Sustaining collaboration between general practitioners and social workers

A report from a project undertaken by CAIPE and commisioned by the Social Services Inspectorate of the Department of Health.

Report compiled by
Lonica Vanclay,
Director
CAIPE – the UK Centre for the Advancement of Interprofessional Education

Published by
CAIPE
February 1996

contents

acknowledgements 4

executive summary 5

1
introduction 8

2
background 9

3
project aims 11

4
project methods 12

5
factors sustaining collaboration 14

6
the role of education, training and development 20

7
implementation needs 25

8
implementation strategies 29

9
conclusions 43

references 46

appendix 49

acknowledgements

Many grateful thanks are due to many individuals, too numerous to name them all individually. These include the following:

Professional colleagues for their advice, guidance,and support in developing the approach and for constructive critical comments and helpful suggestions.

Particular mention must go to the many trainers, educators, general practitioners, social workers,managers and other professionals upon whose cooperation, views and enthusiasm this project has depended. This project is really theirs. It has sought to gather their views and concerns, and to present suggestions they helped formulate.

Thanks also go to Mr David Crosbie of the Social Services Inspectorate and Dr John Horder, CAIPE President for their advice, support and encouragement throughout the project.

Finally, thanks go to Mr William Horder for first suggesting that this topic was one that needed consideration and to Professor Hugh Barr, whose valuable contributions at the early stages helped turn the idea into a project funded by the Social Services Inspectorate.

CAIPE is enormously grateful to the SSI for their generous financial support for this project, without which it would not have been possible.

Responsibility for the development of the project, compiling the report and the synthesis and interpretation of the many contributions rests with the author, hence the responsibility for any omissions, errors of judgement or interpretation lies solely with me.

I hope that the process and outcome of this project will contribute to ensuring that the appropriate collaboration between GPs and social workers and the effective coordination between health and social care services that is so necessary for ensuring effective high quality community care services for users will be sustained and enhanced.

Lonica Vanclay
CAIPE Director

October 1995

executive summary

Background

1. When the 1990 NHS and Community Care Act was passed, the Social Services Inspectorate (SSI) and Department of Health encouraged a number of training initiatives to develop understanding of the requirements and their effects and to facilitate collaboration. The Developing Managers for Community Care Programme and the SSI Implementing Caring for People projects produced guidelines on involving general practitioners (GPs).

2. Reports reviewing the impact of community care after one year found that pilot projects were not always continued; that GPs were still hard to involve; that there was still a lack of linking between agencies; and that some of the training was too early or inappropriate as community care was not yet impacting on GPs.

3. GP practices are a focal point in the community with universal coverage and no stigma attached. GPs are widely seen by their patients as sources of information about and referral to other services. There is fairly widespread agreement that joint working between GPs and Social Services Departments (SSDs) is needed for effective and holistic referral and assessment, prevention and early intervention, coordinated care management, hospital discharge and comprehensive locality planning.

4. Other professionals within the team also need to collaborate to provide care but GPs and social workers are key because they have the major responsibility for initial assessment and referral to appropriate services. They are the gatekeepers. As line managers and increasingly, with fundholding, even direct employers of other professionals, they need to be convinced of the benefits of collaboration and be willing to commit staff time and resources to sustaining it. The cultural differences between them are greatest and of longest standing.

5. The barriers to collaboration are well known but nonetheless continue to exist and to affect practitioners and plans. They remain hard to overcome. They include the following: a long history of mutual mistrust and misunderstanding; different operational contexts, philosophies, language and approaches; separate training; poor information exchange.

Aims

6. This project set out to consider HOW to sustain collaboration and whether education and development events had a role.

7. Considerable good work in some localities was found, but the experiences of others were not always known or used, and in other areas obstacles seemed to prevent developments. WHY?

Factors sustaining collaboration

8. 89 practitioners, trainers, managers and organisational representatives who had participated in events to develop collaboration were asked what would help them sustain the collaboration they'd begun. The factors they identified were much the same as those considered important to develop it in the first place and were:

- better understanding of each others' roles and responsibilities.
- sharing information and knowledge about others' structures and procedures.
- regular face to face contact.
- named link or attached social workers.
- working together on local projects or meetings on specific topics.
- senior management support.

Role of education

9. Appropriate education and training was seen as most important. When asked what form training should take to be most appropriate the following points were made:

- develop a collaborative approach and understanding of other professionals' systems, culture and roles during qualifying training.
- locality workshops on particular cases or specific practice themes facilitated and attended by a mixed professional team.
- external facilitators and joint trainers help begin the necessary local development process and responsibility to sustain it must be clarified.
- joint working between social services trainers and regional postgraduate GP tutors is vital to ensured sustained collaborative development events are integrated within ongoing continuing professional development programmes.
- information on structures, contact points and local services, including voluntary groups, must be shared in appropriate and effective forms eg. practice databases, filofax inserts, and short clear leaflets not lengthy reports.

10. There are many examples of local good practice which suggest that events should:

- reflect practitioners' needs and be case focussed or on specific topics.
- aim to share relevant information and clarify respective roles.
- be held at regular intervals but not too often (twice a year).
- be short, clear and probably at lunch time.

These repeat conclusions made in earlier publications about good training practice.

Implementation needs

11. Hence, more fundamental issues needed addressing. Why in some areas does collaboration work well, why not in others? Why despite knowing about how to run good joint training does it still seem so difficult and rare for social workers and GPs to work together?

12. The answers emerging from 6 focus group discussions involving 47 people; analysing 21 reports; interviews with 14 key people and attending 6 other conferences were as follows:

- key individuals who are effective local networkers are vital.
- enthusiasts who are already convinced of the value of collaboration and are able to inspire and demonstrate its effectiveness are crucial in sustaining collaboration.
- to develop more enthusiasts, long established barriers between GPs and social workers must be broken down and this needs to begin during undergraduate education.
- all professionals need to learn collaborative expertise as an integral part of their professional competence.
- good joint training programmes should be developed and provided through a partnership approach between FHSAs, GP Tutors and regional advisers, Local Medical Committees and Social Services Training Departments.
- develop integrated locality programmes where planning, resourcing and implementing services and the continuing collaborative professional development activities that are needed to ensure quality coordinated provision are part of a comprehensive locality plan. This should be developed by a partnership approach between service planners and providers, training purchasers and providers and include the voluntary and independent sector. This takes time and commitment and needs support.
- sustained top down management support and adequate resources are needed to complement bottom up enthusiasm and ideas.
- user friendly information about initiatives elsewhere and appropriate occasional external interest/stimulus would be useful.
- encouragement, support and a lead from central government is required.

Implementation strategy

13. A local development process that promotes a collaborative and continuous learning culture is required to sustain collaboration. This approach must be developed amongst professionals during qualifying education and supported by continuing learning opportunities,management backing, a national lead and coordinated policy framework .

14. The greatest remaining obstacle is that conflicting policies and wider imperatives continue to inhibit sustained collaboration between GPs and social workers. The short term focus and competition required by the market approach, the lack of clear responsibility and accountability for education within the purchaser/provider split, the lack of value ascribed to education and training, the rapid rate of organisational and structural change and the feeling of demoralisation and frustration among practitioners mean that for many self preservation and survival is most important.

15. While positive experiences of collaboration with colleagues can boost morale, practitioners recognise the futility of their small local albeit important efforts and readily give up if this is not modelled, supported, appreciated and sustained by their organisations.

1
introduction

1.1 The project brief did not include a literature review, so relevant areas of literature which would be helpful in further illuminating the questions this project addresses are but noted. Much however has been written on innovation, managing the implementation of change, sustaining change, and interprofessional education which is relevant. (See the Bibliography which includes just some of these.) Little attention has been given to questions of sustaining collaboration and the role of education, training and development in that.

1.2 It is likely that much could be learned by looking at very different fields requiring sustained interprofessional collaboration – the areas of drug development or engineering and construction are just two possible examples. Interprofessional education and training is also developing rapidly in primary healthcare, child protection, family justice and mental health and links should be made. If the focus is on the **process** of developing sustained collaboration, the field from which insights can be drawn becomes very wide indeed.

1.3 For this project however, the focus was narrower. It sought to collate the experiences and views of those involved in a selection of local projects that began after the 1990 NHS and Community Care Act to provide joint training for health and social services staff and so promote collaboration between them. Collaboration must extend to include all team members, whether professionals or not. Including the independent sector, volunteers, users and carers is especially important. There was a particular interest in social workers and GPs.

1.4 During the first stage of the project, the views of those involved in joint projects were sought on how such collaboration might be sustained and the most appropriate form of training and development. It soon became clear that this question was topical and there was considerable interest in it. It also became clear that there were no simple answers and that the challenges posed were great and longstanding. Some of the factors suggested as important for sustaining collaboration reflected points seen as important for developing collaboration. It seemed obstacles emerged during implementation.

1.5 Hence, the second stage of the project consisted of seminars and interviews which attempted to identify clearly what some of the obstacles were, why they emerged and how they might be tackled. Again the experiences and views of those involved in projects that had tackled these difficulties, albeit with varying degrees of success, were sought. The projects included were suggested during the networking process that was part of the approach of the project.

1.6 The third stage of the project involved several focus group discussions and interviews with key people with experience of relevant service models with a view to formulating suggestions for tackling the implementation obstacles.

1.7 This report outlines the approach adopted, summarises the findings of each stage and suggests strategies for implementation. It includes a Bibliography of relevant literature and an Appendix listing partner projects, reports perused, interviews carried out and seminars attended and organised. A summary is provided at the end of each chapter.

1.8 It suggests that collaboration can be sustained by embedding training and continuing professional development programmes in local service delivery plans, by forging links between trainers and by ensuring a collaborative approach is incorporated in qualifying education.

2
background

2.1 Reports assessing the impact of community care after one year were united in calling for more effective collaboration between health and social care services. (Audit Commission 1992; Department of Health 1994; Henwood 1994; Warner 1994).

Barriers to collaboration

2.2 The barriers to collaboration have been well documented. Barriers noted in the above reports include lack of coordination; lack of clarity of the health role (especially that of GPs); lack of common referral and assessment processes and monitoring mechanisms; inadequate consideration of health needs in community care assessments; and lack of contact between agencies involved locally. A range of projects and publications funded by the Department of Health as part of the Implementing Caring for People training strategy and the NHSTD Developing Managers for Community Care (DMCC) programme suggested approaches to developing greater collaboration. Resource materials have been developed and many Local Authorities established joint training programmes. (DoH 1993; DoH 1994; Leedham 1994; NHSTD 1994; NHSTD & SSI 1993).

