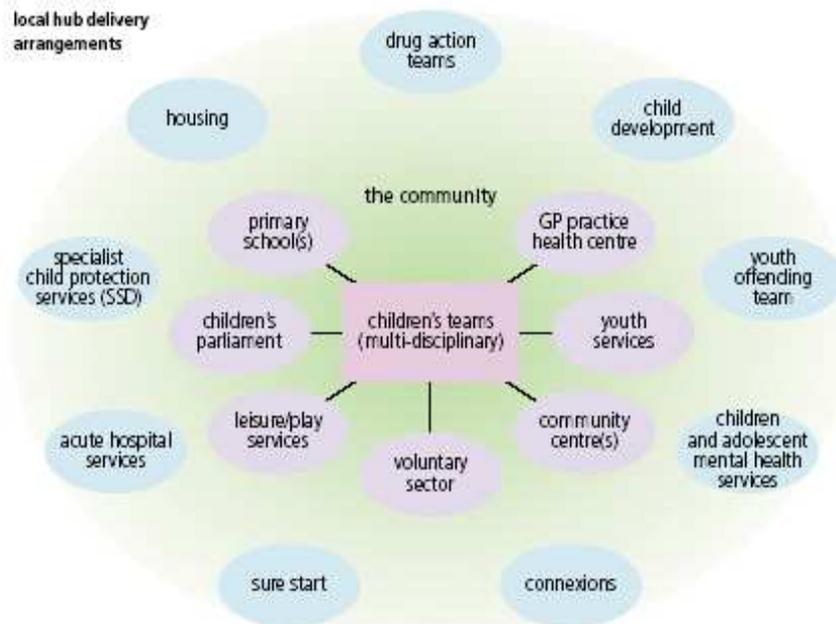
The client and carers are situated in the middle of the circle with support workers in the hub, immediately surrounding them. The coloured segments on the wheel represent different professional groups and agencies. The support worker acts as a bridge between the agencies and the professionals by maintaining an overview of everyone's interactions with the client. The support worker may not have any clinical knowledge or skills what so ever, their role being to act as the link person.

Implementing this model means that repetition and duplication can be avoided and a coordinated plan of care can be maintained. The tyre of the wheel characterises the interprofessional team leader or coordinator who will be a senior clinician or social worker.

Practise review

Children and Young People

There are numerous policy directives, as identified in Chapter 2, for agents and agencies to work collaboratively, across professional boundaries and within multi-disciplinary teams. The following model, published before the NSF for Children in 2004, illustrates this vision.

Source: Local Government Association (2002: 17)

The model demands that services should be 'community-based and local' as well as 'universal, generic, specialist and targeted'. The diagram represents a 'hub and spokes' where agents and agencies work in partnership to 'form a coherent whole'. The hub needs contact with all children within an area therefore should be located in the most appropriate place for a particular community and its boundaries should be clear to all agencies and families within that area.

Atkinson et al (2002) completed a study between April 2000 and September 2001 where they explored the range and success of multi-agency activity within Local Education Authorities (LEAs) in England. They interviewed 139 individuals taking part in one of the 30 multi-agency initiatives from the Education, Health and Social Services sectors of local authorities. They identified the following five models of multi-agency working:

- Decision-making groups: where professionals representing different agencies met to discuss issues and to make decisions. Professionals maintained their distinct role and brought the views of their colleagues to

the group and took away issues from the discussions to feed back to their colleagues.

- Providing consultation and training: Professionals from one agency provided consultation and/or training to another group of professionals to enhance their understanding

- Centre based delivery: A range of professionals were gathered together in one place with the aim of delivering a more coordinated and comprehensive service. Although they did not always jointly deliver services, the fact that they were located in one place facilitated an exchange of information and ideas leading to a better understanding of each other's roles. It also helped service users to access the services.

- Coordinated delivery: Agencies worked together through a coordinator and although they did not always have contact with other professionals, they received information through the coordinator. This has similarities with the 'lead professional' initiative which local authorities have to implement as part of the Every Child Matters programme

- Operational-team delivery: Multi agency professionals were located in close proximity and worked together to deliver a coordinated service to clients. This facilitated a two-way exchange of knowledge and skills making the merging of roles and responsibilities more likely.

The authors reported that the most common models in practice, at that time, were decision making groups and coordinated delivery whilst operational teams were the least evident within their sample.

