UNIVERSITY OF SOUTHAMPTON

Multiprofessional Education and Teamwork in NHS Primary Care Services

by Neil W J Brown

Doctor of Education Thesis

SCHOOL OF EDUCATION
FACULTY OF LAW, ARTS AND SOCIAL SCIENCES

July 2005

Acknowledgements

I would like to acknowledge grateful thanks to my supervisor
Dr Jane Seale for her excellent encouragement, advice and support
together with Professor Helen Simons.

Also my thanks go to all the respondents that graciously gave their time
and commitment to completing the questionnaire and for those that kindly
participated in the interview stages of the study.

Last but not least I wish to thank my family for putting up with me being
most unsociable, locked away in my study, when I could have been
enjoying precious time with them.

Thank you.

University of Southampton

ABSTRACT

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This thesis is presented as a mixed methods case study of the perceptions of primary care professionals in relation to two key objectives. Firstly to establish key stakeholders' perceptions of the existing culture and change processes required to deliver effective multiprofessional education and teamwork in NHS primary care services and secondly, to gain key stakeholders' vision for the future of workforce and staff development to ensure effective teamworking for the delivery of patient care.

The setting for the study focussed upon primary care services delivered within two NHS primary care organisations in the South East of England and the majority of respondents were primary health care practitioners working within these two organisational settings. In addition key interviewees were selected on the basis of their knowledge, experience and roles they performed in relation to context of this study. This study produced several conclusions. There was a need to move towards a common or shared culture which would require the blurring or breaking down of existing uniprofessional barriers and development of 'inter-professional trust' together with the implementation of an organisation wide learning culture.

Failures in collaboration and teamwork can also be linked to inappropriate or lack of communication between professional groups. Evidence also supports the requirement to implement organisation wide staff appraisal and individual training development planning. Workforce Development Confederation (WDC) Planning needs to be fully integrated within the context of local Primary Care Trusts (PCTs) and Higher Education establishments at both under-graduate and post- graduate levels to assist in the delivery of the correct common learning syllabi, skill mix and skills escalator training requirements for primary care services. Power sharing in primary care team settings was a particular requirement in the move towards true team collaboration and trust. The need to modernise the traditional role, whereby the GP has acted as 'gatekeeper' in the primary care setting, towards making more effective use of all other members of the primary healthcare team was found to be critical. Educational integration and convergence of primary care professions is also supported in the evidence gained by the study and key recommendations were made to introduce a new breed of *Primary Care Practitioner* together with structural changes to implement a new *Royal College of Primary Care* and a new *Allied Health Professional Body.*

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CHAPTER ONE-INTRODUCTION

Chapter One provides a succinct statement of the argument, introduction and the context upon which this research thesis has been undertaken. The aim of this chapter is to highlight the specific issues that influenced the shaping of this research and to provide a brief historical background and orientation for the study together with the description of the two overarching research objectives;

Chapter Two provides a review of the literature that contains particular relevance to the overarching objectives of the study and enabled the formulation of the key research questions;

Chapter Three presents the methods utilised during the study and provides a detailed analysis of the principles, procedures employed together with a reflexive account of the principles and procedures that were undertaken;

Chapters Four and Five provide the analysis and interpretation of the data that was collected through the questionnaire stage of the research involving 166 respondents spanning sixteen primary care health professional groups and semi-structured interview process with twelve key stakeholders;

Chapter Six draws together all the key aspects of the research and delivers the conclusions that are supported by the evidence presented in the case.
Finally, the main recommendations are set out together with proposals for future research in the field of study.

1.1 Statement of the Argument

In this thesis the researcher will argue that:

1. In order to increase the effectiveness of primary care services, the different professional groups that operate within primary care need to develop a more collaborative, team-based approach to their work;

2. The development of a more collaborative team-based approach to service delivery in primary care will require an extensive change in culture;

3. The necessary changes in culture that are required can be brought about by:

    a. Promotion of professional adulthood for all professions that work within primary care.
    b. Development of new models of workforce planning, training and development.
    c. The establishment of a Royal College of Primary Care and unified Allied Health Professional Body.
    d. The introduction of a new breed of Primary Care Practitioner.

4. The promotion of professional adulthood in primary care can be brought about by primary care staff becoming confident of their professional identity and core expertise, with the deferment of individual professional autonomy, and discontinuation of the historic tribal attitudes towards perceived status and values inherent within specific professional groups. A strong sense of team identity is key to this confidence;

5. New models of workforce planning, training and development will need to involve a paradigm shift in the culture of professional education, training and development and indeed in the conventional ideas relating to professional career pathways. Traditional uniprofessional models of education, training and

development greatly control and constrict the way in which professionals adjust to the innovations of change. The restrictiveness of the conventional model, favourably adopted by medicine, and historically pursued by related primary care health professions, is an inadequate and unsatisfactory model. This has heralded the need for a proactive relationship between educational evolution alongside the aspirations for the evolution of the primary care led health service in the UK;

6. The establishment of a Royal College of Primary Care and a unified Allied Health Professional Body will support the fundamental challenges to the traditional cultural patterns of professional dominance, particularly in relation to that of decision- making and resource allocation. The autonomy of monoprofessional Royal Colleges and monoprofessional Bodies has historically also dictated and administered the agenda for professional training, education and development. This has been of critical importance in introducing, maintaining and guarding the ongoing culture of tribalistic professional attitudes and issues of power and status within primary care;

7. The introduction of a new breed of Primary Care Practitioner delivers the opportunity for role substitution, innovation and professional boundary changes to be implemented for the benefit of patient centred care. The cultural differences between the primary care professions, particularly the anomalies in relation to professional power and status, have had and continue to have significant importance for the success or otherwise in implementing a primary care agenda, where the prominence is upon cooperation, collaboration and partnership through the effective multiprofessional team. The new Primary Care Practitioner will facilitate the cultural changes required.

1.2 Definition of Primary Care

Primary care is a substantial element of the entire healthcare delivery system of the United Kingdom. The way in which primary care interacts with secondary and tertiary care varies from country to country. The United Kingdom's system of primary care has been delivered through a co-ordinating role with the general practitioner (GP) who has historically acted as 'gatekeeper' and by which the GP has had substantial control upon onward access to other elements of the UK healthcare delivery system. A prescription or referral by the GP is required for the patient to access diagnostic services, specialists or hospital- based services. As a comparison, in other countries such as France and Germany, patients have the choice as to whether or not they visit a GP or refer themselves directly to another specialist in the primary care setting or indeed secondary or tertiary care specialist practitioner (Zayed and Manning, 1995).

Primary care is the population's initial point of contact with Health Services, and provides a broad multidisciplinary approach. In the United Kingdom, primary care has been centralised within the arena of general practice and as a direct consequence the prevailing 'domineer' is the General Practitioner. Historically, the Primary Care Practice Team had consisted of a GP/partner(s) together with clerical /administrative support. District nurse or Health Visitor staff were initially employed by the local authority and more recently by the NHS. The development of a range of NHS professional groups now working within primary care settings also include:

- Chiropodist/Podiatrist;
- Dietician;
- Dentist/Dental Surgeon;
- Occupational Therapist;
- Pharmacist;
- Social Worker;
- Practice Manager;
- Speech Therapist;
- Clinical Psychologist;

- Nurse-Schools;
- Nurse-Practice;
- Nurse-Community;
- Physiotherapist.

There has not been universal or country- wide agreement on how best to define primary care healthcare services. According to Duggan (1995, p. 24) and for the purpose of this research study, primary care can be differentiated from other forms of health care provision on the basis that it is required to deliver:

- The first point of contact for the individual seeking help or advice about a health-related problem or condition;
- Direct access for the individual;
- Care for the whole person, not just the immediate problem or condition;
- A continuing relationship (usually with intermittent contact) between the individual and the provider;
- Co-ordinated care, providing a gateway to a range of other services;
- Care delivered by highly trained generalists backed up by a growing range of community based specialists;
- A network of community based health services, which is linked in turn to a much wider social care network.

All primary care team members undertake a key role in improving health for all and consequently the development of primary care will lead towards the need for improved team-working and collaboration. Three main areas of relevance to primary care have emerged from recent policy directives from the Department of Health:

1. Better team working;
2. Developing professional roles;
3. Partnership with health authorities, secondary care and local authorities. (Department of Health, Primary Care: Delivering The Future,1996).

1.3 Definition of Multiprofessional Education

Multiprofessional teamwork and the development of multiprofessional education has gained significant interest within the NHS context over the last 15 years. Miller et al (2001) suggest this has largely been due to the effects of recent changes in the delivery of care and the subsequent inferences that these changes have to healthcare professions and education. The key legislatory document prompting these changes was the ' National Health Service and Community Care Act' (DOH, 1990, London, HMSO). This legislation created independent hospital trusts and separate community trusts together with the introduction of GP fundholders. The shift in focus through the legislation and subsequent government white paper proposals has been to increase the amount of care delivered within the community setting together with a greater emphasis on multiprofessional service delivery. The successful collaboration between health and social care professions has and continues to play a central theme in supporting this shift from secondary and institutional care into the community. The promotion of multiprofessional education and training (MPE) is an important element in successfully achieving these developments (Pierce and Weinstein, 2000, p.205). According to the United Kingdom Centre for the Advancement of Interprofessional Education (CAIPE) and for the purpose of this research study, multiprofessional education has been defined as:

> *'Occasions when two or more professions learn side by side for whatever reason'.* (CAIPE, 1997).

1.4 Multiprofessional and Team Relationships and the Primary Care

The value of the team relationship in primary health care has been seen to occupy an ever more important place within health service policy. There has been considerable research undertaken in this area, which supports the concept that effective team working is of prime importance (Dieleman et al. 2004). Anecdotal evidence still suggests that there are considerable tensions and lack of trust between individual professional groups in NHS primary care services. Within the literature there are examples of good NHS team working initiatives (Pethybridge, 2004; Bateman et al. 2003), however, there is also considerable research evidence in the literature that

suggests primary care providers have a particularly difficult time in delivering their services in the context of good team working (Ross et al, 2000; Gulliver et al, 2002; Williams and Laungani, 1999). The evidence for poor team working specifies poor communication, medical dominance and issues related to group hierarchy and status, professional autonomy and inability to transcend professional boundaries together with inequalities in pay and conditions. The introduction of the recent Clinical Governance (CG), Continuing Professional Development (CPD) agendas together with national policies (Department of Health, 2000a, 2001 and 2002) support the development of interprofessional teams for the provision of responsive care. Primary care providers must facilitate the appropriate cultural, change and training processes to effectively provide the quality required for service delivery. The document, Primary Care: Delivering The Future (Department of Health, 1996) highlighted the key philosophies underpinning primary health care. Effective team working is seen as critical both in terms of providing high quality patient care and in delivering the professional development necessary to meet the needs of the patients.

One of the most significant policy changes in recent years has been the support for the strategic shift of resources from secondary to primary care (primary care led) and therefore there is an increased importance for development in this service setting. A number of new roles have resulted which has impacted directly upon the historical view that the GP is the gatekeeper of resources and the lead professional within primary care, for example: extended roles of nurse practitioners, consultant grades for nursing and allied health professionals and the introduction of prescribing responsibilities for nursing and allied health professionals. The role of the community pharmacist is also currently being reviewed since there is recognition that they have the potential to improve care provision to patients and support the implementation of targets set out within national service frameworks (Department of Health, 2000a, p58). Overall the emphasis, from a policy perspective, is now on the role that professional development can play in the delivery of the government's overall strategy for the health service and how this can translate into defined outcomes at an organisational level. The historical concept whereby the professional was traditionally restrained within the envelope of a specific framework or boundary has now the political support to be challenged.