2.3 GPs continued to be seen as reluctant to collaborate and their attendance at community care training activities was poor. Special attention was given to identifying strategies to enhance their involvement. (DoH 1994; DMCC 1993; Leedham & Wistow 1992; Leedham 1994).

2.4 Several surveys reported on the perspectives of general practitioners. Factors mentioned by GPs as inhibiting their participation include increasing paperwork; lack of clarity of their role; inadequate information; poor training provided too early using social work jargon and in a style unsuited to GPs; lack of a named contact in social services; lack of feedback after referrals made and slow response from social services. 40% of respondents to a British Medical Association survey at the end of 1993 described consultation, training and information about the community care reforms as poor. (Health and Social Policy Research Centre 1994; Saunders & Hayes 1993; Vallance-Owen 1994; Webb, Lloyd & Singh1994).

Requirements for collaboration

2.5 Promoting collaboration has been considered at least since 1959 (Younghusband) and there is now substantial literature on the theme. The literature suggests there are several important aspects in ensuring that interprofessional collaboration is sustained. One is the need to understand the other profession's culture and to be clear of the particular role of each professional and the form of collaboration appropriate for differing circumstances. Boundaries need to be clear and differences need to be understood. (Huntingdon 1981).

2.6 A second factor regularly noted is the need for management support, and top-down guidance, not just exhortation. Equally important are interagency and policy coordination, including joint planning and comissioning. Adequate resourcing and a partnership rather than a competitive approach are crucial. Appropriate organisational mechanisms and clarity and agreement on priorities, objectives and responsibilities are also crucial. (Audit Commission 1992; Henwood 1994; Hudson 1994; Ovretveit 1994; Rowbottom & Hey 1976; Smith 1993).

2.7 Another is the importance of individual links and relationships of trust with other professionals and a positive attitude to collaboration. "It takes a long time to build a trusting relationship with a colleague and then they move and we have to start all over again" was a comment made frequently by project respondents. Rapid and continuing change for them made sustaining the individual contacts on which collaboration rests difficult. (Hornby 1993).

2.8 Certainly comments from project participants emphasised the importance of these themes. However, given that frequent change is likely to remain part of professional life, education and training face the challenge of developing ways of enabling professionals to learn to collaborate quickly with new colleagues. There is growing attention in the literature to addressing the question of clarifying collaborative expertise and how that may best be developed as part of the "tool kit" of each professional. (Trevillion 1992; Beresford & Trevillion 1995; Whittington, Bell & Holland 1994).

2.9 The focus of this project was on **sustaining** collaboration and concentrated on general practitioners and social workers rather than health and social services for several reasons. Structural and organisational factors are crucial in ensuring sustained collaboration across services. However this is well covered in the literature. The DMCC work had concentrated on senior managers and planners. This project therefore sought to focus on the perspectives and needs of practitioners and middle managers.

Why focus on GPs and social workers?

2.10 Other professionals are also part of the community care team and partners in providing care. The issues of sustaining collaboration affect them too. Indeed community nurses, occupational therapists, care assistants and home helps are likely to be at least as involved in direct provision of care, and as likely to need to collaborate as GPs and social workers. Increasingly, however, GPs and social workers are the gatekeepers to community care resources and services and the line-managers or even employers (as fundholding increases) of other professionals. Hence their support for and ability to sustain collaboration is crucial. It is also between these two professional groups that the cultural and organisational obstacles to collaboration seem greatest and of longest standing. (Cartwright & Anderson 1981; Clare & Corney 1982; Forman & Fairbairn 1968; Goldberg & Neill 1972; Huntingdon 1981; Jeffreys & Sachs 1983; and Prins & Whyte 1972.)

3
project aims

3.1 This project set out to explore what role training has in sustaining appropriate collaboration between GPs and social workers for the delivery of effective community care services. It sought:

- To clarify whether and how GPs and social workers need to continue to collaborate for community care service delivery.
- To consider how collaboration between them might be sustained.
- To consider ways in which training and development could contribute to sustaining collaboration.

3.2 It sought to consider the questions raised by the Implementing Caring for People special study on training and the DMCC work on Involving GPs:

- how to maintain the momentum and ensure collaboration is sustained beyond the life of short term projects.
- how to deliver rolling programmes of training that include GPs.
- how to link training into an overall development strategy.

3.3 The **key questions asked** in questionnaires, interviews and seminars during the first and second stages of the project were as follows:

- In which ways do health and social care professionals, especially GPs and social workers, need to collaborate to deliver community care services?
- Which factors help sustain collaboration between GPs and social workers?
- What sort of education, training and development is most appropriate to help sustain collaboration.
- What is needed to ensure appropriate training is provided?

3.4 As the answers emerged they shaped **subsequent questions** which were posed to interviewees and considered in seminars in the second and third stages of the project. These were:

- How might joint training and collaborative development strategies become embedded in ongoing service delivery mechanisms and structures?
- How can the local development process that is required be supported, resourced and sustained?
- What is the role for national bodies?
- In which ways can shared learning be incorporated within undergraduate and qualifying professional education?

4
project methods

Planning

4.1 The project planning was completed by August 1994. An action research and development approach was adopted. The initial intention was to explore the questions with three partner projects where there had been considerable joint training activity and three where there was reported to be good collaborative practice. It was planned to consider the issues by asking those who had attended joint training and begun collaborating for their views on and experience of sustaining it.

4.2 Six areas were identified. These included rural, urban and London areas where CAIPE already had contacts. Gaining agreement from partners proved to be slow and difficult. A letter outlining the project was sent in early September. Projects were asked to forward questionnaires to participants in joint training they had run, and contribute to a seminar to consider how collaboration might be sustained locally.

4.3 Warwickshire Community Care Development Project (where CAIPE already had links) soon replied affirmatively. One Project had written up their experiences and readily agreed to my participation in the seminar they planned for November to consider continuing joint activity. This was later cancelled due to lack of take-up. Another advised they were unable to cooperate as their training department was undergoing major reorganisation. Another expressed initial interest and agreed to initiate local consultation and use responses to inform a development programme. However, other priorities later took precedence.

Stage one

4.4 Time was becoming critical as the project was to be completed by end March. By now, feedback from the first stage of the project was becoming available. A questionnaire had been developed, piloted and sent to the Warwickshire project during October and to selected individuals during November. Information was collated and analysed from 55 Warwickshire questionnaires (100 sent out); from 5 questionnaires from key organisations (10 sent out); from 7 exploratory interviews with key informants selected by the author to obtain a range of views; from 3 Conferences attended by the author on these themes that were organised by others; and a seminar organised in London as part of the project and attended by 11 people, invited to ensure inclusion of participants from the range of levels and organisations concerned. (Listings in Appendix) Findings suggested that the strategies to sustain collaboration were similar to those already identified as necessary to develop it.

4.5 Comments on appropriate training mirrored points already identified by the DMCC and Implementing Caring for People publications. However, many frontline professionals especially in health organisations, had not seen these publications or considered them too long to read quickly. It seemed that there was broad agreement on how to facilitate collaboration, but that difficulties arose in the implementation stage.

4.6 It also became apparent that many projects had reported their experiences, that many faced the same difficulties, although few knew of others or drew on their experiences. Although many knew of the Nuffield Community Care Innovative Practices Database, few used it actively. The report of a DMCC event for joint trainers indicated many felt isolated.

Stage two

4.7 Hence, the approach and focus of the project altered. The second stage sought to develop the emerging findings. Additional questionnaires were sent to trainers, and interviews and seminars were held in December and January. The focus shifted from practitioners to trainers and middle managers, in order to explore questions of implementation.

4.8 Information was collated and qualitatively analysed to identify common themes. Information came from 11 questionnaires (22 sent out) from joint trainers known to the DMCC; 3 (40 sent out) from practitioners and managers of joint projects from the Nuffield CCIP Database and other projects that became known during the course of the project (mostly suggested by respondents or identified through literature); scrutiny of 21 written reports collected on various projects; 5 questionnaires (from 15 sent) and a discussion with 10 students on the University of Central England Postgraduate Dip/MSc in Collaborative Community Care course; 5 interviews; 1 seminar with the Warwickshire Project management committee; and 1 seminar organised by NISW.

Stage three

4.9 The third stage in February and March involved organising 3 seminar discussions with identified managers, educators and relevant organisations to identify implementation strategies, resources, management structures and support mechanisms for ensuring collaboration is sustained. In addition, 2 interviews were held to explore the relevance of related project models (National Facilitator Development Project and Local Organising Teams of the Health Education Authority) and 2 conferences exploring similar themes in related fields (carers support and mental health) were attended.

4.10 The findings are presented thematically in four sections: factors sustaining collaboration; the role of education, training and development; implementation needs and obstacles; and implementation strategies for tackling some of these obstacles. A listing of respondents, interviewees, seminars attended and reports perused is included in the Appendix.

5
factors sustaining collaboration

5.1 From the 89 questionnaires, it emerged that GPs and social workers believe they need to clearly understand each other's role; exchange information and plans; and sometimes work together for (i) individual users – in the areas of needs assessment; planning and providing care packages; and case reviews and (ii) on a locality basis – for needs assessment, planning, providing and monitoring of services.

5.2 Respondents believed collaboration was sustained by several factors. Some respondents mentioned several factors as being important, some gave just one. Education and development activities (marked a) were considered most significant (mentioned 141times); then organisational and structural factors (marked b and mentioned 72 times); and finally information (marked c and mentioned 55 times).

Factor	No. of times mentioned	Group
regular informal face to face meetings with opportunities for discussion	46	a
each individual having good communication and teamwork skills and a positive attitude to collaboration	41	a
social workers to be part of, or attached to primary health care teams	38	b
clearly understanding each others' roles and responsibilities, priorities, and pressures and a more detailed knowledge of the organisational and employment structures and approach of each profession	36	c
having an appropriate supportive structure eg. agreed joint procedures, protocols and priorities; a local multiagency support group; and joint commissioning.	27	b
adequate protected time,resources and support for joint training	23	a
appropriate information sharing (feedback on referral, client held records, compatible information technology)	19	c
working together on individual cases or local problems and projects – learn by doing	17	a
develop GPs awareness of the influence of social factors and positive attitude to collaboration during undergraduate education	14	a
senior management support and higher priority for collaboration	7	b

5.3 Other points mentioned at least three times include: financial incentives for GPs to participate; having an external facilitator; recognising and addressing power and gender differences; having events at GP friendly times; improving liaison between professional bodies and associations; and publicising the successes and benefits of collaborative development events.

Figure 1: Relative frequency factors sustaining collaboration were mentioned

5.4 These three aspects are interrelated. Almost half the respondents who had participated in joint training made the point that developing an understanding of the role, approach and organisational structure of the other profession was helpful about the joint training they had participated in. Almost a fifth mentioned that learning about available resources was helpful. Clearly the information imparting and sharing aspect of education is very important.