According to Atkinson et al (2002: 225), multi-agency working 'is not easy or easily achieved', and a commitment must be made in terms of finance, resources and time. They proposed that professionals need to be exposed to, and become familiar with, other agencies and organisations during their initial education and training and in continuing professional development.

In the same year, Sinclair and Bullock (2002: 15), analysing former serious case reviews reported that common themes emerge that include: inadequate sharing of information; poor processes of assessment; ineffective decision making; and a lack of intra- and inter-agency communication and working.

At this time, in 2002 it appeared that local authorities had a mammoth task to achieve the three initiatives that have to be implemented by December 2008 as part of the Every Child Matters programme: Common Assessment Framework (CAF) for children and young people; the lead professional (LP) role; and information sharing.

- **Every Child Matters Programme and the NSF for Children**

The proposals of Every Child Matters (ECM) (DfES, 2003) are supported in the Children's NSF (DH, 2004c). The government's aim is to integrate children's services through Children's Trusts within local authorities to ensure that the needs of children are met. Both ECM and the Children's NSF also support the need for: identifying a lead professional; a common assessment framework; pooled resources; the sharing of information across professional

boundaries; co-location of services; robust inter-agency governance arrangements; integrated commissioning; and a common core of training for the workforce.

The Children's NSF perhaps has the most far reaching consequences of all the NSFs launched by the government in that it prescribes an interagency interprofessional model encompassing health, education and care for all children and young people. Implementation of this NSF has been rapid and the evidence of its effectiveness is just beginning to emerge.

- **Children's Trusts**

In the children's NSF, every area was to have a Children's Trust in place by 2006 but this has since been extended to 2008. The intention is that the planning, commissioning and delivery of health, education and social care services, along with other relevant agencies is achieved through a single body that has a pooled budget.

The University of East Anglia in partnership with the National Children's Bureau were commissioned by the Department for Education and Skills (DfES) and the DH to evaluate the 35 Children's Trust pathfinders between 2004 and 2007. The results, outlined below, are being used to guide best practice and inform future policy.

There are numerous reports of best practice in intra- and inter-agency collaboration reported by the DfES and DH (2005; 2006a; 2006b; and 2006c), however there is still some way to go with regards to some issues. The philosophy of Children's Trusts is that children, young people and their families should be given the opportunity to participate in the work of the multi-disciplinary team and become engaged in children's trust arrangements. An interim report in 2005 indicates that the levels of engagement vary across the pathfinder sites (DfES and DH, 2005 and 2006a). Even though professionals recognise the benefits of involving and empowering users of services, some Trusts are still in the process of designing and agreeing their strategies for user participation. The authors claimed that in areas where users were more involved, it was because of numerous years of work developing a collaborative culture with users.

Children, young people parents and carers involved in the evaluation appeared enthusiastic regarding the prospect of being involved in children's trusts arrangements but claimed that their lack of experience and inadequate information about participatory activities limited their involvement. It was also reported that the sample of users invited to participate was not representative of the locality they represented as the same people are asked to be involved, time after time. From their evidence, the researchers claimed that as yet, in England, there is not a culture of listening to users of services (DfES and DH, 2006a).

It therefore appears that if participation with users is to become a reality in children's trusts, local authorities need help and guidance so that the process can commence as soon as possible. DfES and DH (2005 and 2006a) make

numerous recommendations to guide local and health authorities in the engagement of children, young people their parents and carers in children's trust arrangements.

- **Implementation of the Common Assessment Framework (CAF) and Lead Professional (LP)**

Brandon et al (2006) performed an evaluation of the 12 areas that had volunteered to trial the implementation of CAF and LP working to ascertain what helps and hinders the process. The findings were used to inform the national roll out of the programme which started in April 2006.

The authors expressed caution when interpreting the findings because the 12 areas had opted into the trial and were not representative in terms of current multi-disciplinary activity. The authors also reported that although some lessons could be learned, there was a limited amount of CAF or LP work to evaluate as most of the 12 areas trialling the programmes had not started the work as early as they had anticipated.

Brandon et al (2006) reported that in areas where agencies and organisations are already working collaboratively and professional trust is evident, the CAF appears to have been accepted. They also reported that where the role of the LP is working well, there is enhanced communication between families and the team of professionals.

However, there were also reports that the CAF and LP work were adding to the workloads of practitioners and there was not enough guidance and clarity regarding the processes leading to frustration and anxiety. The change in culture with regards to holistic assessments and partnership working with families and other agencies was challenging for some individuals.