In 1981 a report carried out under the auspices of the Department of Health and Social Security defined the primary health care team as:

> *'An independent group of medical practitioners, secretaries, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understands his/her function and those of other members, so that all pool skills and knowledge to provide an effective primary health care service'.* (The Harding Committee Report-Department of Health & Social Security, 1981, p.14).

Work undertaken by Pearson and Spencer (1997) and Ovretveit (1993) suggests that if practitioners do work as independently as the Harding Committee indicates it is difficult to develop a shared understanding and acceptance of what the common purposes and responsibilities might be. Teamwork however, strives to deliver optimum outcomes than would otherwise have been achieved if individuals worked in isolation. The optimism of the members of the Harding Committee, written 24 years ago, that primary health care team players *'clearly understand his/her own function and those of other members of the team'* is a key focus of this study.

1.5 Culture, Change and Staff Development

The culture of Primary Care will be shaped by several factors, which will include the changes in patients' expectations of primary care service delivery. The wide range of professional groups now functioning within primary care will have implications for professionalization and how these individual professional groups interact and respond to the changing NHS environment. The NHS organization structural changes will also have an impact both in terms of the new culture and multiprofessional working practices.

For the purposes of the research questionnaire used in this study the following succinct definition was used to provide a baseline definition of culture for the respondents:

'The customary or traditional ways of thinking or doing things which are shared to a greater or lesser extent by all members of the organisation and which new members must learn and at least partially accept in order to be accepted into the service'. (Mekk, 1988, p.454).

The power distribution within the primary health care team is changing and the patients' needs should be the central focus of that change. The traditional model where the GP was primarily the singular professional in primary care towards the model where multiprofessionalism and teamworking is the norm needs to be considered in relation to how professional education and staff development should be undertaken.

1.6 Workforce Planning

The historical anomalies of resource allocation between secondary and primary care and within different professional groups have implications over potential inadequacies of the existing workforce planning processes together with competing professional self-interests. Historically however:

'The majority of resources within the health service flowed between health authorities and secondary care trusts, those within primary care were junior partners in this relationship'. (Starey, 2003, p.49).

'The core primary health care team can be loosely defined as GPs, primary care nurses, other professional staff and administrative support...not all these services are provided on an equitable basis to practices and localities'.
(Meads, 1996, p.56).

It is possible that these disparities have been exacerbated by medical dominance at the expense of the interprofessional concept of primary health care service delivery. The workforce planning and educational funding processes should be grounded in a patient centred approach to the allocation of resources with a shift away from several mono/uniprofessional parallel tracks of workforce planning towards an integrated process of multiprofessional planning which ultimately leads to producing the same

mix of professional role outputs and undermines innovations in role developments. The basis for this argument is supported by Kendall and Lissauer (2003) who suggest that:

> *'Workforce planning is still based on the process of identifying gaps in the number of existing practitioners, rather than on assessing what types of practitioners with which sorts of skills are necessary to meet the needs of the local population now and in the future'.* (Kendall and Lissauer, 2003, p.73).

1.7 Organisational Context

The research was undertaken within the setting of two Primary Care Trusts (PCTs) in the South East of England. For reasons of confidentiality and anonymity these primary care organisations will not be named.

'Trust A 'was established in October 2000 (as a *level 4* PCT - enabling both commissioning and operational service delivery with the direct employment of the PCT's own staff) and included 116 General Practitioners based within 37 locations throughout the localities and served a population of around 230,000 people. It was one of the largest and first PCTs to be commissioned in the country at the time the research data was collected. As part of this transition process, primary care staff were originally employed in *'NHS Trust B'* until the newly formed PCT attained a 'level 4 status' in order to transfer staff under their direct employment .

'NHS Trust B' formed in April 1998 as part of the merger of two trusts. The service location covered a population of approximately 500,000 with an overall staffing establishment of around 2,700. In April 2002 (several months after the field research was completed for this study) *'NHS Trust B'* was disbanded and was merged to form another NHS organisation.

It needs to be borne in mind that NHS structural changes were particularly active in primary care services at and around the time at which this research study was undertaken. This fact has been considered within the context of the conclusions of this thesis since the adjustments to new organisational structures will have a bearing on

both the culture and the perception of roles and team working relationships **(see Section: 3.17)**.

The area serviced by these organisations includes a rich diversity of communities ranging from re-developing urban areas to rural hamlets. Between 2000-2010 the local population was expected to change quite significantly with a rise by a third in the number of middle-aged adults and a significant increase in the number of the elderly (Data taken from local Health Improvement Plan-not referenced in order to maintain anonymity).

1.8 Purpose of this Study and Overarching Research Objectives

Primary care is centre stage in the NHS plans for modernization and the future of the NHS. The roles and team skill mix is a key area that can be supported to develop but will require innovation and leadership not just from the political and managerial areas but also education providers and the professional team members themselves. Better team working is essential for improving primary care and developing professional knowledge through the undergraduate, postgraduate and continuing education and training processes with a greater emphasis on the talents of the whole team.
The specific issues highlighted in this chapter enabled two overarching research objectives to be worked up and provided a framework upon which the research strategy was to be developed and key research questions ascertained.

The overarching objectives of this study are therefore to:

- To establish 'key stakeholders' perceptions of the existing culture and change processes required for the delivery of effective multiprofessional education and teamwork in NHS primary care services;

- To gain 'key stakeholders' vision for the future of workforce and staff development to ensure effective teamworking for the delivery of patient care.

CHAPTER TWO-LITERATURE REVIEW

2. Overview

The purpose of this chapter is to identify from the literature key characteristics of the culture and change processes required to deliver effective multiprofessional education and teamworking within the context of the NHS Primary Care Trust setting, as outlined in Chapter One. The review also includes a consideration of the key issues of workforce planning and staff development. The literature has provided an essential component to the research study and enabled a series of key research questions to be formulated to guide the study, which are linked to the objectives.

2.1 Historical and Cultural Changes in General Practice and Primary Care

Introduction

The historical changes in general practice and primary care needs to be perceived in order to appreciate more fully the emergence and shaping of contemporary trends in the culture of primary health care services. The understanding of the core values, beliefs and ideas within primary care is contingent upon a number of factors linked to the differential histories and the development of doctors, nurses and allied health professionals working in primary care. In this section the salient historical changes will be considered together with the key cultural issues that have emerged as a result of these changes.

2.1.1 Historical changes

General Practitioners (GPs) and their incumbent status can be followed back in the UK to the 18th and 19th centuries. The Apothecaries Act of 1815 began a regular system of examinations for people intending to set up as family doctors. In the 190 years since that Act four developments have substantially improved the family doctor's resources:

- The family doctor (GP) has become much better trained;

- A series of inventions and scientific breakthroughs has provided him/her with improved technology and reliable diagnostic instruments and tests;
- In the last 70 years effective drugs have been discovered for fighting disease;
- A team of highly trained health care practitioners has been developed in the context of the primary care setting to work alongside GPs.

The improvements in family doctor training resulted directly from the examinations run by the Society of Apothecaries. Soon private medical schools were introduced to prepare candidates. These were subsequently absorbed by medical schools at hospitals and at the new universities, which sprang up in London and other cities during the nineteenth century. The Medical Act of 1858 was passed to bring about more uniformity in the standards required to pass the examinations. This Act established the General Council of Medical Education and Registration (now known as the General Medical Council (GMC).

The formulation of the 'healing' practitioners into the explicit professional groups of apothecaries, physicians, and surgeons and resulted in the formation of the British Medical Association (BMA). The basic standards required for medical qualification and subsequent practice were set and monitored by the BMA (Allsop, 1984).

The 1920 'Dawson Report' along with the 'Family Doctor Charter' (British Medical Association) introduced in 1965, has been integral to forming the structure of primary care and the development of nursing within the primary care setting. This charter also introduced innovative financial reimbursement processes for the employment of practice staff and ancillary workers within the practice setting. This milestone can be seen as the benchmark in the development of the primary health care team.

The NHS was established in 1948 and patients were able to register with one GP. The GP was the central contact point or 'gatekeeper' for patients to gain access to other medical specialities and medical or surgical resources. GPs successfully negotiated a contract with the NHS (Independent Contractor) in order to ensure their independence from the hospital specialities and from other health care disciplines This independent contractor status was further supported by vocational and quality standards set by both

the British Medical Association in 1965 and the Royal College of General Practitioners in 1972, with the prime focus upon maintaining individual clinical freedom in the GPs delivery of care to their patients (Gorden and Pampling, 1996).

NHS organizational changes introduced in 1974 transferred employment of community nurses and allied health professionals from local authorities into the employment of the National Health Service. The Harding Report produced by the Department of Health and Social Security in 1981 underlined the inimitable help afforded by nursing in delivering the desired quality of care within a service with spiraling costs. The suggestion of greater collaboration in relation to the doctor-nurse relationship was espoused. This tenet was not supported in further policy changes proposed in the 1980s. In particular, the Cumberlege Report (Department of Health and Social Security, 1986) was suggesting fragmentation of the existing poor working relationships between GPs and community nurses (Jones, 1992) and advocated that practice nurses should be within NHS nursing teams where their training and development could be more appropriately supervised and their services better integrated with those of other community nurses in a patch based system (Williams, 2000, p. 23).

The eighties and nineties saw continued NHS reforms, which according to commentators such as Chris Ham (1992), the like of which had not been observed since the birth of the health service in 1948. These changes related to both financial and structural frameworks. The White Papers 'Promoting Better Health' (Department of Health and Social Security, 1987), 'Working for Patients' (DOH, 1989), 'NHS and Community Care Act (DOH, 1989) together with the revised GP contract (Department of Health, 1989) introduced a more prescriptive work regime for GPs.

> *'The stated aims of the changes were to raise standards of health and health care, to place greater emphasis on health promotion and disease prevention, and to offer wider choice and information to patients. A key element in the changes was the introduction of new contracts for GPs and dentists'.*
> (Ham, 1992, p.52).

This revised GP contract required GPs to be compliant to a new way of working that, should it be disregarded, would substantially reduce their practice income (Department of Health, 1989). Following on from this, in 1991, the then conservative government led by Margaret Thatcher, introduced GP fundholding and the 'internal market'. GPs retained their 'providers' of health services status but combined this role with the added remit of becoming the 'purchasers' of other health service elements. This 'fundholding' role proposed to reduce the power of hospitals and at the same time increase the power base of GPs by internal market forces, most notably competition. The competitive nature would seek to improve efficiency between providers. Fundholding was eventually abolished in 1999.

As part of the new labour government's reflection on what had worked well through fundholding, the continuation of the primary care led agenda was built upon and developed within the context of the Personal Medical Services. In 1997 the Personal Medical Services (PMS) Pilot reforms were commissioned by the Department of Health (DoH, 1997a). This was an attempt to deregulate the existing mechanism to deliver primary care services by general practitioners.

Following the NHS White paper 'The New NHS: modern, dependable' (DoH, 1997b) the new Labour government established Primary Care Groups (PCGs). These were seen to herald, according to Starey (2003), a much more corporate approach to the primary care sector.