5.5 Almost 40% (35 from 89 total respondents) felt information sharing on policies, procedures and roles was important to sustain collaboration. This and a local problem solving approach were mentioned most frequently as helpful aspects of joint training. Information sharing is also a significant feature of local discussions on agreed topics and short regular meetings which were the third and fourth most frequently mentioned points.

5.6 I will discuss issues of organisational structure and information within this section. As education, training and development is seen as the most important factor, it will be discussed in detail in the next section.

Organisational and Structural Factors

5.7 Respondents clearly emphasise the significance of organisational factors. This also emerged as significant in a survey on teamwork in primary care in Bromley and East Sussex. (Partnerships for Change – see listing of reports in Appendix.) The 250 respondents identified lack of shared

vision and different organisational priorities as the main barriers to enhanced interaction with Social Services.

5.8 Respondents also ascribe great importance to attached social workers. It is clearly important to evaluate this approach further. There are a growing number of areas where this approach is being developed.

> *Hereford & Worcester Family Health Services Authority (FHSA) commissioned an evaluation of their scheme placing a social worker in the primary healthcare team. The evaluation found disabled users were generally satisfied with an improved service. The FHSA plan to extend the scheme. Wiltshire has 50% GP practices with a social services link worker who also undertake some care management. They plan to extend this to 75%. and are considering including limited budget holding within workers' roles. They also consider primary care is a less stigmatising setting than social services; interagency locally based primary care teams can lead to more coherent service planning, can reduce cost shunting and help ensure provision reflects local priorities.*

5.9 Other Social Services Departments and FHSAs are also developing plans and different approaches ae used. Some attach care managers to primary health care teams or to general practice, some use liaison or link workers, and others offer a named Social Services contact. It is crucial to ensure that reports on different approaches are published and attention is given to differences in the detail of programme structure and management. Evaluation is important, preferably according to a common protocol, so that findings can be compared and the most effective models promoted.

> *In Salford written agreements between GP practices and local social services teams (and co-signed by community health provider units) were developed in order to clarify their respective roles and responsibilities. The PASS agreement focuses on clarifying relations between professionals, believing that when this is right, a firm foundation for joint working and commissioning will exist. Information is provided within the agreement which is developed and negotiated at local level. An evaluation is nearing completion.*

5.10 New interorganisational structures and mechanisms are developing to link, coordinate and integrate health and social services. Integration of staff from different agencies and disciplines in one setting can improve interprofessional relations and understanding. To achieve this, strong leadership, coordination and resource management are required.

5.11 Developments in joint planning, commissioning and purchasing of services and on managing services in partnership are proceeding rapidly. Early evaluation suggests joint commissioning and planning, like joint working and training, takes time to develop, needs a lead worker and is hampered by lack of clarity and agreement on goals, conflicting organisational demands and a very rapid pace of change in all sectors. Lack of clarity about how funding is allocated, uncertainty about acountability and responsibility for financial management hamper progress. Reports note it is hard to move from agenda setting to positive achievements and that much depends on

recruiting the right people at the right time. (DMCC 1993b; NHSTD & SSI 1993; Ovreitveit 1994; Wiltshire1994).

5.12 Continuing to collate material from various local developments and evaluating the effectiveness of different approaches in particular situations will be helpful. It will be important to review how plans are actualised, to relate the findings of further evaluation to education and training issues and to ensure that practitioners are informed of conclusions and apply them to practice.

5.13 Shaw (1994) concluded from his literature review and interviews of 10 GPs and 10 social workers that structures can frustrate communication and interaction, and that organisational and institutional barriers can negate any impact from innovative programmes, such as shared learning.

5.14 The literature suggests that to promote joint activities, managers need to identify and promote a culture that facilitates collaboration, openness, participation and trust and to develop a shared understanding of roles, values, goals and language. Practitioners surveyed in this project agree. The same points emerge from reports on mental health, carers support and primary health care development. (DMCC1993b; NHSTD & SSI 1993; NISW 1993; Ovreitveit 1994).

5.15 Sustaining the momentum requires constant renewing and reshaping of plans, or continuous innovation. It involves managing constant change. Champions may be key at first, but to sustain processes, middle managers and frontline workers need to be actively involved and are frequently neglected.

Information

5.16 Service provision is becoming more fragmented and responsibility is being devolved. Practitioners are having more and more demands made on their time and report feeling frustrated, over-stretched and demoralised. Time is precious and in the absence of a central body with a coordinating and information dissemination function to turn to for advice, contacts and information about developments elsewhere, practitioners feel isolated. They are developing projects without the benefit of information from others engaged in similar work. Many don't know how to find out about similar projects or feel they have no time to make contacts. With rapid rates of staff turnover and short term employment contracts becoming the norm, constant information provision is important. A more proactive approach may be required.

5.17 Appropriate information provision and dissemination was the third factor identified by respondents as significant in sustaining collaboration.Questionnaire respondents and seminar participants emphasised the importance of the provision of regularly updated information on each other's roles, structures and services, including contact persons and points. The appropriate form for this was clear, brief summary information, in a concise, jargon free, user friendly format. Long reports simply gathered dust. Better targetting of information is required. GPs especially reported that they are bombarded with written information, and simply cannot always keep up with reading it. Hence, much is quickly binned.

5.18 Lloyd et al. (1995) found information to be crucial. Of the 384 GPs who returned a postal questionnaire by early 1993, only 14% felt confident they understood the community care reforms. The researchers asked what factors contributed to the confusion and found information was most significant. GPs reported that they found information from the Department of Health and Local Authorities unhelpful as it contained too much jargon and rhetoric and the volume of material was too great. They found the BMA guides and Local Medical Committee material clearer, more concise and more useful. Meetings were also an important source of information. GPs felt that having an attached or named liaison social worker would be the most helpful way of improving relations with social services, followed by meetings on individual cases.

5.19 They recommend providing clear explicit information with a local focus; using peers and professional publications for effective distribution; providing routine feedback on referrals; and facilitating more direct contact by liaison or attached social workers/care managers. Additional suggestions on effective forms for providing information follow.

Effective ways of providing information

- faxing referrals and discharge letters.
- compatible, integrated IT systems between social services and health.
- filofax inserts with service contacts.
- A4 size posters for their noticeboard of who to contact (see example from West Berkshire on the following page.)
- ensure information is on the local computer database that most GPs have access to.
- linking up and coordinating information provision through the FHSA and Local Medical Committee and BMA systems.
- providing information for GPs through their practice managers.

5.20 The Berkshire Project (see appendix) also found that information was key. The lack of GP participation in their joint FHSA and SSD funded training programme prompted them to investigate why. They found that 70% of the 83 GPs who responded wanted better collaboration with social services but didn't go to joint training because of a lack of time and difficulty obtaining cover. If they were to be given training they wanted one hour punchy lunchtime sessions near their surgery on relevant topics. Their preference however, was for a link worker who provided them with 'need to know' information about changes, processes and procedures.

5.21 The North East Thames Regional Health Authority considered how to improve joint working between health and social services and how to facilitate exchange and aggregation of information for planning purposes. They too found information management and technology to be crucial. They arranged workshops locally requiring the Chief Executive of the Health Authority and the Director of Social Services (or their Deputy) to participate. Key community care tasks and the information needs to facilitate meeting those tasks were identified. Local groups then considered how they might collaborate and share information and identified key elements of a local and national information strategy.

5.22 It was acknowledged that successful implementation depended on each organisation having the capacity to deliver effectively and that interagency collaboration needed to be maintained and improved. This depended on understanding the partner organisation's culture, objectives, values and methods of operation; effective planning; building on existing good practice and systems and developing plans with small achievable stages that fit in existing operational systems rather than suggesting grand new unrealistic systems. The need for less but better quality information and for auditing information needs was asserted. The need to link collaborative work on information issues to overall joint working was stressed. Problems of sustaining the momentum were acknowledged and the difficulties of ensuring that enthusiasm and good intentions are turned into steady action were noted. (Deacon1994)

Summary

Collaboration is sustained by

- better understanding of each others' roles and responsibilities.
- sharing information and knowledge about others' structures and procedures.
- regular face to face contact.
- named link or attached social workers.
- working together on local projects or meetings on specific topics.
- senior management support.

These factors are similar to factors considered important to develop collaboration.

6
the role of education, training and development

6.1 Respondents saw continuing education, training and development, with the aim of increasing information and developing contacts, knowledge and skills for a collaborative approach to shared casework and local service development as crucial in sustaining collaboration.

How joint training helps

6.2 All 55 respondents from Warwickshire had participated in or contributed to joint training events. 7 found the training events unhelpful, 27 found they helped a little and 20 found they helped a lot. (1 did not answer this question.) 21 of the other 29 questionnaire respondents had been involved in joint training events, mostly as contributors. 12 thought the events had helped a lot, 7 a little and 2 not. Hence, most of those involved with joint training found it helpful or very helpful. (66 of 76 respondents, or 87%). The 76 respondents noted that joint training helped in several ways. Some gave just one answer, some none and some mentioned several points.

Benefits of joint training

Opportunity for:	Times mentioned
developing an understanding of the role, approach and organisational structure of other professions	37
meeting and talking with other professionals	37
defining problems and planning solutions	21
learning about available resources	16

6.3 Many did not mention any aspect they found unhelpful. The aspects noted most often as unhelpful were professional rivalry (8 times); colleagues not motivated (7); lack of GP participation (7 – and mentioned by 6 of the 11 joint trainers); too theoretical (5); insufficiently challenging and not new (5); stereotypical views of the other profession. (3).

6.4 89 respondents made suggestions on the training most appropriate for sustaining collaboration. They were clear that like all good training, joint training and development events should have a clear purpose, be carefully targetted and state intended outcomes.

Features of quality joint training

Quality joint training	No of times mentioned
involves practical problem solving and working together on individual cases or local problems	35
enables information on policies, procedures and roles to be shared	35
includes regular local discussion on agreed topics of mutual interest	29
includes short lunchtime get-togethers and meetings	19
can be provided within existing fora such as primary health care team meetings	16
seeks to develop collaborative attitudes and communication skills	11
should be jointly funded and provided	10
should begin during undergraduate professional education	7
may require an external facilitator	7

Suggested topics for joint training

- communication skills
- methods of assessment
- joint assessment
- record keeping & confidentiality
- assertion
- equality
- managing long term care
- advances in the care of dementia
- benefit entitlements
- regular repetition of basic information about community care, the legislation and the work pressures and structures of others
- learning how to live and work with constant change
- relationship skills
- case discussions
- contracting; purchasing and providing structures and local developments within the mixed economy of care
- ethical issues posed by the market approach
- power issues within a team
- coping with the implications for professional practice of rapid change in service provision structures eg. demands to manage versus wish to counsel and care

Providing joint training

6.5 The 39 respondents who were trainers indicated the factors they considered necessary for the provision of quality joint training.