Even when using the CAF, assessments were duplicated with some individuals finding it difficult to work in a system where there was a lack of collaboration between agents, agencies and organisations. Since areas are given the freedom to devise their own CAF documentation, Brandon et al (2006) reported that the most requested change was for a single, nationally approved CAF form. There were also requests for more information on information sharing and accountability when working across professional boundaries.

- **Information sharing**

In order to facilitate collaborative working, effective information systems are required so that information can be shared. There is a move for professionals to access and use electronic clinical notes, however in the *'National Child and Adolescent Mental Health Service Mapping Exercise 2004'* it was stated that only 29% of professionals had access to such records and only 14% use them (DH and University of Durham, 2005).

The DfES has produced further guidance on information sharing (see DfES, 2006a, b and c) outlining why, when and how professionals should share information with others. There is also an Information Sharing and Assessment (ISA) team, identified within DfES to help individuals working with children to communicate across professional boundaries and share information.

However, it appears that until steps are taken to bring professionals together and work with them to break down imaginary or actual barriers, initiatives such as CAF, LP working and sharing information will not be implemented successfully.

- **Sure Start**

One area where agencies and organisations appear to be working collaboratively is in Sure Start programmes. These were introduced by the Government to reduce child poverty and social exclusion by 2010 and are delivered through local partnerships between agents and agencies as well as parents and other individuals within the community.

The National Evaluation of Sure Start Team has performed a comprehensive evaluation recently, to ascertain the following:

1. Do existing services change? (How and, if so, for which populations and under what conditions?)
2. Are delivered services improved? (How, and if so, for which populations and under what conditions?)
3. Do children, families, and communities benefit? (How, and if so, for which populations and under what conditions?) (NESS, 2005: 2).

The authors of the report concluded that 'there was almost universal recognition that no single profession had all the answers, and that bringing together a range of skills to bear on the problems facing families and communities was beneficial both for the families themselves, as well as for the staff, who benefited from the sharing of expertise' (NESS, 2005: 63).

The authors also made some recommendations to further develop partnership working within Sure Start and some are outlined as follows: commitment for partnership working needs to be evident at senior management level as this will influence front line staff; all agencies need to have shared or complementary objectives and targets; protocols need to be developed in respect of accountability and lead professionals; developing multidisciplinary team working is unique to each centre, 'there is no one-size-fits-all model' (ibid: 69).

- **Connexions**

Connexions was set up by the Government to support all young people aged 13 to 19 in England and to provide support, for young people who have learning difficulties or disabilities (or both), up to the age of 25. Through multi-agency working, Connexions provides advice, guidance, information and

personal development for young people to ensure they reach their potential in relation to learning. It is also tasked with ensuring adolescents make a smooth transition to adulthood and working life by providing such integrated youth support service.

Older people

- **Older people's NSF**

In 2001, with the publication of the NSF for older people a single assessment process (SAP) was advocated along with a recommendation that older people receive 'appropriate and timely packages of care… regardless of health and social services boundaries' (DH, 2001a). The NSF has identified four core principles for those caring for older people. These are: to respect the individual; deliver joined up care; ensure that everyone is able to access specialist care when they need it and to promote healthy and active living. The NSF also places a strong emphasis on the need to integrate care for older people through closer co-operation across boundaries and through the development of agreed pathways.

- **Single Assessment Process**

The use, by the health and social care services, of a Single Assessment Process (SAP) for older people in England was first outlined in the NHS Plan, with more detail given in the NSF for older people (DH 2001a). Scotland and Wales have implemented similar assessment tools (Joint Future Group, 2000; WAG, 2003). Although there is a national directive to introduce the SAP, each local organisation was given the freedom to implement the process as appropriate to their locality. This leads, inevitably, to variations in documentation throughout the country.

The intention of the SAP is to: ensure that older people receive timely, effective and appropriate care as and when their needs arise; provide a framework to standardise assessments across health and social care; and avoid duplication in assessment. It is based on Standard Two of the NSF – 'person-centred care' where it is stated: 'NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services' (DH, 2001a: 12).

The SAP incorporates the assessment of the following domains: the user perspective; clinical background; disease prevention; personal care and physical wellbeing; senses; mental health; relationships; safety and immediate environment and resources (DH, 2001a).