The New NHS modernisation agenda, through the mechanism of a new General Medical Services contract (GMS), was established for review and implementation (Department of Health, 2003). Successive government policy implementations have sought to address this perceived lack of accountability, which has historically been maintained by general practitioners and a failure to deliver improvements in the quality of clinical care across all practices. This new GMS contract has been implemented between the primary care trust and the primary care provider as opposed to an individual contract with each GP.

A provider in this context can be defined as:

- A single handed practice;
- A group practice;
- A group of practices working together as one;
- An alternative provider.

(NHS Modernisation Agency, 2003, p.4).

This new contract has a number of key implications that have relevance to the way in which primary care services have and are developing. The new contract is practice based and frontline nurses (PCT Lead Nurses) initially are able to extend their interests from a clinical perspective towards a more business-focused interest if that is their wish, thereby supporting a more strategically orientated role within primary care. This contract aspires to facilitate their partnership in the practice, provided at least one GP is a signatory to that contract. This 'team based' approach has the potential to facilitate more effective utilisation of skill mix within the practice and lead subsequently towards better patient focused services and access to more appropriate interprofessional and multiprofessional education and training.

2.1.2 Cultural issues that have emerged as a result of these historical changes

The contemporary proposal to introduce a 'culture' of the wider team approach in primary care settings can be seen as a trigger factor that views other professions as key instruments in delivering primary health care. The following fourteen central cultural issues have developed as a result of the historical changes:

- The student occupational culture;
- The GP professional culture;
- The medical model culture;
- In search of an 'audit and performance accountability' culture;
- The internal market culture;
- Cultural conflict in the wider primary care team;
- Professional cultural ideologies and philosophies;
- Seeking a culture of a multiprofessional team;

- Seeking a culture of partnership and integrated service delivery;
- Change in role cultures;
- Cultural innovations in service delivery;
- The contemporary professional tribal culture;
- The contemporary teamwork culture;
- The need for an overarching multiprofessional team culture.

Each of these cultural issues will now be considered:

The student occupational culture

In the nineteenth century, according to Abel-Smith (1982), both the medical and nursing professions evolved separately due to reasons that were bound up with class divisions, gender barriers and the prevailing cultural codes of Victorian Britain. Distinct occupational cultures were acquired by students during their training years:

> *'The education of the members of the medical profession is a set of planned and unplanned experiences by which laymen, usually young and acquainted with the prevailing lay medical culture, become possessed of some part of the technical and scientific medical culture of the professions'.*
> (Hughes, 1956, p.23).

The GP professional culture

The GP professional culture, as independent practitioner, was given further credibility by the vocational training and quality standards set both by the British Medical Association in 1965 and by the Royal College of General Practitioners in 1972. The concept of maintaining independent contractor status has and still is a key argument by the GP profession and Royal College of General Practitioners as necessary to retaining the GPs clinical freedom, both culturally and managerially at arms length from the NHS policies and monitoring requirements. Gordon and Pampling, writing in 1996, drew attention to the fact that this entrenchment over maintaining clinical freedom has led towards considerable variation in standards of GP practice.

Independent autonomy is also an argument that is used by other professional groups and professional bodies to maintain their professional status, although it is only the GP profession that has achieved 'independent contractor' status in the context of the primary care team setting.

The medical model culture

Nursing, in the form of health advice and health promotion activities was a particular example of widening the team approach in the late eighties. The view held by GPs was that they could delegate these duties and continue to lead the 'medical model' of service that they had always undertaken, namely diagnosis and disease management. The outcome was that whilst other primary care professions undertook role and responsibility changes the GPs did not perceive a requirement to change (Wilson, 2000). These 'health promotion clinics' as they became known, added financial incentives and provided the impetus to enable GPs to employ increased levels of practice nurses to facilitate the achievements of the health promotion targets set by the government. It also provided the financial and structural flexibility to directly employ practice nurses to undertake these tasks. Department of Health monitoring data (1990) confirms that there was an overall increase in nursing staff at the time from approximately 3,500 in 1983 to approximately 17,500 in 1990 (Wilson, 2000).

In search of an 'audit and performance accountability' culture

In January 1989 the White Paper 'Working for Patients' (Department of Health) together with other key policy documents were published and numerous cultural themes were established that required more wide ranging structural changes and service delivery changes to be introduced:

> *'...an important theme in the White Paper was the need for doctors to become more accountable for their performance...considerable emphasis was also placed on the involvement of doctors and nurses in management through an extension of the resource management initiative, and on making medical audit a routine part of clinical work'* (Ham 1992, p.178).

The desired 'audit and performance accountability' culture cited in the 'Working for Patients' White Paper (Department of Health, 1989) never materialized, primarily because, months after its publication, the Royal College of General Practitioners sought to recapture the initiative and produced their own audit guidelines which created and reinforced a 'medical' model of medical audit. This has relevance in relation to professional accountability since the 'Working for Patients' audit, had it gone ahead, would have included overall team performance. However, the power base and vested interests of the Royal College prevailed:

> *'A version of audit, which has kept it as a non- threatening activity, carried out only by doctors and rigorously protected from public gaze'.*
> (Harrison & Pollitt, 1995, p.101).

The medical audit was composed of six predominant features, namely:

> *-Only doctors should conduct audit;*
> *-Its main purpose should be educational and developmental, not regulatory or judgemental;*
> *-Participation should be voluntary and non-attendance should not be penalized;*
> *-Standards should be set locally-by participating doctors;*
> *-Absolute confidentiality should prevail;*
> *-Where doctors regularly fell short of locally determined standards this should be dealt with by medical peers, not as a management problem.*
> (Harrison and Pollitt, 1995, p.101).

The internal market culture

Another key cultural theme was the new health care 'internal market' generated by the purchaser/provider split and introduction of GP fund-holding in 1991. The effect was also to increase the GP 'gatekeeper' role (Dowling, 2000) and status of the GP as an independent contractor.

As a result of GP fund-holding, the new labour government was faced with a dilemma, since numerous GPs had committed themselves to the culture imposed by the internal market, and that there was a substantial belief that:

> *'The purchaser-provider split, including fund-holding, had brought some important benefits to the wider NHS, in particular new services in primary care, improved efficiency and savings, and some improvements to access to specialist services'.* (Dowling and Glendinning, 2003, pp.13).

Cultural conflict in the wider primary care team

These cultural changes also led to another increase in the make up and skill mix of the primary health care team with allied health professionals, alternative/complimentary health specialists, psychology and counselling specialists plus fund-holding managers together with a mix of information management personnel. The flexibility provided by GP fund-holding, meant that GP practices could either directly employ or set specific fixed term contracts for the delivery of the full range of primary care services. The end result was to greatly expand the range of multidisciplinary activities but without any consideration of addressing the poor professional relationships between the multitude of primary care professions now working at closer proximity than ever had been experienced before. The poor working relationships related to a lack of multiprofessional working practices and weak communication between professional bodies and groups, particularly between the GP and the nursing profession (Stanley & Hatcher, 1992). This situation compounded the difficulties of hierarchical team working and professional tribalism and reinforced the GP as leader of the team, since the GP was the overall budget holder, employer and commissioner of all the primary care services.

> *'Doctors have a long history of a high degree of independence, tend to have a greater role in management than many professions'.*
> (Ferrer & Navarra, 1994, p.311).

Professional cultural ideologies and philosophies

Soon after the publication of the 'Working for Patients' White Paper the Department of Health produced 'The NHS Community Care Act' (DoH, 1989) and Rowbottom, writing in 1992, suggested that there were erudite anomalies over the way in which professionals viewed the same problem. A particular problem was in relation to the process whereby individual professional groups use their own language and vocabulary and in essence work from quite different cultural ideologies and philosophies from the other groups. This had the result of undermining primary care teamworking and collaboration between professionals. The result of these differences frequently led and still leads to conflict. These differences potentially reinforce the various professional bodies and groups towards uniprofessional treatment paradigms and lack of integrated and collaborative practices (Dorwick, 1997).

Seeking a culture of a multiprofessional team

The aim of the 1997 Personal Medical Services pilot reforms (DoH, 1997a) was to facilitate cultural innovations in how providers could consider alternatives in delivering primary care. Historically the term given to those services provided by GPs was known as 'General Medical Services'. As part of this new government backed piloting arrangement the Department of Health fully supported and indeed advocated the use of other professional groups to substitute service delivery away from the direct delivery by GPs. There was, as expected, considerable interest in putting forward pilot bids, examples included were: use of nurse practitioners, introduction of salaried practitioners who were directly employed by the NHS Trust (as opposed to the existing 'Independent Contractor' model). This process can now be viewed in hindsight as another milestone in supporting the introduction of a culture of a multiprofessional team approach to the delivery of primary care services and undermining the prevalent culture that acted as a barrier to prevent organizational and structural changes and innovations in practice. These barriers, exhibited in both legislative and procedural hurdles, were being dissembled and were essentially the death knell of the monopoly held by GPs over the delivery of General Medical Services (Coulter and Mays, 1997).

Seeking a culture of partnership and integrated service delivery

The NHS White Paper 'The New NHS: Modern Dependable' (DOH, 1997b) supported the cultural shift that independent contractors (GPs) together with healthcare professionals were, according to the policy documents, to have more power and influence in working in partnership and delivering and ultimately commissioning services. The political pressure was geared to ensure that there was a rapid transition of newly established Primary Care Groups into autonomous Primary Care Trusts (PCTs) with full employment of the full range of staff required to deliver primary health care, termed 'PCT level 4' status. The NHS Plan (DoH, 2000) positioned Primary Care Trusts at the centre of future developments. The core functions of the PCT were to focus upon the following key criteria:

1. Improving the health of and addressing health inequalities of their local community;
2. Developing primary care services including reducing the variability of services, developing clinical governance and increasing integration of primary care services;
3. Advising on or commissioning directly a range of hospital services.

(Smith, 2001,p.8-9).

Change in role cultures

The study undertaken by Jenkins-Clarke et al. (1998) suggests that patients often prefer to access a credible alternative for their health care needs. The findings of their research report suggests that nurses could be accessed more responsively than the doctor (GP) and indeed those patients who had previously visited and had been seen by the nurse practitioner were more likely to access the nurse again as opposed to seeking an appointment with their doctor. These patients in the study were most satisfied with the care they had received. Further evidence gleaned from this report also suggests that the GPs themselves may also be becoming more culturally supportive of an advanced role for nurses. The reasons for this support are based upon two important assumptions. Firstly the GPs would perceive an advantage to them

personally in delegating aspects of their work to suitable trained nurses. Secondly, GPs would perceive that it is a clinically effective process for patients to undertake.

Cultural innovations in service delivery

There have been limited opportunities for cultural innovations to be introduced in service delivery. These opportunities have become available primarily as a result of GP fundholding, the internal market and the structural changes associated with the introduction of Primary Care Trusts. An example of successful innovation in practice would be the opportunistic introduction of Primary Care Trust podiatric surgeons. Foot surgery can be undertaken by podiatric surgeons on a range of procedures previously only carried out by orthopaedic surgeons in secondary care (acute) settings:

> *'...this has led to a reduction in orthopaedic waiting lists since patients are seen earlier than if they had been booked to see the orthopaedic surgeon...easier cross referral, quick and effective communications, and has led to a greater understanding of the skills of other professions'.*
> (DoH, 2003c, p.20).