Essential requirement	No of times mentioned
financial resourcing	14
commitment from participants	13
senior management and organisational support	13
a clear approach, purpose and strategy for the training	10
enough time to plan and organise the events	10
an independent facilitator	9
incentives for practitioners to attend (accreditation, locum cover etc.)	9

6.6 20 people holding joint training and development posts made similar suggestions at a DMCC workshop. Most participants held short term contracts and felt they needed support with their developmental role. They felt they needed opportunities to develop their own consultancy skills and their understanding and ability to facilitate change in individuals and organisations. They indicated they would value opportunities to collect and disseminate their experience and expertise as joint trainers and developers in community care through a national network, so that new postholders could benefit from lessons they have learned. They felt the developmental model they had evolved to develop community care could be extended to other areas of joint service provision. Success depended, they felt, on a long term plan which built key objectives for joint training into a grand strategy and used an enabler/facilitator model of organic development rather than a training model.

6.7 Project seminar discussions also emphasised that continuous shared learning oppurtunities are crucial in sustaining collaboration. Indeed, collaborative development was considered more appropriate terminology than joint training, especially for GPs. Plans must be developed locally through discussion between practitioners, managers and trainers from health and social services, commissioning, purchasing and providing agencies and include the independent sector, users and carers. This process is time consuming but necessary in securing the shared commitment essential for success. A local grouping must take responsibility for seeing the process is sustained and plans are implemented. Ideally, training and development activities will be provided and funded as part of a comprehensive locality plan which recognises that they are not separate and marginal but a core and essential component of operations, helping to ensure that service delivery is of a high standard.

The form of quality collaborative development

6.8 Participants identified the following factors as being essential components of the process of quality collaborative development. Activities should:

- have clear and relevant learning objectives and outcomes.
- acknowledge the different perspectives and approaches of each group and use them in a complementary partnership.
- be legitimised by writing them into job contracts and linking them with targets and quality measures.
- be accredited as a fourth PGEAcategory for GPs and for social work PQ awards.
- be led by a facilitator with time, responsibility and knowledge to act as bridge builder between organisations.
- be managed by a joint steering group.
- involve senior operations managers.
- reflect the preferred learning styles of various individuals.
- take account of available resources and work pressures.
- be evaluated so that the benefits can be clearly specified.

6.9 Contact between those responsible for continuing professional development for GPs and social workers should be facilitated, so that joint events can be incorporated within professional trainng programmes. Trainers seldom knew how other systems worked, who their counterpart was, or how to initiate contact with them. Joint trainers facilitated such contacts, but mapping systems and encouraging contacts to be made when joint trainers were not available was essential.

6.10 Credit accumulation and transfer schemes mean that credit systems for GPs and social workers for courses can be flexible. Local and national systems can interact. Work based learning is also developing. Useful open learning packs on joint working and training in community care are available. Some are designed specifically for interprofessional use, although GP participation is frequently limited. (Dundee University 1995; Leedham 1994.)

6.11 Considerable attention has been given to developing the skills of managers of joint working, and open learning materials (HSSM/MESOL materials – see NHSTD & SSI: 1995) and action learning sets have been produced (DMCC:1994 &1993b; NHSTD&SSI:1993). Much of this is relevant to practitioners and trainers. Development requires:

- space to talk, think and agree a development agenda
- exercises to recognise and understand stereotypes
- information exchange
- exploring new approaches and areas of practice by project activity
- shadowing

6.12 Local projects wanted occasional external stimulus and interest and central government lead and support. Barnes & Wistow (1991) also found that the reflected glory of being part of a national network with links to other projects enhanced the impact, credibility and attraction of local development activities. Information about developments elsewhere was helpful as busy practitioners had no time to make contact with others themselves.

6.13 The need to begin collaborative development early was repeatedly stressed. Participants suggested increasing health input in social work training and social input in medical training. They thought medical and social work educators should seek to enhance understanding of the other profession's roles and approaches. It will be necessary to articulate more clearly what skills, knowledge and attitudes underlie a collaborativeapproach and teach that within professional education. Such an approach may prevent stereotypes developing and facilitate collaboration.

6.14 Trainers and developers will need training themselves in how to facilitate a collaborative approach in their students. They will need information, suggestions, resources and literature to help them. Opportunities for local developers and joint trainers to meet with others occasionally and share ideas and experiences will be needed.

6.15 Hence, education, training and development should be seen as developing a collaborative culture. This involves helping GPs and social workers examine and change their attitudes and providing suggestions for identifying and tackling common problems together.

Summary

Education, training and collaborative development should concentrate on three main activities:

- the need to develop support for, interest and skills in collaboration and knowledge of other professionals' systems, cultures and roles. This should begin early, hence during qualifying professional training.
- activities at postgraduate and continuing professional development level of two main types: (a) lunchtime networking events providing the opportunity for regular face to face contact and discussion and (b) locality workshops on particular cases, specific practice themes or locality problems. Case studies of worrying or difficult situations motivate GPs successfully. These collaborative development activities should be facilitated and attended by a mixed professional team and integrated with service provision as part of providing quality services. Management support is essential.
- workshops should be facilitated by and attended by a mixed professional team. For this linking and joint working between social services trainers and regional postgraduate GP tutors and advisers is vital.

7
implementation needs and obstacles

7.1 Many of the findings outlined above are already well known and appear frequently in the literature. Hence, it would seem that what to do is well known and generally agreed. In many areas joint training and development and collaborative service provision continue. In other areas very little was happening and respondents reported feeling frustrated and despondent about the failure of such activities despite the time and effort that had been put into attempts to promote collaboration. Even when people knew what to do difficulties and complications arose at the implementation stage. Lack of time, money, management support, competing priorities, conflicting agendas, complications of the purchaser/provider split with resultant competition and growing number of small agencies were cited as obstacles. In all of the partner projects these factors posed real and great obstacles to sustaining the collaborative development process.

7.2 These same obstacles were cited in work considering training issues for the development of managers of joint work (NHSTD & SSI:1993). Barnes & Wistow (1991) in their review of a Community Care Special Action Project in Birmingham came to a similar conclusion. Frontline workers reported good collaboration but faced many structural obstacles. These included competition for resources; tension between devolved decision making and intra-agency activity and the need for highlevel, coordinated support and inter agency work and insufficient time to develop new ways of working and change attitudes.

7.3 Seminar participants noted that social work led education events failed to attract GPs and medical led initiatives failed to attract social workers. Developing integration and coordination between medical and social work training programmes at both undergraduate/prequalifying and postgraduate/continuing professional development levels required greater contact and linking between the trainers and educators. This was difficult for the following reasons:

- educators and trainers don't know enough about the education system of the other group to begin to develop ideas for shared learning.
- teachers are often bogged down in their day to day work and it is difficult to make the time to begin contacting their counterparts to explore options.
- it was difficult to find information about activities already developed and tried elsewhere.
- there is little opportunity and time available for developmental work within current education provision and funding mechanisms.
- proof of the beneficial outcome of innovatory approaches is needed to convince senior managers of the value of investing in such approaches.

7.4 Both GPs and social workers are experiencing fundamental role changes requiring them to develop management and budgetary skills and use clinical skills less. This is exacerbated by major and rapid organisational changes. For both, a preoccupation with internal affairs prevents active involvement with collaborative activities.

7.5 The payment structure and pattern of organisation of GP services act as major obstacles to the implementation of collaboration and joint training. GPs are independent contractors, so the decision to provide services above the specified minimum or to participate in joint training or indeed any training above a specified minimum is an individual choice.

7.6 GP participants were clear that it could NOT be assumed the FHSA represented GPs or that involving them in joint training ensured widespread GP involvement. Relationships between FHSAs/DHAs (or the new Health Commissions formed as they combine) and GPs varies enormously from one area to another. In some the training or incentives provided by FHSAs/DHAs to develop and sustain GP collaboration is valued and supported by GPs. However, in other areas it is not. Links with the Local Medical Committee, GP Tutors and Advisers, regional Postgraduate Medical Centres and Departments of General Practice are also necessary in order to really attract widespread GP participation. However, the extent to which GPs, whether fundholders or not, come together in consortia or are actively involved with their local Medical Committees also varies greatly. This does present practical difficulties to trainers seeking to influence GPs and encourage them to participate in joint training. Considerable time is necessary to link with each practice team individually. Facilitating the influence of peers on their colleagues and seeking support from the regional RCGP Faculty, British Medical Association and the General Medical Council as appropriate is important but also time consuming and more difficult from a local base without national guidance and coordination.

7.7 The impact of GP fundholding will become clearer as it continues to develops. The systems are still evolving. Khan (1995) suggests that fundholding can be positive and can offer GPs flexibility and close contact with and greater control over services for patients and so help overcome age old interprofessional problems. Other respondents were concerned that as GPs employed other professionals, age old barriers and power and status differentials might remain entrenched.

7.8 Another obstacle mentioned was that community care is one concern among many for GPs, whereas for social workers it could be the sole focus of their work. Community care is not a priority for GPs. 25% of 270 GPs surveyed by Lloyd et al (1995) in 1994 had not completed any community care assessments and 50% had just been asked to contribute a medical view. They felt inadequately consulted over the community care plan.

7.9 Community care is only just now really beginning to affect most GPs directly and hence to be of concern to them. Previous joint training sessions may have been too early as few GPs were directly affected then. Now with hospital discharge difficulties and an increase in the number of patients being cared for at home and going to GPs for medication, the impact and relevance of issues to GPs is growing.

7.10 This issue of competing demands for GPs time and attention extends to projects promoting joint working and collaboration. In one area there was competition between the Community Care Development Project and the Local Organising Teams for primary care development and health promotion to attract GPs to their programmes. The LOT events were better funded and could offer more attractive events, so were better supported. As mental health, carer support and disability groups all seek to promote a collaborative approach between GPs and other professionals through training, information provision and development activities, it will be important to coordinate efforts and activities and seek to develop a **general** positive approach to collaboration in order to avoid further competition and a negative GP response. Policy coordination at national level is also necessary to ensure such overlapping programmes and approaches are integrated and work in harmony not competition.