Dickinson and Windle (undated: 8) in reporting on their evaluation of the SAP in one locality suggested that:

- Front-line workers did not feel adequately prepared for the SAP and lacked 'understanding of the purpose of the tool'
- There was 'subversion of the SAP by professionals'
- Professionals lacked an understanding of the roles of other staff
- There was a feeling by staff that they were 'doing each others work'
- Staff did not trust other professionals to perform assessments
- Changing roles was viewed as a threat

The authors reported that since the SAP was viewed in a negative way by most of the staff involved in the evaluation, they demonstrated a reluctance to implement the process stating instead that they preferred the documentation they were currently using. The reason for such preference was that staff and/or their colleagues had been involved in developing the documentation for the assessments.

Dickinson and Windle (undated: 16) concluded that 'no evidence of information sharing was found during the evaluation'. Front-line professionals had not received a copy of an assessment from any other professional group nor had they passed on information regarding the older person in their care to anyone else. However since the publication was undated, it is not clear how soon after the introduction of the SAP that this evaluation was conducted.

Challis et al (2004) are undertaking a systematic evaluation of the implementation and impact of the SAP for elderly people in England. The study commissioned by the DH, commenced in November 2003 and is due to be completed in the autumn of 2006. It is reviewing how the SAP has been implemented and evaluating how key stakeholders such as the elderly and their carers and professionals from health and social services view its impact.

Their interim publication, reports on a review of literature published after 1985, concerning the SAP (see Abendstern et al, 2005). What is not clear from this review is whether the literature they cite on multi-professional and interdisciplinary working was prior to or after the launch of the NSF for older people in 2001. If it includes research conducted before 2001, the results they report may not reflect the policy and guidance given at that time.

Abendstern et al (2005) report that findings from the literature imply that when the indicators published in the NSF for older people were used to judge the SAP, professionals did not appear to place elderly people at the centre of care. Although care plans should describe the objectives and outcomes of the assistance offered and should be agreed with the older person who then maintains their own copy, this practice is not consistent.

The authors also report on findings from the literature regarding multidisciplinary working and blamed 'the existence of different professional values or ideologies' for thwarting collaboration (Abendstern et al, 2005: 1). Individuals were reported to protect their professional roles at the expense of working in partnership with other professional groups thus jeopardising the best possible outcomes for the elderly. The authors also found evidence that it was still common practice for professionals to conduct their own assessments

and not share the findings with members of other agencies or professional groups. Consequently assessments were duplicated and this was blamed, in part, to 'interprofessional mistrust' and lack of infrastructure to enable sharing e.g. inadequate information technology. They conclude by suggesting that even if appropriate systems are put in place to enable information exchange between agencies and professional groups, the barriers will remain until professional values and cultures are addressed.

The publication of *'Better Health in Old Age'* in November 2004 was a report on the progress in implementing the NSF for older people. It is stated in it that 'we have promoted joined-up services by bridging the gap between hospital and home, developing a single assessment process and developing integrated services for falls, stroke, mental health, and continence' (DH, 2004d: 2) and that 80% of Councils had implemented SAP in October 2004 compared with 0% in 2000 (ibid: 28). However there is no evaluation of such services in the publication or an indication whether the initiatives are functioning successfully.

The West Midlands Regional Single Assessment Process Group reported on an evaluation of cross-boundary working following the introduction of SAP in the West Midlands Region in 2004. It was reported that different localities, in devising their own SAP documentation had produced forms of varying length and content. Whereas one site had a seven-page assessment form, another locality's form ran to 31 pages. What is more, what was contained in the form differed as each site had selected some areas or domains as suggested in the NSF, but not others. This seems to disregard the NSF where it is stated that 'the single assessment process should be designed to identify all of their needs… Some older people will benefit from a fuller assessment across a number of areas or domains, and some may need more detailed assessment of one, or a few, specialist areas' (DH, 2001a: 31). It appears that localities have devised assessment forms to fit their purpose and not the diverse needs of elderly people living in the areas.

The evaluation also reported that whereas some areas reported that they had introduced the SAP, the documentation was only used by some professional groups. The report also highlighted that 'In many places, organisations were not yet thinking beyond the "front end" of the process the actual assessment and recording of need'. It was reported that professionals had not, as yet, considered 'the link with care pathways, how appropriate care would be delivered, the role of a Care Coordinator and how information would be updated' (West Midlands Regional SAP Group, 2004: 15)

In conclusion, there was a belief that areas that had employed a dedicated project lead to take the SAP work forward had made more progress than those without this resource.