Employers in Primary Care Trusts should be proactively seeking to introduce cultural innovations in service delivery in order to utilize their staff's skills and competences more effectively, rather than simply applying traditional professional roles, to determine who can do which tasks:

> *'Dieticians are taking on extended roles, including monitoring blood, adjusting insulin and using psychological techniques to support people with diabetes'.*

> *'Many physiotherapists are working in orthopaedic teams, others play key roles in general practice, rheumatology and respiratory clinics'.*

> *'Podiatrist, specializing in podiatric surgery, are reducing waiting times for patients'.* (DoH, 2000d, p.12).

The contemporary professional tribal culture

Wilson (2000) suggests that a large element of the tribalistic culture that has been rooted in early medical practice persists in characterising medicine and the culture of the family practice and primary care professional groups today, in spite of:

> *'the attempts of every major report and primary care reform, from the 1920 Dawson report (HMSO, 1920) to the present 1997 white and green papers (Department of Health, 1997b) and the revised GMS contractual status (Department of Health, 2003) to support the notion of team working and interprofessional collaboration. The struggle to maintain independence and clinical autonomy has continued to exert its influence. Thus GP's have established for themselves up to and including the present time a somewhat unique position, both 'within' and yet 'apart' from the team'.*
> (Wilson, 2000, p. 45).

The contemporary teamwork culture

In reality, the relationships between the PCTs, GPs, Professional Bodies and health professionals has not led to cultural changes leading to effective integration and teamworking as a result of the introduction of a new corporate structure. According to Starey (2003, p.27):

> *'The extent to which the primary care team acts in any kind of collective fashion, directed towards the common good of the community it serves, is very variable across the country but is usually very limited...the danger of reforming the arrangements governing the working of primary care teams is that we may damage and undervalue their heritage without improving their effectiveness'.*

The need for an overarching multiprofessional team culture

According to Miller et al (2001, p.19) a situation that can be best described as a culture of professional protectionism could be inherent in professional bodies:

> *'The commitment of professional bodies to the preparation of professionals for more integrated practice was called into question by some trust managers we spoke to who sat on the consortia responsible for purchasing education. They were concerned that ultimately professional bodies would protect their own specific body of knowledge and 'pull up the drawbridge' around their role and the knowledge and skills required for that role'.*

The NHS Executive (1996) expressed the desire to encourage both statutory and professional bodies to explore the possibility of integration further by the use of occupational standards within the proposed and existing professional educational programmes. The adoption of this approach can be viewed as seeking to create a cultural shift in the 'common language' for the:

> *'...expression of individual and multiprofessional competencies; improving links between academic, vocational and professional structures and enhancing access routes into professional education'.*
> (NHS Executive, 1996, Annex B, p.6).

Primary Care Trusts have been issued with major cultural requirements in order to focus on more diverse populations with a shift of emphasis away from secondary and tertiary care towards primary care prevention (Dowling and Glendinning, 2003). Progress needs to be made in establishing the overarching multiprofessional team culture that as yet has proved to be quite elusive.

2.2 Organisational and Professional Cultures

The new labour government's reforms in the NHS, whilst appearing to acknowledge an appreciation of the lessons learnt from history, exhibit no recognition that the current primary health care culture is seriously constrained in its ability to support significant change, or that substantial reforms in primary care would have to fundamentally challenge traditional cultural patterns of professional dominance, particularly in relation to that of decision making or resource allocation.

The view that culture is both understood and appreciated, is held by many in the NHS:

> *'We have found that managers and clinicians at all levels in secondary and primary care recognise the significance of culture'.*
> (Bevington, Halligan and Cullen , 2004, p.30).

A case has also be made by recent Department of Health publications in relation to Clinical Governance (DoH, 1998c, p.32) that there is no intrinsic cultural disparities between doctors, nurses or allied health professionals in primary care, in as much as all primary care professionals are viewed from the cultural perspective of delivering health care to the best of their ability to their patients. The dilemma with these conceptualisations is that it does not reflect the multifaceted nature of culture. The complexities of culture are such that it will be dominated by past and present events, together with professional matters of contention. It also needs to be borne in mind that professional culture will not necessarily positively influence patient care, despite rhetoric to the contrary.

The concept of culture has been adopted from the field of anthropology, in which it is used to make reference to the customs and rituals that societies develop over the course of their history. In 1871, Edward Tylor, a leading anthropologist, first introduced the term 'culture' into the English language (Brown, 1998, p.4).

The term 'culture' has many definitions and connotations depending upon whether it is being applied to an 'organisation' or 'team within an organisation' and as a result

will often produce semantic and conceptual complexities within organisations and teams that are multi-faceted in nature. However, not withstanding this difficulty, the literature is abundant with a vast array of ideas over the most appropriate way to identify, categorize or define culture. The following extracts provide a range of these definitions that have been made to seek to explain the complexities and parameters of culture:

> *'The pattern of shared basic assumptions-invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration- that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems'.* (Schein, 1997, p.92).

Schein's perception of organisational culture is that of a multifaceted phenomenon in which component parts coexist. It therefore can be argued that culture can both break down and ultimately lead to the reconstruction of the values and norms of a primary health care team and that culture is perpetually undergoing change, in as much as there is recurrent learning being undertaken with reference to the internal organisational and team environment:

> *'The culture of a group can be defined as a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems'.* (Brown, 1998, p.34).

Mallory and Paton (2002, p.38-39) have provided an excellent overarching summary of the dimensions of culture, whether it relates specifically to the organisation as a whole, to individual professional groups or the Primary Care Team. This study has been positioned in the context of Mallory and Paton's dimensions of culture, namely:

- Culture is *real*: NHS Primary Care Trusts may differ in the emotional, cognitive and interpersonal nuances that they experience from their

employees. Any differences are usually subtle, however, the values, beliefs and the way in which their employees communicate and relate maintains a degree of coherence and persistence;

- Culture is *pervasive,* but to a great extent *implicit*: Whilst individuals may be very familiar with the culture of their NHS Primary Care Trust or other organisation they may not be aware of it- by a similar analogy individuals may 'know' their personalities but are unable to describe them easily and their attempt may indeed be mistaken;
- Culture is not just *'out there'*, a characteristic of organisations; it is also *'in here'* since it is how individuals, as employees of an NHS Primary Care Trust or other organisation, deal with each other and consider their work and working relationships. Individuals reproduce the culture of the organisation and assist in its evolution by how they conform or adjust to unwritten rules;
- Culture is *multifaceted* and the complex interrelationships among the dimensions of culture needs to be analysed in order to seek to understand why and how an organisation functions the way it does. The relative importance of each dimension will vary. For example, in an NHS Primary Care Trust the cultural dimension of the employee/ patient or client relationship should be seen to play a central role as compared to the role that it might play within an armed services/military institution.

This concept of culture is helpful because it seeks to discern aspects of team and organisational behaviour that could otherwise be quite incomprehensible. The culture of an organisation has a significant influence on employees and given the importance and the strength of some organisational cultures it is important for employees to understand their organisation 'from the inside'.

On the other hand professional cultures are specific to each individual professional group and therefore, by themselves, will not assist in promoting an organisational culture. A good example of this can be seen in relation to training processes. Uniprofessional training tends only to deliver skills that are profession specific and can be seen only to further promote the insular focus of professions thereby exacerbating the isolated professional culture relationship. Whilst this is not

inevitable, it is historically the case since shared learning opportunities between different professional groups provides opportunities which have not been available through mono/uniprofessional training. Although there will always be aspects of learning that can be effectively derived on a uniprofessional basis (e.g. core skill training):

> *' The promotion of effective multiprofessional teamworking is not the only agenda for multiprofessional education, but it is one agenda for which multiprofessional learning can clearly demonstrate added value over the monoprofessional alternative'.*
> (Miller, Freeman and Ross, 2001, p.157).

In order to ensure that there is a coherent cultural approach, which is moving strategically in the direction of the Primary Care Trust, there needs, therefore, to be an organisational culture introduced that transcends the professional cultural divide upon which individual staff are committed and inspired to accept. The conflict between the professional culture and the organisational culture will influence the success or failure of the trust to varying degrees.

> *'The organisational culture will generate its own influence that will challenge the traditional roles of professionals and reduce their respective power bases, and consequently their level of influence over the functioning of the organisation'.* (Cole and Perides, cited in Soothill et al. 1995, p.73).

Leadership, in ensuring the development of the most appropriate culture, is seen to be both critical and manageable:

> *'Organisational culture may be traced, at least in part, to the founders of the company or those who strongly shaped it in the recent past'.* (Furnham, 1997, p.154).

> *'Organisational cultures are created in part by leaders, and one of the most decisive functions of leadership is the creation, the management, and sometimes even the destruction of culture'.* (Schein, 1997, p.386).

'If the leader is a great person, then inspiring ideas will permeate the corporation's culture. If the leader is mundane, then the guiding beliefs may be uninspired. Strong beliefs make for strong cultures. The clearer the leader is about what they stand for, the more apparent will be the culture of that company'. (Davis, 1984, p.79).

The leader in the primary care organisation will ultimately be the Chief Executive. However, historically, the GPs have taken on this role and as a consequence substantially influenced the culture in primary care.

Culture is a strong force and can, if not managed appropriately, be a serious barrier to change. Although it is not realistic to expect that it is a quick process to reshape NHS primary care organisational cultures, it can be encouraged and influenced through innovation and constructive criticism together with positive leadership. In essence leadership and culture are two sides of the same coin, in as much as leaders bring culture into being when they create a team or organisation.

An array of typologies of the types of organisational cultures have been set out by academics and researchers over the years. These classifications are helpful in depicting the variations that are present between cultures, however, there is considerable variation in their sophistication and application. Two such typologies are those proposed by Scholz (1987) and Quinn & McGrath (1985).

Scholz's Typology (1987) has identified three culture types, namely: production, bureaucratic and professional. These culture types were then distinguished by their degree of standardisation, routineness, skill requirements and variety of property rights. I have utilised this typology to provide a primary care interpretation. Property rights in the primary care setting relate to facilities such as access to clinical consulting rooms or theatre space, for example:

- The Professional Culture (e.g. GP) would achieve a high skill requirement with property rights being awarded to them as a direct virtue of the knowledge and skill they possess. They would be awarded a low routineness and

standardisation element. Another example of this culture could also apply to any other primary care professional group and all would derive a similar 'scoring' for each of the dimensions;

- The Bureaucratic Culture (e.g. Middle/Senior NHS Manager) would gain a medium rating for routineness, standardisation and skill requirement and derive property rights dependant upon their hierarchy in the organisation.

Quinn & McGrath (1985) based their typology on the nature of transactions linked to organisational information processes. They propose four generic cultures, namely: the Rational Culture (Market), the Consensual Culture (Clan), the Ideological Culture (Adhocracy) and the Hierarchical Culture (Hierarchy). The basic rationale for this typology is the notion that there is an exchange of facts, ideas, permission, between individuals and groups, which have value. These values or 'transactions' are associated with status and power. Additionally, the transactions will be governed by norms, rules that reflect values and beliefs. Again, I have made an interpretation in relation to examples that could be applied within the context of the primary care, for example:

- The Clan Culture (e.g. NHS District Nursing team) would be established through consensus with the aim to maintain the group's cohesion and power base. The dominant values of the clan include fairness, equality and a degree of moral integrity. Equally, examples for all the professional groups (Health Visiting, Physiotherapy etc) could be considered and would, according to Quinn and McGrath's dimensions be viewed the same way;

- The Hierarchy Culture (for example: NHS Management) would be established to execute regulations and control. Compliance will be maintained through rules, control and order.