7.11 Another obstacle mentioned was the lack of mutual understanding. During their basic medical education doctors may never have spoken to social workers. Only when they develop an understanding of social workers will they collaborate (and vice versa) and this must begin before negative stereotypes become ingrained. Hence, appropriate opportunities for shared learning should be sought within undergraduate/prequalifying education systems.

7.12 The question of why collaboration is sustained in some areas, but not others was asked. Invariably, the answer was that it is due to the enthusiasm and initiative of people who are already committed to and convinced of the benefits of a collaborative approach and competent in collaborative skills. They take the lead in facilitating a developmental process to involve the wide range of people and agencies whose involvement is needed to develop, implement and sustain such a programme.

7.13 Two examples highlight this. The Local Interagency Training Forum in one area produced a brochure of all the existing training organised by various organisations in order to promote communication and avoid duplication. However, this is now discontinued because the local enthusiasts leading it have moved on, everyone is very busy and there is no person or point in the system with the responsibility for initiating the steps to ensure it is continued. In another area there is **no** joint training – highlighting that developing and sustaining local developments frequently depends on individual creativity and goodwill. This leads to great discrepancies in developments between areas.

7.14 In another area, after an initial impetus for short joint training sessions, there was a lull. As the original individual enthusiasts moved on there was a request for information about each other's roles and organisational structures. Joint training, however, assumed low priority and was led by short term and/or part time joint trainers. Courses were originally supported by a joint training steering group but this folded after one year because of a lack of commitment and attendance from the different agencies.

7.15 Securing ongoing funding after the pilot stage was seen as another obstacle. The Warwickshire Project failed to secure joint funding after the pilot ceased. The application for joint finance for a Primary Project Care Development Project to continue the work of **both** the Community Care

Development Project (funded mainly from a charitable trust until March 1995) and the Local Organising Teams of the HEA Primary Health Care Unit was turned down, despite having been planned by a wide group involving all significant organisations.

7.16 In another area, joint training originally involved a series of talks. Then the GP Forum, tutors and associate advisers, social services and other agencies formed an educational network which felt it was important to encourage practitioners working together to identify what they needed to know through workshops. An action learning joint training pack was developed by interviewing professionals about their perceptions of other professionals, the answers were analysed and the issues further discussed in workshops. The process was time consuming and the group felt they needed a facilitator to help continue the work. Funding for a facilitator is proving difficult to find.

7.17 These examples also highlight another obstacle raised in seminars – that of establishing responsibility for organising, funding and providing joint training. Collaboration needs to be ascribed higher priority and more time and resources.

Summary

The main difficulties in sustaining collaboration emerge during the implementation phase. They fall into four main categories:

- rapid changes and conflicting organisational priorities.
- dependence on key individuals already committed to collaboration.
- lack of clarity or defined lead responsibility for ensuring the collaborative development process is sustained.
- lack of responsibility for ensuring ongoing funding.

8
implementation strategies

8.1 These obstacles are familiar and have been noted in earlier SSI and DMCC reports. They have been noted in the literature since the 1960s. (Rowbottom & Hey:1976; Younghusband:1959). Nonetheless, they are real and continue to impede developments. Constant and rapid change means familiar contacts move on too quickly; competition and shortage of resources inhibits collaboration. People are too busy, collaboration is time consuming and not a priority given the many other concerns of agencies. Training and development are not valued or linked to strategic planning. Practitioners and trainers feel frustrated and demoralised, disillusioned with the lack of followup and support for developmental pilot projects and clear that eighteen month pilots are too short unless a clear plan for continuation exists beforehand. Differing organisational structures and lack of coterminosity complicate the interagency relationships and the coordination necessary to support seamless service provision and shared learning.

8.2 Being clear when, why and how collaboration is needed is important. The findings of this project suggest sustaining collaboration requires constant repetition of the same steps that are required for developing collaboration and constant grappling with wellknown but ever present difficulties. In some areas, good collaboration does continue, sustained by regular contact, appropriate training, steady management reinforcement and organisational backing, including joint commissioning. It is possible.

8.3 In seminar discussions **factors critical for success** were identified as:

- shared learning at undergraduate and postgraduate level
- developing a positive approach to collaboration among professionals and enthusing practitioners
- local integrated development
- linking trainers and coordinating programmes
- appropriate structures

8.4 Examples of approaches adopted in some areas are outlined. Short term pilot projects are inadequate and the focus should be on integrating training within existing mechanisms and linking training/development to service operations and provision.

Locality Development Models

8.5 Local integrated collaborative development activities were seen as vital. These need management support, adequate resourcing and supportive structures. Evaluation to demonstrate local benefit is crucial. Several examples of approaches were identified.

Local collaborative development models

- *Kent FHSA and the Social Services Department organised a locality workshop to review local progress since the implementation of community care, to identify gaps in provision and to identify the training and development needs of staff to equip them to improve the service.*
- *The joint planning council in West Surrey includes health, social services and voluntary sector representatives from commissioning and providing agencies who meet together to identify needs and plan appropriate services required to meet those needs. All contribute funds to ensure the training needs, identified as necessary to enable the provision of services, will be met.*
- *Monthly lunchtime meetings at rotating venues on a particular topic, perhaps with a speaker, for professionals to meet, discuss mutual concerns, and get to know each other. In Westminster a one day workshop is organised twice a year by the Locality Implementation Group. Multidisciplinary practice team presentations on the identified topic are followed by case discussions to problem solve. The solutions are presented to senior managers who join in the afternoon, so including a feedback loop.*
- *In North East Thames, social services trainers and regional GP postgraduate tutors meet and run joint training events locally that include voluntary sector providers. The training is task centred using problem based learning methods.*
- *In Derbyshire, the joint training strategy was developed after a comprehensive local needs assessment and offers a range of activities aimed at promoting collaborative working, information sharing and skills in change management. It has cross agency senior management support which includes funding. Regular evaluation is undertaken, and the programme is managed by a Joint Training Network.*
- *In Tayside, job shadowing and a joint interagency induction programme for all new health and social services staff have been developed.*
- *The Barking & Havering Community Care Training Unit has joint Health and social services funding. A management committee was established with representatives from social services, FHSA, Community and Hospital Trusts, housing, voluntary sector and District Health Authorities. A three year model with organisational representation was chosen to ensure responsibility did not just lie with individual enthusiasts. Considerable canvassing had been necessary initially to attract a broad membership. Monitoring progress and demonstrating the achievements of the training unit helps ensure senior management support is sustained.*

8.6 Clearly, the situation in each locality and Borough is different. However a local development process and developing shared ownership are essential.

8.7 Sharing information about existing training programmes and seeking shared participation is also useful. However, project participants stressed that it was essential that a learning needs analysis be undertaken in relation to intended service provision first. It must be clearly identified whether

the gaps are ones of procedures, responsibility or skill. Then the appropriate training and development programme that is needed can be identified. Ideally, a dynamic locality based problem solving and learning process within a local structurally integrated forum to discuss issues and progress action is required.

8.8 Participants noted that a needs analysis does not pick up unknown needs. Motivation and self interest are also important. Not all GPs find it necessary to collaborate with social workers. They need to be shown how collaboration can lead to higher quality patient care. It is useful to work closely with other members of the health team (eg. health visitors and community nurses) to help convince GPs of the benefits of collaboration. The role of practice managers is also important.

8.9 In order to develop commitment, a culture of collaboration, quality management support, effective leadership and responsive services there must be a training and development strategy. To develop a collaborative culture, it is necessary to develop a vision and strategy, motivate staff, convert it into practical steps, develop a plan for carrying it out that is supported by skills development and information, and to review and evaluate the plan and revise it as appropriate.

8.10 To overcome the reluctance of professionals to collaborate, and to help them recognise the benefits of collaboration, a permeation training approach is necessary. There is a need to begin to make GPs more interested in social care, more convinced of the links between physical and social factors in health, less focussed on managing individual disease and more concerned to provide care and more sure of the benefits of collaboration with social workers. The converse applies for social workers. The only real permanent solution was seen to lie in changing undergraduate education and opportunities now exist, as curricula are being revised and becoming more community based.

Shared learning during professional training

8.11 There was widespread support for the view that the only long term solution to the problem of sustaining collaboration between the professions is to develop a greater understanding of the role and approach of colleagues during undergraduate/prequalifying education.

8.12 Tope (1994) found considerable support amongst students for this. Questionnaires were completed by 300 teachers and 1383 students of a range of health and social care professions including medicine and social work and interviews were conducted with a random sample of teachers and students. 97.7% of all respondents thought that integrated interdisciplinary learning should take place during undergraduate training to prevent stereotypes developing and address potential conflict. 95% of the 137 social work respondents and 69% of the 376 medical respondents were very interested or interested in interdisciplinary learning. Qualified medical practitioners ranked social work as the second most important group with which to learn; medical students ranked them sixth. Tope suggests medical practitioners realise that patients' social problems and needs play a crucial role in health and illness, while medical students are still focussed on the reactive interventionist medical model of care. Respondents thought the learning strategies to be adopted in an interdisciplinary initiative should concentrate on a hypothetical case study approach and on problem based learning.

8.13 Carpenter & Hewstone (1995) showed that even a short one week exercise could be effective. This research looked at programmes of interprofessional education for final year medical and social work students at Bristol University. The programmes drew on social psychology theories of intergroup behaviour looking at the conditions under which more positive attitudes may be established between conflicting groups. Key features included institutional support for the programme and opportunities for students to work as equals, in pairs and small groups, on shared tasks in a co-operative atmosphere. The one week programme included field and classroom based sessions on topics such as alcohol abuse, dealing with psychiatric emergencies, community services for people with learning disabilities and deliberate selfharm.

8.14 A comprehensive evaluation of the effects of the programme on one cohort of 85 students revealed that overall attitudes to the other profession and their competence improved. They found evidence of appropriate differentiation, and participants reported increased knowledge of the attitudes, skills, roles and duties of the other profession and of how to work together more effectively. Their conclusion is that although interprofessional education cannot remove all barriers to cooperation, for barriers are structural as well, the programmes, brief though they were, do demonstrate that attitudes can be changed and knowledge increased. These are necessary conditions for collaboration.

8.15 Clearly, it is important that additional information about the effectiveness of interprofessional education and shared learning both at enhancing interprofessional understanding and collaboration and more importantly in ensuring coordinated and effective service provision is obtained. Courses that have been more comprehensively evaluated are few in number. Barr and Shaw (1995) review those that have been written up.

8.16 The recommendation that social work and medical undergraduate education include learning about the other profession was first made over twenty years ago (Prins & Whyte: 1972). As yet, few examples of interprofessional education at undergraduate level are known to exist in UK. An early initiative in Thamesmead in 1976 developed shared learning between social work and medical students (Barr & Shaw:1995). CAIPE is currently carrying out a survey of interprofessional education and shared learning initiatives throughout the UK (Report due end of 1995). Indications are that the number of initiatives is growing. Some examples do exist in other countries.