In the most recently published guidance on the implementation of the NSF (DH, 2006b: 14) the government claim that 'there has been an extensive engagement of health and social care practitioners and managers in local communities to agree local solutions to meeting the SAP requirements'.

However, to build on this success, they call for further development of IT so that information can be shared across the sectors.

Mental health

In the NSF for mental health there is a call for 'a comprehensive package of services' for individuals, which should be 'a multi-agency endeavour' (DH 1999: 44). It identifies the need to integrate the systems of assessment, care planning, implementation and evaluation developed independently by individuals working in social services and the health service. It also recommends that services involved in mental health care need to develop policies to enable the sharing of information.

There are numerous reports in the literature where different agents, agencies and organisations are working in collaboration for the benefit of people who access mental health services (see DH 2004e; 2005b; 2006c).

However, there are also reports that more needs to be done to achieve integrated working in mental health services. In a report by the DH (2006c: 41) it was suggested that 'inpatient care needs to be better integrated with other acute and community services to break down barriers and make the service more responsive and flexible'.

Comments were also made regarding user involvement by the DH (2006c) who reported on a review of academic and grey literature regarding the views of service users and carers regarding mental health nursing in adult settings. The findings indicated that although service users and carers commend the listening skills of mental health nurses, both groups felt they were not given adequate information and did not have many opportunities to be involved in care. Service users also reported that in their view there was little evidence of interdisciplinary collaboration.

- **Care Programme Approach**

The Care Programme Approach (CPA) was introduced in 1991 and supported by the NSF for mental health. The aim of the CPA is to ensure that specialist mental health services are coordinated and that individual's work collaboratively to plan, deliver and evaluate an individual's care. The CPA process has four stages: a systematic assessment of an individuals social and health care needs; development of a care plan to address the individuals needs which has been agreed by everyone involved in the care including the service user and carer; identifying a key worker to coordinate care; regular review of progress and make changes to the care plan as required. Service users, according to the standard set in the NSF, should hold a copy of their care plan and be involved in the evaluation of their care.

Mind (2004) reported that through calls to their advice line, they had learned that service users do not always receive a copy of their care plan. Even when care plans were shared with the service users, and certain needs were documented on them, this did not mean that they would be able to access the

services required to meet those needs. Mind (2004: 4) reported 'care plans are no guarantee to accessing services, so many people find they have been assessed as requiring a service which is then not available to them'.

Mind (2004) also reported that regular reviews of progress are not performed at all times and some take place without the knowledge of service users.
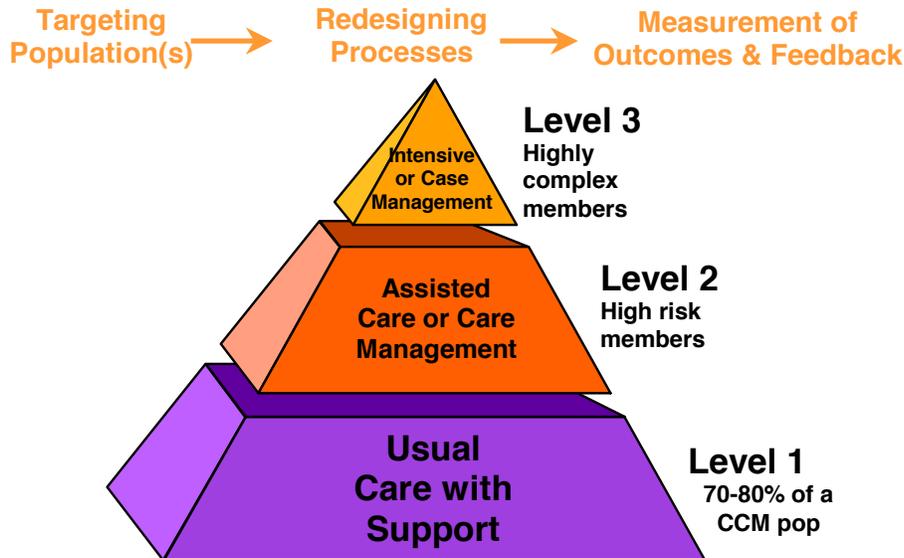
Long Term Conditions (LTC)

It has been estimated that in the UK more than 17 million people are living with a long term condition (LTC) (NHS MA, 2005), most of whom continue to live in their own homes, cared for by informal carers, such as family, friends or neighbours, and supported by the health and social care services. The list of LTCs seems endless however asthma, arthritis, chronic obstructive pulmonary disease (COPD), diabetes, neurological and renal conditions are cited commonly.