The use of these typologies, whilst helpful, fall short in taking into consideration the complexities of the NHS primary care organisation. Classifications of cultures provide an 'ideal model' into which the actual organisation can be examined and

compared. The key value of these models is that they present us with an interesting mechanism by which we can review the dimensions that are important in particular cultures and how they interact to provide a coherent social whole. They are too simplistic to go beyond superficial analysis and only represent an 'ideal' for examination and reflection.

The culture of an organisation has a significant influence on employees and different professional groups within an organisation such as an NHS Primary Care Trust, will have different group cultures. Martin (2003, p.153) suggests that:

> *'In a large hospital, there might be a very different culture in the operating theatres from that in a finance department. The culture of an area of work is often closely linked with the nature of the work'.*

There is a need to appreciate not only the culture of the whole organisation but also the individual professional discipline or team culture in order to deliver the best possible service to our patients. The failure to achieve this understanding will inhibit or block totally working collaboration between colleagues and primary care teams.

Cultural issues are cited by numerous researchers as playing a critical role over the success or otherwise of health professionals to achieve NHS objectives particularly in relation to the implementation of clinical governance (Dowling and Glendinning, 2003; Marshall et al., 2002; Scally and Donaldson, 1999). A possible rationale for this is that a common purpose, shared equally by individuals, is more likely to deliver a more consistent outcome than otherwise would be achieved through a diverse approach.

When the 'New' Labour Party came to power in 1997, it inherited a NHS culture based on market forces and provider competition embedded in the concept of the 'internal healthcare market'. The White Paper entitled 'The New NHS: Modern – Dependable (Department of Health, 1997b) used the overarching headline that a culture of collaboration and partnership would take the place of a culture of competition whilst continuing to support the previous government's doctrine of a Primary Care led NHS. This was encapsulated in the phrase 'the third way' (Giddens,

2002) along with the establishment of Primary Care Groups (PCGs) and ultimately Primary Care Trusts (PCTs).

The concept of interprofessionalism was born out of of numerous 'bad news' stories regarding the failure of the NHS and Social services to deliver seamless, patient centred services:

> *'Calls for increased emphasis on teamwork and co-operation in practice have been a feature of a multitude of government reports (most recently Bristol Royal Infirmary Inquiry-2001) and yet the reality of relationships in the field has not altered significantly'.* (Irvine et al. 2002, p.207).

Cultural issues are particularly important and influential factors for all staff within the Primary Care services. Observers of the introduction of the Clinical Governance agenda post 'Bristol' (DoH, 2002a), have made specific recommendations that inconsistencies in judgement will continue to be made if an inward looking professional or 'club culture' does not specifically enable professionals to focus on the same single dimension. For example, if several members of the team consider several completely different or diverse dimensions of the same problem (no shared objectives or aims) then they are likely to produce inconsistent outcomes or 'collective preferences' (Marshall et al. 2002).

The culture of an organization can therefore be seen to be made up of an aggregation of its 'subcultures'. This view is upheld and resonates in the educational and NHS organizational research work and writing undertaken by Rudduck et al (1996), Prosser (1999) and Scott et al (2003).

In terms of the NHS, a complex system of subcultures operates and its analysis requires an evaluation of both the cultural influences of the employees and patient. The important subcultural influences, although not exhaustive, would include the following:

- Occupational;
- Technical;

- Gender;
- Class;
- Religious.

(Scott et al, 2003, p.22).

It is important to realize that individuals may identify with their organization, a particular subculture within the organization, their professional group or a combination and dynamic mix of cultural possibilities. Cultural change is therefore necessary in order to enable the leveling out of the existing hierarchical relationships, between general practitioners, nursing and allied health professionals and others working in primary care including the patients. It is argued that a collaborative culture will make a difference to the primary health care professional and patient relationship. According to Williams (2000) a balance needs to be struck between the primary health care professionals, both in terms of delivering responsive, high quality care to their patients and the development and evolution of their individual professional expertise. A key point in this argument is that it is significant to understand that a more collaborative and responsive professionalism in primary care, is influenced by professionals not only being self-assured about their professional role, but are also by their ability to fully value the roles and contribution of others in the primary care team. The development of a culture that values professional and team identity is key to this confidence.

2.3 Multiprofessional Teamwork

John Adair (1986, p.121) suggests that there are in fact three areas of 'overlapping needs' present in working groups or organisations, namely the need to:

1. Develop the individual;
2. Build the team;
3. Achieve the task.

In addition, Adair suggests that individuals have needs that must be met through the context of their work, namely:

- Trust: they must trust themselves and their capacity and others in the team;
- Autonomy: members need to be part of the team, and also to have distinctiveness from it;
- Initiative: members need to feel that in at least some areas of work they can act on their own decisions, and their freedom to do so needs defining;
- Industry: people want to work, and have activities which are valid and worthwhile;
- Integrity: people want to be able to act consistently according to beliefs and values that they espouse;
- Security: members like to understand how others regard them in their work role, and that they are making a valid contribution which the organization values. This is related to whether they feel that their job will continue to exist and that they will continue to be employed.

The literature contains many examples of attempts to augment team working in primary care. These tend to be descriptive and applicable in only very particular circumstances. For example, in the area of discharge planning (Pethybridge, 2004) and mental health teams (Gulliver et al, 2002) thereby failing to provide generalisable evidence to support the team approach in primary health care. However, this lack of generalisable evidence is not surprising, given the complexities of issues and relationships that need to be addressed within the team setting. These issues include professional rivalry, gender and political influence (which are fashioned by changing societal structures), cultural recognition, technological achievements together with the economic factors appertaining to health care delivery. In addition, the sociology of professions within the cultural context plays a dominant part in the successful delivery of teamworking. As Macdonald (1995) argues:

> *'The close affinity between professions and the class of the gentry explains the keenness of aspirant professional groups in Britain to emphasize their members' respectability and 'gentlemanliness'...from the power base achieved the medical profession was able to dominate paramedical occupations and to mount a major confrontation with the government over the public provision of health care'.* (Macdonald, 1995, p.77).

The concept of professions as social actors, was expressed by McKinley (1973, p.6):

> *'Several dominant occupations (especially medicine and law) have come to occupy uniquely powerful positions in Western societies from which they monopolistically initiate, direct and regulate widespread social change. Principal among them are the emergence of a mythology concerning professionalism'.*

Team working and professional collaboration clearly has a particularly important function to perform in the primary care setting as it does within other healthcare settings (Partnership in Action, Department of Health, 1998). The aspiration to deliver the highest quality of care, with and through a multidisciplinary mix of professionals, each with their own professional skills and competences and tribal rivalries, is a challenge to say the least. The historic boundaries between health professionals have for some time been open to challenge, not least by consumers of the NHS services:

> *'Why are there so many professions? Is the growth of the professional specialization inevitable for the rest of human history? Or may the trend be beginning to reverse, and a measure of fusion starting to emerge? Could we perhaps be moving now towards one profession of medicine- a profession of many parts, but one profession?'.* (Young, 1990, p.12).

Interprofessional collaboration within the context of NHS services has long been recommended and examples of how to sustain interprofessional collaboration have been evidenced in the literature (Freeth, 2001). The 'Clinical Skills Initiative at St Bartholomew's' in London provides an excellent case study into the key conditions required to sustain interprofessional collaboration *'through a combination of continued need to collaborate and empowerment to do so'* (Freeth, 2001, p.37). This 'two-fold' motivation of opportunity and need, suggested by Freeth, can be seen as a prerequisite for sustaining collaboration between professions in other settings such as primary care:

> *'Eventually, sustained interprofessional collaboration becomes routine interprofessional collaboration. It no longer occurs to people that they could approach a particular task without involving members of other professions'.* (Freeth, 2001, p.44).

Belbin's seminal work (1992) states that effective teams embrace characteristics such as a sense of common purpose together with a clear comprehension and respect for individual team member's roles and responsibilities. A shared responsibility for outcomes is also perceived to be of value.

The need for shared objectives, beliefs and tasks advocates that:

> *'A participative and collaborative approach is more likely to lead to a patient-centred approach'.* (Poulton & West, 1999, p.11).

There is a plenitude of literature that has concentrated on multiprofessional teamworking and commends the argument that effective teamworking is supported by individuals acquiring shared beliefs, the introduction of creative working patterns and methods, good communication within the team and the positive benefit accrued by focusing on the team's shared tasks. (Lowe and O'Hara, 2000; Ross et al. 2000; Meads and Ashcroft, 2000; Molyneaux, 2001; Hudson, 2002; Stewart et al. 2003; McWilliams et al. 2003., Dieleman et al. 2004). Research undertaken has also evidenced team members' perceptions that multiprofessional teamworking and collaboration can deliver improved benefits to patients (Dieleman et al., 2004., McWilliams et al., 2003). However, this is not unproblematic. The delivery of effective health care, does not only require effective teamwork, it also requires positive professional development. Poulton (1995) described a positive relationship between multidisciplinary teamworking and effectiveness. Effectiveness in Poulton's study was measured according to four main dimensions: team functioning; organizational efficiency; quality of patient care; and a needs based approach to patient care delivery. The need to understand and support each other's professional roles will have a positive influence on the effectiveness of the primary care team. Primary health care professionals must harmonise their efforts to deliver the best

possible service for their patients. It is however remarkably difficult to achieve in practice. As Hitchings (1999, p.6) suggests:

> *' It is an illusion to fancy that an organization that is internally unrelational can deliver an effective relational service'.*

According to Jenkins-Clarke et al. (1998) primary care service delivery can be seen to possess a central nucleus of two professional groups, namely the general practitioner and the nursing groups. This analysis over simplifies the context of multiprofessional modern team approach that needs to be delivered in primary care. The quality of service provision will be moulded by all the primary care workforce and individual professional member's ability to function as a team. In addition to the two central disciplines, referred to by Jenkins-Clarke, the allied health professionals, managers and all members of the primary care team have pivotal roles to deliver for its effective function. All the professional groups are therefore all central to the delivery of primary care.

Structural and educational demands on practice and role changes within the delivery of primary care has been ongoing for the last 16 years or so. This has inevitably had an effect on staff's sense of security and motivation plus the ability to retain and recruit within the professional areas:

> *'Frequent changes have left morale at a low ebb and raising it will be a huge challenge. If PCTs take on a real support role and deliver a 'bottom up' approach to meeting the needs of patients and employees, they could achieve a re-engagement of the workforce'.* (Smith, 2001, p.6).

Poor morale and motivation has had a negative effect on the achievement of 'professional adulthood' (see section 2.5) in the team setting:

> *'There is a need for professionals to feel secure enough in their own professional role, skills and expertise, in order to be able to share this expertise, whilst still retaining the specialist skills of their own profession'.* (Laidler, 1991, p.5).

The GP has been accustomed to undertaking the role of leader in the UK primary care system and acting as the 'gatekeeper' to onward referral to diagnostic and hospital based specialist services:

> *'Very often in team situations, the physician assumes the responsibility for leadership and other team members collude with this'.* (Dombreck,1997, p.15).