Common foundation course in Sweden

For the first ten weeks of their professional education, medical, nurse, physiotherapy, occupational therapy and social work students at the University of Linkoping in Sweden study a common course, entitled "Man in Society". The unit adopts a problem based learning approach. The course covers four themes: biological perspectives, social structures and contexts, conditions of health and ethics and philosophy. Students learn interprofessionally again in several short topic focussed workshops in later years of their course. The problem based approach, focus on primary care, emphasis on communication and early interprofessional learning ensures knowledge, skills and attitudes are integrated and students develop a collaborative approach.

Interactive workshops and common tasks in Adelaide

The University of Adelaide in Australia developed two undergraduate programmes. The first was for second year students and was entitled Working in Health Care. It drew students from 8 different disciplines (medicine, social work, occupational therapy, nursing, physiotherapy, podiatry, human services and environmental health). It aimed at enabling students to understand concepts of primary care and the potential contributions of the different professions, especially in the context of community and preventive health services.

The course was compulsory and assessed and ran for one afternoon per week for 8 weeks. The methods involved a mixture of lectures, tutorials, readings, discussion, group work and presentations. All students followed a core syllabus covering introduction to the health of Australian society, community health, health personnel (which included social work), interprofessional cooperation and practical experience of interprofessional activities in the management of specific health problems. In addition, the 550 students were allocated to one of 8 streams guided by students' own preference and the wish to attain a broad professional mix in each stream.

Stream titles were better health and the professions (a public health perspective); legal and ethical concerns in community health; the health professions, past, present and future; the workplace and health; the role of human ecology in primary health care; women's health; primary health care across the health span; and ethnicity and health.

Community practice workshops for final year students ran throughout the year. Each workshop was three days and compulsory. They involved lectures, discussions, videos, reading, field visits and student presentations. There was a balance of theory and practice, and workshops aimed at developing skills in and understanding of interprofessional working. Assessment was based on workshop participation and completion of prescribed tasks. Topics included domestic violence; management of musculoskeletal injury; ethics in community health settings; social disadvantage; the prevention of chronic disease; alcohol and legal issues.

8.17 Options for developing shared learning at undergraduate level were formulated during project seminars. They include:

- GP and social work trainees doing a practice placement in common community settings and teams. Or a social work student doing a placement in a general practice team, perhaps supervised by a local authority social worker.
- Some shared workshops on particular themes with common or overlapping interest eg. ethics and law; communication skills; values.
- Seminars – eg. fourth year medical students doing geriatrics could combine with social work students for a workshop on care of the elderly – perhaps using a structured case presentation format focussing on approaches to assessment.
- Medical students could link with social services during their 4th year GP attachment – perhaps attend a morning seminar.
- Medical students could be attached to a social worker for a morning and write an essay on the hopes, goals, role and stresses of the social worker. Social work students could write about a GP.

- Shared participation in a seminar on chronic care, with user, carer and community organisation representatives presenting material.
- Medical and social work students could together plan, carry out and write up a community research project.

8.18 Ideally, an interprofessional strand would be integrated and included throughout and each year would build on previous learning. However, because such an approach takes considerable time and requires concerted negotiation with teachers of other aspects of the course, patricipants felt it would be easier and quicker to begin with small projects with limited but clear learning objectives. If systematic evaluation was built into this from the start, the evidence of valuable outcomes would be available to encourage incorporation and integration of interprofessional education into programmes in the future as the courses are being revised.

Postgraduate course models

8.19 Courses provided at postgraduate level also seek to develop and sustain collaboration between professionals. The University of Central England offers a postgraduate Diploma/MSc in Collaborative Community Care. The course was developed after a survey of local needs. Managers and agencies wished the content to include management skills, while practitioners wanted to develop skills in working with users and carers and reflective skills. Insufficient time and money were the factors both employers and students thought would inhibit their participation. The approach of the course includes action learning, reflection, project and research work. It has an interprofessional student cohort and seeks to develop collaborative practice. Students reported being drawn to the course because they were already keen collaborators and valued the groupwork, information and varied learning methods on the course.

8.20 Similar courses with collaboration and community care in their titles are offered by Brunel University , the University of Dundee and the University of Huddersfield. Others such as Bournemouth University, the University of Westminster, the University of South Bank, Exeter University and the London School of Economics seek to develop collaboration and improve interprofessional collaboration in general. None however have had more than one or two GPs although all have had several community nurses and social workers as participants.

Collaborative Skills

8.21 Considerable work is underway at present on developing and clarifying what skills are most significant for collaboration. There is considerable overlap between suggestions offered by different writers. It is increasingly accepted that collaborative skills extend far wider than teamwork skills, as collaboration across agencies is required. The concern is to develop skills for relationships and activities that lie between organisations and are the responsibility of no one organisation in particular, as well as ability to deal with overlapping functions. (NHSTD & SSI:1993).

8.22 Many of the skills apply equally to managers and practitioners, and apply to work in fields of service other than community care. Child protection, mental health, family justice and primary health care are just some examples.

Skills required for collaboration

- systems manipulation and design
- persistence and commitment
- liaison, networking and negotiating skills
- analytical and reframing skills
- problem solving and lateral thinking skills
- political nous and diplomacy
- ability to sustain cooperative working relationships
- handling conflict
- conducting multidisciplinary meetings
- ability to adapt to, participate in and promote regular and frequent change
- assessment, planning, clarifying and reviewing skills
- ability to identify and engage various stakeholders
- ability to build alliances
- good communication and interpersonal skills
- empowering and partnership skills with users and professionals
- ability to evaluate progress, achievements and outcomes
- facilitative skills
- ability to understand group dynamics

(Barr: 1995; CCETSW: 1992; DMCC: 1993b; Leathard: 1994; NISW Practice and Development Exchange: 1993; Trevillion & Beresford: 1995; Whittington, Bell & Holland: 1994)

Linking trainers and coordinating initiatives

8.23 Another strategy for ensuring collaboration is sustained is to integrate collaborative development within existing training programmes and move away from short term pilots. This will require much closer contact between health and community care training programmes, trainers and developments, at both national and local level. Possibilities were suggested at seminars.

Suggestions for linking professional training and collaborative activities

- GP tutors and advisers and social services trainers could meet locally, share information and plan future programmes together. A facilitator may be required to bring them together initially.
- Links between NATOPSS (National Association of Training Officers in Social Services) and the National Association of General Practice Tutors should be developed.
- Learn from and link with the Health Education Authority primary health care team development and training projects. They have established LOTS or multidisciplinary Local Organising Teams. The teams sometimes include social services and seek to promote and support an integrated primary health care service. Considerable expertise in supporting and developing the skills of the team members has been built up over the years. Teams already have extensive links with general practices. Although teams initially concentrated on smoking and nutrition, they now focus on team building, change promotion in general practice and locality development of services.
- Learn from and link with facilitators (270 throughout UK according to the National Facilitator Development Project database). They work closely with GPs and their practice teams in most health districts to develop collaborative approaches for stroke prevention, immunisation, and asthma. The facilitators adopt a developmental process, provide information to GP practice teams about other local services and become bridge builders, enhancing cooperation. Most are employed by FHSAs, others by DHAs or jointly. Their role developed from the view that personal contact and help from a trusted colleague could achieve much more in motivating GPs to change than directives. They are already well linked in to GPs but few have contact with community care training programmes or social workers. A National Facilitator Development Project is based in Oxford to provide information, training and support to the facilitators. The Mental Health Foundation has funded a pilot project based at St George's Hospital to explore the relevance and potential for adaptability of facilitators who have focussed on stroke, asthma etc. to mental health.

8.24 LOTs and facilitators work closely with GPs, and emphasise collaboration yet there seem to be few links with community care and social work. Approaches emphasise working with the team to identify a collective task or mission, discussing how that might be achieved, identifying critical factors for success, determining the tasks and appropriate team member for carrying them out and reviewing progress. Both programmes have developed a wealth of material, approaches, resources and tool-kits for trainers which would be useful to community care trainers. Trainers and facilitators could usefully work together to encourage collaboration.

8.25 Both the programmes also run many train the trainer events. Undoubtedly, these could provide information and resources for activities to support and develop the facilitative and training and development skills of community care trainers. Encouraging both to participate in such events would help develop better knowledge and understanding between trainers, opening up possibilities

for integrating the approaches. In Liverpool, proposals have been developed for the John Moores University to offer a certificated course in Primary Health Care facilitation. This could provide useful material for developing facilitation skills in community care.

8.26 Courses in the facilitation of teamwork in primary care focus on managing change, building effective teams, developing facilitative skills, and linking primary health care to other organisations. They include discussion of models and case histories to increase theoretical understanding and provide insight into organisational process; demonstrating how to create a learning organisation by working on an issue within the group; tackling specific obstacles highlighted by participants that inhibit individuals' development and effectiveness in their organisations.

8.27 The NISW managing innovation and change project supports the view that cultural change is required. It is drawing up a model adaptable to local circumstances that will assist with developing plans for ensuring changes are incorporated within organisations and become integrated within it and that a learning and change culture develops and is sustained. A recent NHSTD conference exploring interprofessional collaboration in mental health also highlighted the need to develop a learning organisation culture.

8.28 Other bodies support similar strategies. The Institute of Health Services Management supports joint planning and coordination of service delivery. It encourages practice based study groups to prepare managers to work strategically and flexibly across boundaries and in partnerships and alliances. It notes the need to undertake a long term analysis of needs and plans for care and training. To achieve this, they suggest that organisational development is needed. (Baker & Willmer 1995)

8.29 It seems there is widespread agreement on what to do, and that comments for community care parallel those for primary care, mental health, management development and child protection. With such clarity of where to head, it should be possible to devise means of tackling the obstacles to sustained collaboration and secure support for doing so. A growing collection of models and guidance is developing.

8.30 Ultimately, collaboration must be afforded higher priority if it is to be given the constant attention needed for it to be sustained. The most effective incentive will be self interest. The challenge, therefore, is for education and continuing professional development initiatives to encourage more professionals to see that a collaborative approach is in their and their users' interests; to develop their collaborative skills and to encourage and support their efforts locally.

8.31 The new Regional Education and Development Groups and local health education purchasing consortia provide an opportunity for such linking to occur. At present, they offer minimal representation to the social services and undergraduate medical education sectors. Strong and integrated linkages must be made. Their success will depend on the spread and representativeness of their members, the active contribution and enthusiastic input of members, the serious and concerted attention that members give to their deliberations and the availability of adequate time and resources to develop and implement comprehensive and coordinated training and development

programmes that will serve to sustain effective coordinated service delivery and the interprofessional collaboration necessary to achieve it.