Caring for people with LTCs in the community is now a key driver of government policy. More than 80% of GP consultations relate to LTCs and the NHS modernisation Agency has predicted that by 2030 the incidence of chronic disease in people over the age of 65 will have doubled. A further startling statistic is that 5% of all patients admitted to hospital occupy 42% of all bed days. These 5% are people living with an LTC. Delivering the public health agenda is critical if people are to be prevented from developing LTCs relating for example to smoking, obesity, sexually transmitted diseases, or substance abuse.

There has been a significant shift away from the reactive 'one size fits all' medically led, treatment of sickness model, towards a more proactive individualised care package that empowers people to make choices and live more independent lives. The rationale for this shift in care is based on the evidence that previously when an acute episode occurred the patient was admitted to hospital, treated for a short period and then discharged home until they required re-admission, which was usually quickly. Unless there is joined up thinking with a sustained approach to care, the patient becomes involved in the so-called revolving door syndrome, in one door and out the other.

To prevent, or minimise the chances of, this happening, a greater flexibility in service provision has proved essential. It is allowing a broader range of service providers to give more timely care interventions where possible in the users own home or as close to home as possible. This is enabling people to get on with living their daily lives with the minimum disruption. The new care model focuses on self-care and where integrated professional care is proactive, delivered by a health and social care team.   The Kaiser Permanente triangle has been adopted:

Population Management:
More than Care & Case Management

Targeting Population(s) → **Redesigning Processes** → **Measurement of Outcomes & Feedback**

Level 3
Highly complex members

Intensive or Case Management

Level 2
High risk members

Assisted Care or Care Management

Level 1
70-80% of a CCM pop

Usual Care with Support

Source: NHS MA (2005)

Level 1 patient's are managed at home, or as close to home as possible, using evidence based care pathways and integrated records. Level 2 patients administer self-care but are risk assessed and supported by health and social care. There is immediate and active management of this level of patients if their risk factors increase. A multidisciplinary expert team bridging acute care and community care supports the core primary care team. Level 3 patients require frequent admission to hospital for acute and highly specialised interventions to treat or stabilise their complex problems. A commitment to care for people of all ages at home wherever possible is evidenced within each NSF.

Accepting that 'supporting, caring for, and treating people with long term conditions will be the dominant theme for health and social care services in the first half of the new century' (NHS NWP, 2006: 1) a Workforce Development Resource Pack has been developed specifically for those caring for people with LTCs. Changing the way the workforce thinks, learns and works ultimately will decide the quality of care that those living with LTCs receive and indeed deserve (ibid).

Self care, better case management, new technology, new treatments all offer the opportunity to get things right and it is evident that it has been decided at a strategic level that interprofessional, interagency models of care delivered seamlessly across the entire health care arena is the way to address these challenges. There is no doubt that new roles and newly configured teams that work across organisational boundaries are required however if this is to succeed an integrated all systems approach must be adopted involving

strategists, commissioners, workforce planners. Failure to embrace an all systems approach will lead to failure in what promises to be the most effective model of service delivery to date.

What then can we conclude are the components of caring for people with long-term conditions? In every publication we have reviewed, the keys to success are multidisciplinary teams, interagency working, integrated working between specialist and generalist practitioners; greater co-ordination and collaboration between primary/secondary and social care.

Workforce Learning

We have made it clear in this series that our remit has been to identify policy that focuses on interprofessional, interagency practice. We have excluded therefore nearly every reference that is specific to education and training. It is not possible however to ignore this completely. Interprofessional education and training for undergraduates and postgraduates is now well documented. Similar learning opportunities for the rest of the workforce are less common. Life long learning for the NHS workforce is intended for all and with the Government's policy of identifying new ways of working through redesigned roles life learning together assumes an even greater urgency. The key driver is the Framework for Lifelong Learning (DH 2001b).