This collusion is a result of some members of the primary care team wishing to maintain the status quo and thereby avoiding change. Other members may potentially simply lack motivation to progress their professional development, whilst others may believe sincerely that the GP status as leader is appropriate and salient. The added challenges for the nursing and allied health professions could be seen in the context of this new dilemma in as much as there will be an inherent tension between the desire to maintain the status quo and the pull towards innovations in professional and role development (Kendall and Lissauer, 2003). Demarcations that have historically been made between doctor and nurse purely based upon the 'cure and care' mantra, proposed by Beardshaw and Robinson (1990, p.43), are now becoming blurred. This will present challenges to the supremacy of the medical profession particularly as the central role of the patient becomes, as it should, more prominent, with the introduction of better communication technologies and diagnostic strategies:

> *'To a great extent the move towards the consumer-orientated society is itself being fuelled by the revolution in information technology. In medicine, this is changing the dynamic of the doctor/patient relationship- in favour of the patient-forever. A fundamental part of doctor's professionalism has traditionally rested on the unique body of knowledge and skill to which only professionals have access. But the internet has given every citizen direct access to the database of medicine. So the doctors' monopoly of information no longer exists'.* (Irvine, 2002, p.74).

Irvine's comments, himself a medical doctor, appear to equate professional skill with acquired information. This argument fails to significantly address how health care

professionals can use their skills to work with patients and help them make the best use of the information that they have acquired.

The historical development of both the nursing and allied healthcare professions within primary care can be seen to have been guided by the same policy shifts that have re-engineered the medical profession (Tovey, 2000 p.49) and therefore there is a level playing field within both these professional areas to theoretically support the successful opportunities for implementing innovations in practice. However, the difficulties in achieving multiprofessional teamworking was appropriately stated by Pereira-Gray (1987, p.1):

> *'...that the various health care professionals should unite their efforts to provide the best possible service for their patient is bland, true and self evident. It is however quite extraordinarily difficult to achieve in practice'.*

2.4 Tribalism, Status and Power

'Tribalism', as with the term 'culture' has been borrowed from the field of anthropology (Marcus and Fischer, 1986) and is a helpful metaphorical term in the exploration of contemporary professional territorial conflicts within primary care.
The definition of tribalism, as defined by the Collins dictionary (1989) is:

> *' a social division of people defined in terms of their territory and culture'.*

Interest in tribalism should be seen within this research thesis in the context of the political and strategic movement towards delivering a primary care led NHS, with support for greater collaboration and partnership between health professionals. For the purpose of this study, the term tribalism is used to describe the collective response of individual professional members to their professional territory, identity, perceived status and power inherent within their individual professional group.

Tribalism between NHS professional groups has been a cause of concern for many years. The Chief Executive of the NHS Training Authority in the early 1980s identified as a priority the need for multiprofessional education across occupational

boundaries since there was far too much tribalism (Dearden, 1985). Collaboration by primary care health care professionals is frequently an association of unequal partners or status:

> *'The status of many nurses and health visitors in practice attachments is equivocal. On the one hand they are superficially members of the team, they have direct contact with doctors, and their advice is sought. However, they do suffer a certain subtle, but no less potent, undermining of any aspirations to partnership they may have. If partnerships with doctors exist at all it can be best described as a junior partnership'.* (McIntosh and Dingwall,1978, p.130).

Beattie et al (1995) stated that specialist training schools for medicine, nursing and the health professions- like many state and private schools, particularly boarding schools (Kapferer, 1981; Donald, 1985) have been able to exert a powerful controlling influence over the consciousness, language and values together with the sense of identity of the students trained by them. Becher's (1990) analysis of 'tribes and territories' in higher education settings suggests that the traditional pattern of training within a medical school is one dominated by 'partition' which has an association towards the development of 'high social distance and cosmopolitan loyalties'. The traditional training pattern in schools of nursing, according to Becher, has been dominated by 'patronage', which has an association towards task completion and local loyalties. Beattie (1995) adds further support to the view that tribalistic behaviour originates within higher educational settings:

> *'It is in these segregated seminaries, and in the everyday rituals of learning through which they create separate and distinctive ways of thinking and ways of relating, that the 'tribalism' in health care is originated and perpetuated anew in every cohort and generation of student professionals'.*
> (Beattie, 1995, p.116).

Wilson (1994) suggests that teams can be defined as a collection of individuals who have an explicit reason for working together and that the main rationale for this willingness to work together is in the fact that there is benefit to be gained through each other's specific skills and abilities with the need to refrain from tribalistic

tendencies and historical attitudes associated to individual professional status and power.

According to Davies et al (2000) the contemporary position remains one of unequal partners:

> *'...nurses remain subordinated within the division of labour by virtue of the legal monopoly that the medical profession continues to hold over diagnosis and treatment...given that the medical profession has traditionally been dominant within the increasingly pluralistic health care division of labour in Britain, a key question is how this can be explained'.*
> (Davies, Finlay and Bulman, 2000, p.311).

There is a 'tribalistic' misplaced perception that it is often only doctors who deal substantially with front line patient contact and care delivery, which bears little resemblance to the front line realities of those working within primary care teams made up of the full range of professional groups:

> *'Most doctors, in contrast with many other professional (including those in health care), remain on the front line, dealing directly with patients, listening to them, examining them, carrying out procedures, providing comfort, to the end of their careers'.* (Tallis, 2004, p.213).

It has also been argued by Salvage (2002) that, notwithstanding the increased training and development undertaken by nursing and other health care professions, these professions still lack power and status compared to doctors, and that there is still a basic premise that these other professional groups must practice according to medical edict and authority.

Status and power play a central factor in the discourse relating to cultural distinctiveness, and although the replacement of doctors, in particular instances, by nurses and other allied health professionals could be seen to impugn the generalist role of the primary care physician, policy changes have and continue to support the dominance of doctors rather than empowering nursing and allied health professionals.

The profession of medicine persists in being favoured by power, status and domination. In comparison, the abiding anxiety for other primary care professionals has been closely linked to lack of power, status and dominance. It is necessary therefore to exhibit a reflexive consciousness of the central cultural issues of power and status in relation to effectively deferring tribalistic behaviour in primary care. Professional boundary changes, associated with role substitution, can also give rise to either anxiety affiliated with a desire for innovation, or alternatively, a withdrawal into the protection of individualistic 'professions', which clings to tribalistic behaviour and the maintenance of status quo. The argument formed therefore is that the cultural differences between the primary care professionals, particularly the tribalistic and protectionist behaviors have significant importance for the success or otherwise in implementing a primary care led agenda where the prominence is upon cooperation, collaboration and partnership through multiprofessional primary health care teamworking:

> *'The medical profession must recognize that traditional individualistic professional autonomy is no longer a viable path'.*
> (Frankford and Konrad, cited in Williams, 2000, p.99).

2.5 Professional Adulthood

The requirement to shift away from the traditional tribal boundaries in health care, to a more proactive, innovative and flexible approach to redrawing professional and team territorial boundaries is critical for the new direction of primary care. Attainment of a primary care led NHS, needs extensive change in tribalistic cultural behaviour, and the way in which all the professional groups in primary care deliver their work. The accomplishment of what can be best expressed as 'professional adulthood' would support this cultural change.

The primary care team can be seen as a collective of professional adults, however, there is an inherent resistance to relinquish professional autonomy which can lead to protectionist behaviour and the subsequent diminishment or collapse of teamwork and holistic patient care. The reduction in professional autonomy with simultaneous retention of individual professional identity, core professional skills and attribution of

responsibility is described, by Laidler (1991), as 'professional adulthood' and will facilitate the reduction and eradication of tribalistic behaviour. Laidler's concept related directly to the area of the multiprofessional stroke rehabilitation team, however, it provides an overarching application and resonance to the context of the primary health care team setting.

There is therefore a need for staff from the diverse range of primary care professions not only to feel confident in their roles and professional identities but also to be confident enough in their professional identities to relinquish their professional autonomy in order to work efficiently as a team.

This achievement of the equilibrium necessary for the delivery of professional adulthood requires maintenance by a reduction in individual professional autonomy balanced by the increase in core expertise of individual team members. It is argued in this thesis that this will only be achieved by the development of a culture of flexibility in both role development and role substitution.

Laidler's multiprofesional model of working provides a positive model that places the patient centre stage and seeks to facilitate the sharing of ideas and expertise between professionals. Upon reflection, whilst the model is commendable, the process by which professional adulthood can be achieved in practice is both problematic and complex. For example, the process may be undermined by elitism within individual professional groups in the context of the wider primary care team. This elitism could be as a result of individual profession(s) not wishing to relinquish their professional autonomies or by a lack of historical conflict resolution.

The advancement of primary care, in terms of service delivery, will likely reflect past events, which has been dictated by the dominant GP gatekeeper profession. It therefore follows that the GP referral patterns, for example, frequently impose the service input, not necessarily manifesting itself in the appropriate utilization of the professions involved in these allied primary care services. In addition, the GP gatekeeper and other primary care professionals may be unaware of what might be available within one or all of the allied primary health care services (Boaden, 1997).

The lack of awareness of professional roles and competences can lead to unsuitable referral, or indeed to an absence of referrals.

The argument advanced in this thesis is that the GP as coordinator of care reflects the historical and contemporary dominance of medicine in the context of professional services providing primary care. This situation needs to change, as other professions emerge into professional adulthood. A lack of delivery of professional adulthood may best be termed as professional immaturity and will continue to give rise to interprofessional conflicts with the consequential decline in the delivery of patient care.

2.6 Workforce Development Planning

The process of workforce planning has failed to deliver an appropriate mechanism to ensure that the correct number of suitably qualified and experienced health care professionals have been in place to meet the needs of patients. The Department of Health's document 'A Health Service of All the Talents: developing the NHS workforce' (2000) made specific reference to the fact that the existing process of workforce planning was failing to produce a locally sensitive method. The process must also engage in the short-long term requirements involved in the education and training of all health professionals. Unless the optimum mechanism is in place to ensure that the correct number of suitably trained and experienced health professionals, are available, patients' health care needs will risk being unmet. The most important factor in the delivery of health services is the availability of an adequate number of well motivated staff, who are appropriately experienced, educated and trained. In order to ensure the supply of staff, priority needs to be given to workforce planning, education and training, good employment practice and reward systems. This has not been achieved to date. Four key areas were identified in the Department of Health's 'A Health Service of All the Talents' (2000b) as being main areas of concern with the existing arrangements, namely:

- Fragmentation of planning and lack of technical skills;
- Lack of management of ownership;

- Training and education weaknesses;
- Career structure and workforce numbers issues.

Each of these areas of concern will now be considered:

Fragmentation of planning and lack of technical skills

First and fundamentally, greater attention needs to be paid to making proper links between service, finance and workforce planning both at a local and national level. The approaches to workforce planning for doctors and dentists and for other clinical staff are not aligned and there are major weaknesses in the information base used for workforce planning.

Lack of management ownership

There is lack of proper engagement by many senior NHS managers and policy makers in workforce issues in a way that would be inconceivable in relation, for example, to financial issues. While many organisations and individuals are involved in the workforce planning at present there is not always clarity about their role, responsibilities and accountabilities.

Training and education weaknesses

There is a need to develop and improve the relationship between the NHS and providers of education and training, particularly in relation to those clinical staff, including nurses, whose education is funded by the NHS, but provided by Higher Education Institutions. Some higher education staff are also perceived to be out of touch with modern NHS service needs. There is also a perceived dominance of professional interest groups in determining the content and delivery of training, such as Royal Colleges in accrediting training places.