Summmary

Requirements for replicating learning and sustaining collaborative activity are:

- development and training must be targetted and appropriate for practitioners.
- a systematic programme of development and implementation is necessary.
- networks and other initiatives should be tapped.
- corporate mechanisms and executive authority need to support and sustain the implementation of new developments.
- programmes seeking to promote collaboration need coordination.
- links between educators and trainers should be developed.
- collaborative development programmes should be integrated with service development.
- inter professional education should be integrated within professional education.

OBSTACLE: Lack of clarity in the system for leadership and of responsibility for undertaking joint development.

STRATEGIES TO OVERCOME THIS OBSTACLE

- Set quality standards and performance indicators for collaboration between health and social care and link training and development with them. This will require organisations to give attention to training/development programmes and ascribe responsibility for them.
- Produce policy requirements for integrated joint locality service provision and training/development programmes. These could include requiring Community Care Plans to accord training/development higher priority and to outline provision. This could resemble the Area Child Protection Committee structure and should ensure resources and legal backing were available.
- Establish a joint structure with wide local representation with a clear accepted mandate for oversight and responsibility for joint development.
- Disseminate more widely the experience of existing locality programmes (and there are quite a few good examples!) Use regional Research and Development money for this.

OBSTACLE: Local developments are overly dependent on individual enthusiasts and collapse when they leave.

STRATEGIES TO OVERCOME THIS OBSTACLE

- Make more people enthusiastic! Ensure participants in local collaborative development processes see it is achieving beneficial outcomes and results in enhanced user services and ensure their morale and commitment is maintained by participating in the process.
- Develop joint structures to support individuals and take responsibility for programmes, as above.
- Ensure purchasers require service providers to ensure staff training and development activities are included in contracts as part of quality service provision, and include joint programmes as appropriate.
- Provide a supportive continuing national framework. The DMCC Network was valuable but has been discontinued just as its networking was bearing fruit. The national network has not been sustained without government support.

OBSTACLE: The need to increase the priority of collaborative development activities for those who are uncertain and make them enthusiastic.

STRATEGIES TO OVERCOME THIS OBSTACLE

- Increase GPs' interest in social issues and social workers' interest in health issues and begin in undergraduate education.
- Develop a module on working together that is taught to all professions in mixed groups. Require that this is part of the core competence of each professional.
- Encourage inclusion of interprofessional competence as a requirement for professional reaccreditation.
- State the benefits of training/development for patients, especially groups which impact on most GPs eg. hospital discharge, elderly.
- Job Shadowing – eg. attach GPs in their practice years to SSDs for a day and social workers to a GP surgery.

OBSTACLE: Who is to pay for joint training especially when money for training is limited? How to make the responsibility joint?

STRATEGIES TO OVERCOME THIS OBSTACLE

- Influence commissioning and purchasing so service provision contracts require that provision for training/development is included. This must be accepted and adhered to by providers.
- Establish agreed quality standards for interagency training and write them into specifications.
- As joint working and development processes and strategies progress locally, purchasers will see the benefits and will commit money to joint initiatives. Flexible funding plans will develop. In local consortia, each agency should be required to contribute a certain amount for joint training and development.
- Explore and develop further models for joint health and social services purchasing of collaborative development.
- Share information about and use existing funding sources more creatively – eg. the Social Services Training Support Grant has an element for joint work and training within it.

OBSTACLE: The great number of agencies and the competition between them for contracts hinders collaboration. This is exacerbated by different boundaries. Rapidly changing structures and staff turnover frequently mean the essential local developmental process is often disrupted, wasted and has to start again with new people.

STRATEGIES TO OVERCOME THIS OBSTACLE

- Continue to seek coterminosity of areas.
- Attach or link social workers to primary health care teams. Establish truly joint community based care teams combining health and social services. Evaluate the many existing projects and disseminate the experiences.
- Urge that joint health and social services mechanisms be established at regional and national level.
- Link primary health and community care developments and seek an integrated approach.
- Establish performance indicators and standards for activity that falls outside the remit of any one organisation. However, responsibility and agreement over tasks need to be agreed first, and the mechanisms must be clarified.

OBSTACLE: Trainers/tutors don't know others' systems or who to contact to make links to begin discussing coordinating provision.

STRATEGIES TO OVERCOME THIS OBSTACLE

- Provide information about educational systems and examples of good practice.
- Support local development programmes through national organisations to encourage linking up of programmes.
- Develop training for the trainers.
- Provide information to trainers and educators about each others systems.
- Provide annual information about programmes and trainers.

OBSTACLE: Interprofessional courses are hampered by the time consuming and complicated procedures required for the accreditation processes of each separate professional body.

STRATEGIES TO OVERCOME THIS OBSTACLE

- Encourage professional validating bodies to begin discussions together seeking agreement on common principles, approaches and a single agreed validation process. (Models could build on recent HEQC work on agreeing processes for quality assurance between healthcare professions and academic bodies.)
- Consider agreeing and jointly validating modules on collaborative expertise that all professions would undertake.
- Encourage professional bodies and courses to articulate clearly desired learning outcomes. This will enable opportunities for developing them jointly to be considered.

OBSTACLE: How to share the learning from local and pilot initiatives effectively with others and ensure joint trainers and enthusiasts for collaboration are supported and not isolated.

STRATEGIES TO OVERCOME THIS OBSTACLE

- Use trade journals/professional press to reach a wider audience than glossy reports do.
- Distribute information in appropriate user friendly formats proactively.
- Identify centres of excellence and share the learning.

9 conclusions

9.1 Four themes emerged as crucial in sustaining collaboration:

- the need to develop support for, interest in and skills of collaboration and knowledge of other professionals' systems, cultures and roles beginning from qualifying professional training.
- the need to offer regular locality workshops for practitioners on specific cases or practice themes. These collaborative development activities should be facilitated and attended by a mixed professional team and integrated with service provision as part of providing quality services. Management support is essential.
- the need to enable regular contact between practitioners and provide updated information about each other's roles, structures and services including contact points in appropriate formats.
- the need to ensure appropriate organisational structures and coordinated policies support developments.

9.2 It is necessary to go beyond pilots, to get developments into mainstream provision, to change structures and cultures. Whilst national policy guidelines would help, the responsibility for leading and ensuring the development of joint training lies primarily with local bodies. This responsibility must be clearly ascribed and plans must be agreed and supported by Social Service Departments, NHS purchasers and providers and joint commissioning bodies.

9.3 Developments are hindered by the frustration and weariness of middle managers and the disillusionment of practitioners. Joint trainers/facilitators feel isolated and want support and occasional opportunities to meet together and share ideas. General guidelines are useful but senior management encouragement is also needed to sustain the local developmental process.

9.4 Recent literature and conferences in the areas of mental health, carers support, primary health care, learning disability and child protection also call for linking of GPs and social workers and identify factors essential in sustaining collaboration.

Factors sustaining collaboration

- top down support for bottom up initiatives
- broad agreement on services
- shared values and service philosophy
- mutual trust and positive personal working relationships
- agreed priorities for action
- openness on finance
- willingness to transfer power while retaining accountability
- putting client outcomes above personal, professional, or organisational interests
- co-terminosity
- proximity and good information sharing
- interprofessional education from undergraduate level
- continuing professional development
- organisational support
- an integrated policy lead is necessary

9.5 These steps are difficult, take time and are hindered by contradictory policies which demand collaboration on the one hand and require competition on the other. There are no easy solutions. Nonetheless, training, education and development can play a key role.

9.6 Pilot projects are popular because it is time consuming and complex to develop an integrated approach and it is much easier to start with a small demonstration and evaluate it. Nonetheless, starting with small achievable steps can be helpful.

9.7 Central support for the coordination of education, training and development must continue. If government wants to promote and develop sustained collaboration it has to take a lead in encouraging and supporting this. It must help local initiatives with problems of resourcing and prioritising. Effective collaborative development will take time and serious commitment. Short term uncoordinated initiatives will not result in sustained collaboration.

Summary of suggestions for future action

- Hold a biannual workshop to support joint trainers and help them develop their skills and share experiences.
- Produce publications and hold regional workshops to bring social services trainers and GP tutors together. Offer suggestions for local joint continuing professional development activities. This will be most effective if supported by and undertaken in partnership with national bodies.
- Host a workshop (preceded by information gathering and sharing) for voluntary organisations to share their approach to encouraging collaboration and identify common themes and good practice approaches for training. Many are developing approaches and resources for a particular client group and experiences could usefully be shared.
- Share information about local initiatives and developments in shared learning and collaborative practice. Develop an information strategy and encourage the writing up and disseminating of material by identifying responsibility and helping with funding. This would proactively supplement the work of the Community Care Innovative Practices Database. Occasional regional workshops would facilitate discussion and enable debate on matters of common concern.
- Collect and evaluate the experiences of projects attaching social workers to primary health care centres and include users' views of whether and how collaboration and coordination improves service delivery for them. Effective dissemination of the findings is essential.
- Compile information from evaluations of the effectiveness of interprofessional education and shared learning initiatives in promoting collaboration and improved service for users, and develop more effective evaluative tools.
- Share information about and coordinate developments in Mental Health Facilitator projects, Local Organising Teams, Community Care, child protection and primary health care facilitation.
- Provide guidelines and resources to assist professional educators and trainers to adopt an interprofessional approach.

references

Armstrong, E. "Facilitators in Primary Care" in **International Review of Psychiatry (1992), No 4**, p 339 – 342

Audit Commission (1992) **The Community Revolution: Personal Social Services and Community Care** HMSO

Audit Commission (1992) **Community Care: Managing the Cascade of Change** HMSO

Baker, A. & Wilmer, M. (1995) **Agenda for Change** Institute of Health Services Management

Barnes, M. & Wistow, G. (1991) **Changing Relationships in Community Care** Nuffield Institute for Health Working Paper Number 3

Barr, H. & Shaw, I. (1995) **Shared Learning: Selected Examples from the Literature** CAIPE

Beresford, P. & Trevillion, S. (1995) **Developing Skills for Community Care: A collaborative approach** Arena

Braye, S. & Preston-Shoot, M. (1995), **Empowering Practice in Social Care** Open University Press

Burnes, B. (1992) **Managing Change** Pitman

Burns, T. & Stalker, D. (1961) **The Management of Innovation** Tavistock

Carers National Association (1995) **Working With Primary Care for Carers** CNA

Carnall,C. (1990) **Managing Change in Organisations** Prentice Hall

Carpenter, J. & Hewstone, M. (1995–in press) " Shared Learning for Doctors and Social Workers: An Evaluation" to be printed in the **British Journal of Social Work**. Presented at Conference on 22/3/95 at **CAIPE and in CAIPE Bulletin No 9 spring 1995**