In 2001 the DH published their framework for life long learning for the NHS. Entitled *'Working together: learning together'*. The paper stresses the inextricable links between life long learning and the wider agenda of building and strengthening a new NHS. Acknowledging the value of the workforce learning and working together, crucially it notes that this is not always 'as systematic as it could be' (DH, 2001b: i). Described as 'fundamental to delivery of the NHS Plan within NHS trusts, PCTs and other NHS organisations, the working together initiative was aimed at those responsible for the quality of training in the workplace namely the 'Workforce Development Confederations, regulatory and professional bodies, trades unions and education and training providers'.

The Government revealed its plans for an NHS University (NHSU) that would begin in 2003. 'Drawing on the excellent work that exists across the NHS, in health and social care settings and elsewhere', the Government signalled its intention to work in partnership to make sure this happened. Although, for a variety of reasons, the NHSU was a short lived initiative, it quite clearly sewed the seeds for the subsequent new ways of working as it was noted that one of the key elements of modernising the NHS would be achieved by:

'Growing the NHS workforce so that we have the right number of staff, with the right skills in the right place and at the right time by modernising workforce development, education and training; increasing training places and widening access to training; developing substantial recruitment and retention and return to practice programmes; continuing action to improve the working lives of staff and helping NHS organisations to re-design jobs, career pathways' and work roles so that staff can use their skills more flexibly (DH, 2001b: iii).

This document offers the first real evidence that learning and working in practice is the vision for the entire workforce all of whom will be given the opportunity to build on their knowledge and experience and to develop their career through the development of a skills escalator. This remains an incredibly ambitious undertaking as the NHS is diverse and expanding and alone employs more than one million people.

The rationale given for the changes needed is lengthy but two of the key messages for creating an interprofessional workforce are the: 'continuing shifts in the boundaries between primary, secondary and continuing care combined with new ways of delivering care, new standards for care, as set out in NSFs and other documents, and the re-shaping of processes and pathways to support care that is truly patient-centred' (DH, 2001b: 3) and the 'greater emphasis on team working and on developing partnership working between organisations to deliver care for whole communities' (ibid: 4).

The Government has also signalled its intention that 'wherever practical, learning should be shared by different staff groups and professions' and that this should be as close to the workplace as possible. Just how much learning and working together happens in practice has been afforded much greater credence recently. Core knowledge and skills applied by each individual and each team in the workplace are viewed as 'central to supporting the development of common learning programmes for all health care professions and to strengthen team working' (ibid: 8).

For those working towards a professional qualification there are very clear directions 'There should be core skills elements in learning programmes for all health professional students, which provide the basis for common and interprofessional learning and easier transfer to another course during pre-registration education or a career change after qualification (by allowing a shortened period of education in a different discipline)' (ibid: 26).

The importance of learning 'on the job' should never be underestimated and the increased use of NOS as a basis for practice is identified. User and carers have a critical contribution to make into all learning opportunities and the emphasis 'should be increasingly focused on the development needs of clinical teams, across traditional professional and service boundaries' (ibid: 40).

A number of quality assurance initiatives have been implemented which support the Governments 'overall aim of promoting innovative interprofessional post-registration education which maintains a consistent standard on outcomes and content, and is planned to ensure the development of professionals who have the right knowledge and skills to support clinical governance and meet changing healthcare needs' (ibid: 42).
Clinical networks are intended to support individual and team learning across individual, interprofessional and team boundaries. The entire workforce is being encouraged to gain job related qualifications if they so wish which will enable the development of new and more flexible roles and new ways of working.

Conclusions

The key question is whether interagency interprofessional services are benefiting service users and their families. Inevitably policy must be implemented before evidence of its success can be measured. There is a tension however in that there is never enough time factored in for new policy to embed before evidence is demanded of its success (or otherwise). Some studies have demonstrated that more positive user outcomes are achieved by collaborating interprofessional teams (cf West et al, 2002) but until recently most have tended to focus on factors which support or refute joint working. There is emerging evidence however that users are benefiting from the new ways of working particularly with the introduction of the new support worker roles, however concrete evidence must be gathered over a sustained period.

In April 2006 David Behan speaking to delegates at the Care & Health Conference warned that 'the challenge of delivering personalised care cannot be met by simply bringing organisations together, it can only be met by changing the nature of the relationship between those who commission and provide care and those who receive care'. Significantly from the creating an interprofessional workforce perspective he continued 'the delivery of innovative personalised services will require partnerships between health, councils, housing and others' thus signalling the Government's continuing commitment to a widening interprofessional interagency care model (Behan 2006).