Career structure and workforce numbers issues

There is a perceived lack of coherence on workforce issues across the NHS Executive and Department of Health in terms of a perceived policy vacuum. Underlying this are more fundamental issues about the numbers of doctors and other health care staff

required and the number of doctors and other health professionals, which should be trained in the UK.

The general picture is that the workforce planning and development process has not been embedded into the NHS culture and that there has been too much short- term crisis handling without paying proper attention to the impact of many day-to-day decisions on delivering the NHS workforce required for the 21st century.
Livesey and Turner (2000, p.95) stated that:

> *'The current system (in truth its doubtful if we actually have one) is unproductive and unmanageable'.*

The historical funding arrangements for the training of doctors and dentists, has been through a centrally funded income stream called the 'Medical and Dental Education Levy' (MADEL). This has been regulated by the General Medical and General Dental Councils with post-graduate deaneries together with Royal Colleges agreeing training approval. All other health professionals have since 1996 been working with Local Education Consortia linked by contractual arrangements to Higher Education to secure pre and post basic training and education via a funding levy entitled 'Non-Medical Education and Training' (NMET). In 1997, NHS Health Authorities and subsequently Primary Care Trusts have taken over the responsibility of delivering a three- year 'Primary Care Investment Plan' which must include GP vacancy factors that theoretically links into the overall Workforce Development Consortium planning cycle (Swage, 2000). The financial disparities across professional groups in funding post graduate training and education has not proved helpful in ensuring equity of access to appropriate professional development courses.

The crisis in recruitment and retention of clinical staff across all health professional groups is a great cause for concern. The crisis is believed to be most acute within the General Practitioner profession where it has been linked to GP dissatisfaction over NHS reforms, increased workload and poor morale (Leese & Young, 1999).
The requirement to implement family friendly employment practices together with more opportunities for flexible and part time working is critical. According to Humphris & Masterson (2000) the composition of the future professional NHS

workforce will be predominantly female, even in the field of medicine where the medical school intake is currently over 50% female. Planning in individual Trusts will be limited by numerous constraints that are external to the organisation and therefore local Workforce Development Plans need to be sufficiently flexible to respond and, if necessary, adapt to take advantage of any current externally determined political trends.

According to national statistics (Health Service Journal, 2003, p.26):

> *'...as the baby-boom generation reaches retirement age, with more than one-tenth of the workforce aged 50, the NHS staffing crisis could deepen significantly'.*

The NHS workforce by 2030 is expected to have contracted by 10% and the implications for the NHS are thought to be considerable in terms of retention and training of staff and the ability to continue to deliver services. Research undertaken by the Royal College of General Practitioners states that 150 new registrars will need to be trained in order to replace every 100 GPs that are due to retire because so many of the new workforce plan to work on a part time basis. In addition a third of all GPs in England are aged 50 or over. GPs are able to retire at 50 with an ablated pension. A survey undertaken in the North West of England has stated that half of the GPs aged 50 or over were planning to retire by 2005 at the latest (Mathie and McKinly, DoH, 1999). This staffing 'time bomb' is not just restricted to General Practice and has been evidenced by the Department of Health (DoH, 2002) to be incumbent within numerous health care professions including nursing. Another key factor relates to the rising costs of continuing with the GP model. Recent government legislation (DoH, 2000a) seeks to support the shift towards more primary care based services and day case surgery, as opposed to hospital based, health care. Annandale (1998) indicates that the most significant factor in health care trends in the millennium will be the removal of the traditional clinical boundaries between nursing and medicine. This analysis can also be seen to reflect changes that are occurring within the Allied Health Professions. These strategic developments, when set alongside the 'cost-value' analysis, delivers a cogent case for the political support for continued change in terms of skill and role substitution. A shortfall in the literature, at the time of writing, relates

to a robust evaluation of any new role developments. This is understandable since there are currently only 'ad hoc' examples. However, there is an urgent need to ensure that new or potential roles secure such evaluation.

In 2001, Workforce Development Confederations were introduced to replace Workforce Development Consortia. These Confederations were established alongside a National Workforce Development Board and have now been integrated into the Strategic Health Authorities in order to support and influence the strategic planning process. The rationale behind the new Confederations has been to seek to ensure that the Confederation takes the lead in developing integrated workforce planning for healthcare communities based on assessment of future requirements for skills and competences spanning both the health and social care divide. Additionally, their role will be to take overall responsibility for developing the existing and future workforce through robust education and training processes linked to higher education. The concern remains that unless there is a radical shift away from the uniprofessional training philosophy towards a patient centred and multiprofessional focus nothing is likely to change in the long term. This will require a fundamental cultural shift that places the patient front and centre. New innovations in role developments will be one implication that will require support both in terms of finance and political persuasion to achieve successfully, fully supported by the Workforce Development planning process.

2.7 Staff Development and Education

This section begins by providing an overview of the main terms and definitions of the staff development and educational processes, followed by a detailed consideration of the processes as they apply to NHS primary care services.

2.7.1 Terminology

There are a series of definitions of Continuing Professional Development to be found in the literature. The following, asserted by Walsh and Woodward (1989, p.129), is helpful in elucidating the complexities:

'...the systematic maintenance, improvement and broadening of knowledge and skill, and the development of personal qualities necessary for the execution of professional, managerial and technical duties through the professional's working life'.

Research carried out by Pringle (2000) in developing 'Continuing Professional Development (CPD)' initiatives for allied health professions and clinical psychologists, identifies that there are three terms that are frequently applied synonymously in relation to post- basic or post- graduate education. The three are as follows:

- Continuing Professional Development (CPD);
- Continuing Professional Education (CPE);
- Lifelong Learning (LL).

A differentiation between CPD and CPE has been made by Eraut (1994) in which it is suggested that CPE has a more specific focus upon formally or accredited courses and targeted educational events whereas CPD is less specific and relies more upon informal work based learning such as shadowing and ad hoc opportunities. The status of these less formal CPD opportunities are often regarded as below that of CPE since more formal accreditation set within the context of an external training event tends to be more valued by participants:

'These work-based opportunities for professional development are also dependent on a set of attitudes and beliefs about learning. These attitudes span both the individual, team and organisational level'.
(Pringle, 2000, p.81).

Continuing professional development and lifelong learning have close linkages. The literature suggests that over the last 40 years educators and trainers have sought meaningful responses to meet the demands of the workplace. Numerous terms have arisen that seek to describe adult learning following statutory education, higher and basic professional training.

Lifelong Learning is now an established term in the vocabulary of education and training and is seen as a positive connotation expressing openness to positive learning opportunities. Although lifelong and learning together with the associated notion is currently in vogue, it is certainly not a new concept and its origin can be traced to the beginning of the twentieth century:

> *'Immediately after the First World War, a government committee on adult education demanded that 'adult education should not be regarded as a luxury for a few exceptional persons here and there...adult education is a permanent national necessity, an inseparable aspect of citizenship and therefore should be universal and lifelong'* (Ministry of Reconstruction Report, 1919), *the term has been introduced into more general use internationally through the work of UNESCO in the 1970'.* (Cooke, 1998, p.1).

Hoggart et al (1982) cite *'recurrent education'* and United Nations Educational, Scientific and Cultural Organisation (UNESCO) *'continuing education and post initial education'* as definitions for Lifelong Learning. *Lifelong Learning* as defined in Department of Health documentation is:

> *'A process of continuing development for all individuals and teams which meets the needs of patients and delivers the healthcare outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential'.* (Department of Health, 1998a).

However, the holistic notion of lifelong learning is seen by work undertaken by Smith and Spurling (1999,p.9-10) to consist of a two- part framework:

1. An empirical element;
2. A moral element.

The elements are interdependent.

At the empirical level Lifelong Learning is intended and planned learning and stretches on through the lifespan. At the moral level Lifelong Learning involves:

1. Personal commitment to learning;
2. Social commitment to learning;
3. Respect for others' learning;
4. Respect for the truth, as defined by the individual.

This two-part framework is helpful when applied to staff working within the context of primary care service delivery. The primary care team member, regardless of which perceived status or professional tribe they belong to, will meet difficulties in qualifying as a lifelong learner if they have not adopted both the empirical and moral elements.

Special importance and significance has been provided through recent government documentation (Working Together-Learning Together, DoH, 2001) on the need to integrate training, continuous professional development (CPD), formal skills development (for example: gaining new qualifications), management and leadership development. A definition expressed by Wood (1998) shows marked dissimilarities to the concept of integrated training and CPD as suggested by the Department of Health and is more akin to the idea that professional development should remain within the traditional professional structure:

> *'Individuals can and should create their own definitions of continuous development each individual will arrive at a personal understanding of the term through his or her own unique experiences which, of course, will be determined by unique changing circumstance'.* (Wood, 1998, p.87).

The conscientious professional has always undertaken opportunities to improve their knowledge and skills through appropriate training both privately or through more formal occasions. The trend now is towards structured training interventions linked to professional portfolio accreditation. The importance of evidencing competences to maintain practice will become a mandatory requirement for all professional staff wishing to remain registered to practice. The government in the white paper 'The New NHS: Modern-Dependable' (Department of Health, 1997b) aligned itself to professional development as a key aspect of NHS policy. Delivering a workplace

culture that supports this philosophy both pragmatically and financially can be seen to be of the utmost importance.

The United Kingdom Centre for the Advancement of Interprofessional Education (CAIPE) is a charitable organization which has for many years been promoting interprofessional education for health, social care and the related professions at pre-qualification and CPE/CPD levels (The Joint Evaluation Team (JET) of CAIPE has been actively involved in its commitment to demonstrate a thorough evidence base for interprofessional education. However uniprofessional training currently remains the predominant model of delivery (www.caipe.org.uk).

An abundance of terminology has emerged in relation to the definitions of interprofessional and multiprofessional educational definitions (Leathard, 1994). Gyarmati (1986) denotes that whilst a multiprofessional approach purely means that two or more professions are placed side- by- side accepting shared aims related to a mutual problem, *interdisciplinary education* requires the combination and integration of the constituent elements of two or more professions.

The UK Centre for the Advancement of Interprofessional Education (CAIPE) has set the following definitions:

- *Interprofessional education* occurs when two or more professions learn with, from and about one another to facilitate collaboration in practice;
- It is a subset of *multiprofessional education* during which professions learn side by side for whatever reason. (Barr, 2002, p.6).

In the context of changing existing roles and responsibilities it is important to remember that true *'shared learning and development'* can only be achieved if individual practitioners are disposed or inclined favorably towards releasing their expertise, skills or knowledge. This is often the hardest 'mountain to climb' for professionals since there are cultural and structural stumbling blocks impeding this process. These definitions are helpful in the context of this study to facilitate the analysis, conclusions and recommendations that are developed from the data. The

questionnaire, used in this study, reflected the multiprofessional education definition provided by Owens et al. (1999) which is:

> *'Multiprofessional education can be defined as any event (course, seminar, study day, training session) at which members of two or more professions are present together'.*

A postal survey was conducted by Owens, Goble and Pereira-Gray in 1999 on behalf of the Institute of General Practice, University of Exeter, in order to try and determine how much shared CPD in the form of multiprofessional education was being undertaken at the post-graduate level. This postal survey was targeted throughout North and East Devon, to over two thousand practitioners from twenty-four health professions. Key findings were that nearly three quarters of the respondents had been involved in some form of multiprofessional education but there was considerable variation across the professional groups. Nursing groups ranked high in their multiprofessional education rates (health visitors-94%, school nurses-86%, district nurses-86%, practice nurses 85%) with dentists reporting 25% and pharmacists 22%. Another key finding was that a number of professions were virtually excluded from learning in a multiprofessional context although the research found that there was a clear demand from respondents from all professional groups to undertake more opportunities for such learning. The exclusion of the Dental and Pharmacy professions was most notable in this research and it is unclear from the findings whether this is evidence of a national or a purely localized situation. One explanation could be that a uniprofessional culture or isolationism is more evident in these two professional groups thereby presenting inequality in multiprofessional education opportunities.