Cartwright, A. & Anderson, R. (1981) **General Practice Revisited** Tavistock

CCETSW (1992) **Multidisciplinary Teamwork** CCETSW

Clare, A. & Corney, R. ed. (1982) **Social Work and Primary Health Care** Academic Press

Deacon, N. (1994) "Partners in Information" in **Community Care Management and Planning** Volume 2 Issue 5 October 1995. Longman

Department of Health (1993) **Training for the Future** HMSO

Department of Health (1994) **Implementing Caring for People: Training and Development** Health Publications Unit, Department of Health

Department of Health (1994) **Implementing Caring for People: The Role of the GP and Primary Healthcare Team** Health Publications Unit, Department of Health

Department of Health (1995) **An Introduction to Joint Commissioning** Department of Health

Developing Managers for Community Care Network (1993) **Involving General Practitioners Successfully** NHS Training Directorate

Developing Managers for Community Care (1993b) **Joint Commissioning Issues for Training and Development** NHS Training Directorate

Developing Managers for Community Care (1994) **Inter-agency Management Development Techniques** NHS Training Directorate

Dundee University (1993) Community Care Studies Programme – **Publications List**

Forman, J. & Fairbairn, E. (1968) **Social Casework in General Practice**

Goldberg, E. & Neill, J. (1972) **Social Work in General Practice** Allen & Unwin

Health and Social Policy Research Centre, University of Brighton (1994) **Preliminary Indications of the Impact on General Practice of the NHS and Community Care Act** Report Commissioned by the Royal College of General Practitioners Patients Liaison Group

Henwood, M. (1994) **Fit for Change? Snapshots of the Community Care Reforms One Year On** Nuffield Institute for Health and Kings Fund Centre

Hornby, S. (1993) **Collaborative Care: Interprofessional, Interagency and Interpersonal** Blackwell

Hudson, B. (1993) "Collaboration in Social Welfare: a framework for analysis" in Hills M. (ed) **The Policy Process: a Reader** Harvester Wheatsheaf

Hume, S. & Sharples, A. (1995) **A Study Which Explores the Education and Training Needs of the Emerging 'New Professionals' in Community Care** Institute of Health and Community Studies, University of Bournemouth

Huntingdon, J. (1981) **Social Work and General Medical Practice** Allen & Unwin

Jeffreys, M. & Sachs, H. (1983) **Rethinking General Practice** Tavistock

Khan, A. (1995) "Doctors, Social Workers and Community Care" in **Professional Social Work** February 1995 BASW

Leathard, A. ed. (1994) **Going Interprofessional** Routledge

Leedham, I. & Wistow, G. (1992) **Community Care and General Practitioners** Nuffield Institute of Health Working Paper

Leedham, I. (1994) **Community Care and GPs' Development Pack** Nuffield Institute

Lloyd, M., Webb, S. & Singh, S. (1995) **General Practitioners and the Community Care Reforms** Royal Free Hospital School of Medicine

Malin, N. ed (1994) **Implementing Community Care** Open University Press

Murphy, M. (1995) **Working Together in Child Protection** Arena

Naish, J. & Benaim, R. (1995) **Putting Carers onto the Agenda in General Practice** Academic Department of General Practice and Primary Care, St. Bartholomew's and London Hospitals

NHSTD & SSI (1993) **Managing Services in Partnership** NHS Training Directorate

NHSTD (1994) DMCC **Directory of Projects**

NISW Practice and Development Exchange (1993) **Empowerment, Assessment, Care Management and the Skilled Worker** HMSO

Ovretveit, J. (1994) **Integrated Commissioning for Health** Brunel Health & Social Services Management Programme

Ovretveit, J. (1993) **Coordinating Community Care** Open University Press

Owens, P., Carrier, J. & Horder, J. (1994) **Interprofessional Issues in Community and Primary Health Care** Macmillan

Plant, R. (1987) **Managing Change and Making It Stick** Fontana

Prins, H. & Whyte, M. (1972) **Social Work and Medical Practice** Pergamon

Rowbottom, R. & Hey, A. (1976) "Collaboration between Health and Social Services" in Jacques, E. ed. **Health Services** Heinemann

Saunders, L. & Hayes, R. (1993) **Study of GP Practices and Multiple Social Service Localities within Surrey** South Thames Regional Health Authority

Shaw, I. (1994). **General Practitioners, Social Workers and Community Care** End of Funding Report of Project funded by Nuffield Foundation Social Sciences Small Grants

Smith, R. et al (1993) **Working Together for Better Community Care** SAUS

Soothill, K., Mackay, L. & Webb, C. (1995) **Interprofessional Relations in Health Care** Edward Arnold

Spratley, J. & Pietroni, M. (1994) **Creative Collaboration: Interprofessional learning priorities in primary health and community care** Marylebone Centre Trust

Tope, R. (1994) "Integrated Interdisciplinary Learning Between the Health and Social Care Professions: A Feasibility Study." A **PhD Thesis** available through InterLibrary Loans from the School of Education Library, UWCC, Cardiff Synopsis in **CAIPE Bulletin No 8 autumn 1994**

Trevillion, S. (1992) **Caring in the Community: a networking Approach** Longman

Vallance-Owen, Dr. A. (BMA spokesman) "National Standards" Article in **DMCC Programme Bulletin August 1994**

Warner, N. (1994) **Community Care: Just a Fairy Tale** Carers National Association Report

Weinstein, J (1994) **Sewing the Seams for a Seamless Service** CCETSW

Whittington, C., Bell, L. & Holland, R. (1994) **Learning for Organisational and Interorganisational Competence in Social Work** Summary Paper Nine. Kings College and CCETSW

Yee, L. & Blunden, R. (1995) **General Practice and Carers: Scope for Change?** Kings Fund Centre

Younghusband, E. (1959) **Report of the Working Party on Social Workers** HMSO

appendix

Questionnaires Completed

Stage 1

55 Warwickshire Community Care Development Project Participants

5 key people from relevant organisations

Stage 2

5 students from UCE Postgraduate Dip/MSc in Collaborative Community Care

11 Joint Trainers from trainers known to DMCC

13 practitioners and managers from joint projects known to the DMCC and Nuffield Community Care Innovative Practices Database

Reports Scrutinised

1. Birmingham Community Care Project Interagency Training Programme Report March 1993
2. Community Care in Gateshead: The First Three Months – Report on Survey of GPs September 1993
3. Continuing Professional Development for General Practitioners and Primary Health Care Teams in Liverpool September 1994
4. Derbyshire Joint Community Care Training Strategy 1995/6
5. Inter-Agency Patch Training Report – Gwynedd July 1994
6. Learning Together Summary of Points Made at the DMCC Event held in Birmingham July 1994
7. Liverpool Primary Health Care Facilitation Project May 1994
8. Multidisciplinary Team Workshop Programme by Primary Health Care Unit of the HEA 1993
9. Network Group in South Glamorgan Report on Conference "Healthcare at Home" plus note on future plans November 1994
10. North and South Warwickshire Community Care Development Project Interim Report August 1994
11. Northumberland Developments. Described in an article entitled "Where Joint Approach Unites the Professions" by D. Parkin in Care Plan September 1994
12. Partnerships for Change – Report of a research project to create a framework for action for the development of GPs and Primary Care Teams by Bromley Health and East Sussex FHSA September 1994
13. Putting Theory into Practice – Attitudes and Involvement of GPs in West Berkshire Joint Community Care Training May 1994
14. Revolution and Evolution: Continuing Medical Education for GPs in North Thames Dr Burton 1994
15. City of Salford Papers on Practice Agreements with Social Services
16. Staffordshire Social Services Department Community Care Training Initiative Project Outline February 1995
17. A Swedish Model of Medical and Interprofessional Education and Linkoping University Curriculum Papers CAIPE April 1994
18. Tayside Shared Learning Opportunities Group. Report of Mutidisciplinary Workshop on "Care in the Community" November 1994
19. The Upton Project. Hereford and Worcester FHSA Evaluation of the placement of a social worker in the primary healthcare team February 1994
20. West Sussex Joint Agencies Community Care Training Initiative Training and Development in 1994/95
21. Wiltshire County Council Social Services Training Plan and Programme for 1994/95

Interviews Conducted

Derek Churchman, Birmingham FHSA (telephone)

Giles Darvill, NISW

Paul Fallon, Gateshead FHSA

Elaine Fullard, National Facilitator Development Project

Professor George, Chairman, Education Committee General Medical Council

Susan Gooding, Primary Health Care Unit, Health Education Authority

Paul Gorman, DMCC

Ian Leedham, Nuffield Institute of Health

Dr Margaret Lloyd, Royal Free Hospital Dept of General Practice

Glenys Marriott, Cheshire FHSA

Dr John Moss, University of Adelaide Australia

Gerald Smalle NISW (telephone)

Andy Stephens, Community Care Programme, CCETSW

Dr Paul Thomas, Liverpool Primary Health Care Facilitation Project

Seminars arranged as part of the project

1. In London on 15 /11/94. Attended by representatives from the Kings Fund; BASW Community Care group; CCETSW; the RCGP Commission; the HEA Primary Health Care Unit; a London Health Authority; a London FHSA; a Community Care joint trainer ; an ADSS representative; and an Interagency Training Forum.
2. In Warwick on 2/12/94. Attended by project facilitator for the north of the county; Chairman of the steering group of the south of the county; representative from Social Services and the FHSA and GP Regional Adviser.
3. In Birmingham on 30/1/95 with some 10 students undertaking the UCE Postgraduate Diploma/MSc in Collaborative Community Care.
4. In London on 22/2/95. Attended by a JPTI development worker; a social work lecturer; a community care lecturer; a lecturer from a Dept. of General Practice; and a medical curriculum change facilitator.
5. In London on 22/2/95. Attended by JPTI worker; community care training coordinator from a London Borough; a GP Associate Adviser; a GP; a GP Tutor; a representative of a London Interagency Training Forum; a lecturer from a university interprofessional course; and a voluntary organisation representative.
6. In London on 28/2/95. Attended by a Dept. of General Practice lecturer; an FHSA Training Manager; an Education Development Adviser from AMGP, a Training Coordinator from a large voluntary organisation; a GMC Education Committee representative; a CCETSW representative and a mental health trust development worker.

CAIPE

Published by CAIPE
344 Gray's Inn Road
London WC1X 8BP

© **CAIPE**
February 1996

ISBN 0 9520830 35