There is no 'one size fits all' model but a full understanding of what partnership and workforce integration entails is essential. We have no doubts that there are numerous benefits for all in interprofessional interagency practice however for it to be a success effective sustainable systems must be implemented with adequate and sustainable resources. A team leader who has 'vision and tenacity' at a strategic level and who engages team members who demonstrate personal commitment and drive and who are willing to work flexibly, collaboratively and innovatively is crucial for success.

Sustainability

One of the key issues in measuring the success or otherwise of initiatives, which promote interprofessional, interagency working is whether or not they are sustainable. With frequent reorganisation and reconfiguration of services and in a time of severe financial constraints, harsh decisions have to be made daily about how and where funding is allocated and where it is has to be withdrawn. One of the biggest problems is that new ways of working and the consequent changes in service delivery take time to embed, to evaluate and provide evidence of quality improvements in service delivery. (NHS Institute for Innovation and Improvement, 2006b)

Several authors suggest that up to 70% of organisational changes are not sustainable and that inevitably this has a negative impact on quality improvement (Daft & Noe, 2000, Beer & Nohria, 2001).

Acknowledging the problems in sustaining new initiatives recently the NHS Institute for Innovation and Improvement (2006b) has published a Sustainability Model for use by all those involved in redesigning local services. The Institute provides a succinct and very useful definition of sustainability as 'when new ways of working and improved outcomes become the norm'. The Sustainability Model could be described as a 'trouble shooter' which diagnoses actual or potential risks to a new initiative and advises teams how they can minimise or eradicate these in order to improve their chances of sustaining the changes.

Critically, from an interprofessional, interagency perspective the sustainability model relies not only on management support but also on individuals, front line teams and user involvement. Using the model effectively in practice depends on team engagement and their feedback on the initiative being scrutinised and acted upon if required. More information regarding the Sustainability Model can be found on the [Institute for Innovation and Improvement](#) website.

Funding agreements perhaps present the most complex, but not insurmountable challenges. In the current climate of financial constraints, rising costs, balancing the books is foremost in the minds of the Chief Executives of every government agency. Transparency, accountability, proportionality (the size of each organisation and the amount of money involved) and a consistent approach are fundamental criteria. Sustaining new initiatives present a new, but cost related challenge. All partners must have confidence and trust in their colleagues particularly when new projects, which as is sometimes the case, do not go according to plan. The partners must be able to work together to solve the problem. Bailing out other partners who have overspent their budget however is not acceptable. In reality, if more and more projects are going to be funded jointly, then it will be essential that clear lines of financial accountability are in place with the fund holding organisations being able to demonstrate how the money is being spent, the impact and outcome of their investment.

No one is going to volunteer to transfer their funds to be managed by other agencies unless they are convinced that this will prove better value for money. This raises the fundamental question of whether joint funding, placed in a big pot, does deliver better value for money and most importantly of all does this provide better care and support for the populace?

In 2006, with the first hard evidence beginning to emerge that joint funding within Children's Trusts can not only save costs but also improve services for children and young people, the qualified answer seems to be yes shared budgets are the way forward.

One of the ways that this works is for the workforce to work across agencies, for example health, education and social care for children and young people, or health and social care when caring for frail elderly people, people living with long term conditions, or vulnerable adults and work in partnership with the community and voluntary sectors as appropriate.

Informing, consulting with and incorporating the views of service users, and their advocates in the case of children and vulnerable adults, is critical to effective interagency interprofessional practise. Building on existing networks and forums is one way of achieving this. Service users and their advocates however need to engage actively in service developments by responding to local and national consultations.

Informal unpaid carers and the voluntary sector are also essential team players. The value of their contribution is being acknowledged increasingly and they too are fundamental to the success of the creation of an interprofessional workforce. Informal carers however must not be exploited. Their contribution must be seen as added value not as a replacement for funded care.

In these three Chapters we have identified policy that indicates clearly the gathering momentum for interprofessional, interagency working not only in the health and social care arena but also built on a wider foundation. Health and social care policy is now linked and cross referenced to, for example, policy relating to the environment, housing, and transport. The momentum we suggest is now unstoppable. For the first time, there is real evidence that a strategic top down, bottom up, joined up holistic model is evolving which is having a positive impact on the health and welfare of the whole population. A synergistic model of interagency, interprofessional working is fundamental to its continuing success.

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