2.7.2 Staff Development and Education Processes

Barr (1997) outlines in his paper 'Competing agendas in interprofessional education: the issues at stake' three key movements that have commonalities and present either positive or conflicting agendas for multiprofessional education. The collective movement, the comprehensive movement and the collaborative movement.

According to Barr, the collective movement is the process in which groups come together not just within their own profession but also with other professional groups to achieve a sense of shared purpose. A recent example of this movement in action relates to the introduction of the Health Professions Council (HPC) and the abolition of the Council of Professions Supplementary to Medicine (CPSM). The 'collective' approach delivers benefits to the parties involved such as 'streamlined' regulation and validation of health care professionals.

Barr's comprehensive movement is typified by the consensus achieved or not achieved between two divergent groups, for example, between primary care managers and university educators, in order to encourage multiprofessional education. A recent example relates to the Common Learning programme pilots. The Common Learning programme has been highlighted in the government's modernization agenda (DoH, 2001) as a valuable mechanism for changing the culture and delivery of education and training within health care. The divergent groups involved in the Common Learning programmes have their own specific 'agendas' with different motivations, for example, university educators could be motivated by the need to deliver economies, whereas the NHS employers could be motivated to ensure greater skill mix in service delivery. The accessibility associated with Common Learning will largely depend upon appropriate evaluation of the success of the pilot sites and perceived viability in the context of political judgement.

The collaborative movement, as put forward by Barr, reflects a more patient centred and user involvement conceptualization, grounded in the delivery of front line practice. Collaboration theoretically will facilitate less tribalism and assist in delivering increased knowledge and understanding of each other's professions. A recent example of this movement is in relation to the NHS Direct and Nurse Prescribing roles that have been introduced into primary care settings. This movement, according to Barr, has a direct relation to practice on the ground and if achieved will lead to less professional prejudice and an increased knowledge and awareness relating to the range of professional skills together with mutual professional respect.

All three movements can deliver added value to achieving better interprofessional communication between health care professions. This will assist in the process of ensuring that there are more opportunities for team working across professional boundaries and thereby improve patient satisfaction of the care they receive.

The workforce planning consultation document 'Service of all the Talents: Developing the NHS Workforce' (Department of Health, 2000b) emphasized team working and the development of flexible working to make the best use of the diverse range of skills within the NHS and particularly within the primary care setting. Following on from this consultation document a further Department of Health paper entitled 'Working Together-Learning Together' (DoH, 2001) was published and highlighted the current government's commitment to harness learning and development as central to delivering the vision of patient centred care in the context of the NHS Plan and lifelong learning.

The Department of Health's document (DoH, 2001) provides guidance on the principles and criteria for delivering locally based systems for continuing professional development. Central to these themes is the government's vision for lifelong learning. This will require a change towards a 'culture of learning'. This term means that there is a requirement to deliver a cultural shift so that professionals recognize that all areas of their practice may and indeed should deliver opportunities for continued learning in order to provide the continuous improvements of service to their patients. This relates to an acknowledgement of the benefits for patient care that arises through the delivery of shared knowledge, values and skills. Thereby allowing patient care to be delivered at some level by any member of the primary care team in order to ensure continuity of care.

Seagraves et al (1996) have suggested three groups of work- based learning, which are helpful: Learning for work, learning at work and learning through work. Learning for work will include vocational higher education courses. Learning at work could include a range of in-service courses. Learning through work relates to the opportunities of learning integrated in the daily routine, for example, clinical supervision or team discussions. All three groups are helpful and are to be valued. The opportunities for quality improvement initiatives spans all three areas of work based

learning processes. Sharing these opportunities for team implementation primarily would be delivered through the 'learning through work' process.

In addition to the government's commitment to lifelong learning it has also specified its intention to deliver more pre-registration inter-professional education programmes which incorporate 'common learning' in the core skills and knowledge:

- All health professionals should expect their education and training to include common learning with other professions;
- Common learning runs from under-graduate and pre-registration programmes, through to continuing professional education;
- Common learning takes place in practice placements as well as the classroom;
- Common learning centres on the needs of patients.

This commitment has been stipulated to ensure common learning is in place for all pre-registration students by 2004 (Working Together: Learning Together-DOH-2001).

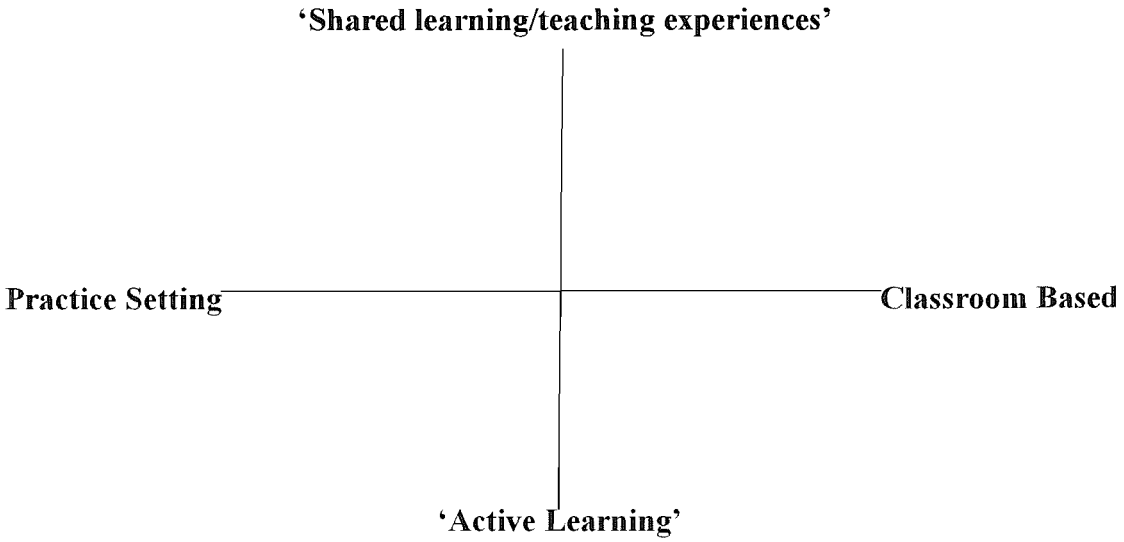
The Department of Health recognized four national common learning sites in 2003 to implement common learning in the context of reforming pre-registration programmes for students engaged in health and social care education. These pilot sites are:

1. The University of Southampton & University of Portsmouth (New Generation Project);
2. Kings College London, St Georges Hospital Medical School and University of Greenwich;
3. University of Sheffield and Sheffield Hallam University;
4. University of Northumbria at Newcastle.

Two main dimensions have been attributed to common learning and the way it is understood. These are associated with the learning process involved and the environment in which the common learning is undertaken. The following diagram, **(Diagram: One),** proposed by Tatum (2002), is of some help in conceptualizing how experiences can be positioned relative to the degree those experiences reflect the

specific type(s) of learning activity. However, the visual representation of these two dimensions is perhaps over simplistic. For example, it would appear to suggest that shared learning cannot also be active learning. It does not make sense to suggest that shared learning is passive, if it were, then shared learning is unlikely to bring about any changes in professional and team behaviour. Tatum's explanation of her two dimensions, appear to be less simplistic than the diagram would suggest.

Diagram: One -Common Learning Components



Tatum, 2002, p.3.

According to Tatum (2002, p.4), the degree to which the learning opportunity involves pro-active sharing and interaction, as opposed to just being together in an identical environment, is dependent upon whether or not active discussion is undertaken or exchanged. This results in 'active learning' within the context of the multidisciplinary group:

> *'...in the active learning experience students are working/learning together in teams focusing upon common issues, drawing upon their professional knowledge backgrounds...this requires students to 'research' out information and so is likely to take students beyond the classroom to the external world'.*

Tatum's use of the word 'Shared' describes learning experiences where students from a range of professions are brought together in either a classroom/practice setting to learn in the same location and about the same topics. Conversely, her use of the term 'Active Learning' involves multiprofessional groups, in either the classroom or practice setting. The difference in this learning experience is that participants are learning together in teams to focus upon common issues which will involve pooling their professional knowledge, skills and expertise.

The New Generation Project aspires to implement common learning into the pre-registration programmes of eleven health and social care professional groups. Craddock and O'Halloran (2004) state that this specific project site is composed of two curriculum strands, namely:

- *Learning in Common:* Comprises subjects that have a relevance to all the programmes, however, will be taught and subsequently assessed within the individual profession programme;
- *Inter-Professional Learning:* Targets the provision necessary for students to work collaboratively and learning is undertaken in multi-professional groups for this aspect of the common learning process.

A combination of University based and placement- based learning is undertaken across a range of organisational environmental settings. The units of study that have been implemented have particular resonance with 'real world' NHS primary care issues. These include: collaborative learning, team working and negotiation skills. In addition role flexibility in relation to the introduction of change and in the context of inter-professional service provision have been implemented:

> *'By studying new service developments students will have the opportunity to see the new roles that are emerging for allied health professionals such as Podiatrists'.* (Craddock and O'Halloran, 2004, p.14).

The issues that have hindered interprofessional education and working have been reported by numerous academics and field researchers: (Cashman et al, 2004;

Calleson & Seifer, 2004; Willumsen & Hallberg, 2003; Crow & Smith, 2003; Johnson et al, 2003; Harris et al, 2003; Tunstall-Pedoe et al, 2003; Bateman et al, 2003; Freeth, 2001; Henderson, 2001; Clifford and Hicks, 1995). Ineffective communication and a culture of professional 'tribalism' (Brown, 1998) has been reported as a key factor in hindering inter-professional education and working. The delivery of separate professional education both at undergraduate and post graduate levels is likely to continue to lead to the stereotyping of ideas and lack of understanding of other professional groups. These 'tribal' views will reinforce perceptions of status and power (Harris et al, 2003; Freeman et al, 2000). Work undertaken by Freeth and Reeves (2004) utilised the form 3P (presage-process-product) model of learning and teaching to assist in analysing the phenomena of educational opportunities designed to progress collaborative working. Valuable insights into the factors that affect education for the delivery of collaborative practice have been gained through this process and as Freeth and Reeves argue:

> '*...untangling or at least seeing the web of influences on learning to work together promotes critical awareness and encourages more informed and timely decisions'*. Freeth and Reeves, 2004, p.43).

Stereotyping of each professional group's role within primary care can become established at an early stage of undergraduate training. Pietroni (1991) looked at individual's descriptions of each other's role over a two- year study period and found that the socialisation into own roles and the views related to each profession were established early on. Freeth and Reeves (2004) also considers the importance of stereotyping of professions that occurs early on together with the associated 'baggage' that can arise as a consequence:

> '*Neophyte practitioners will have chosen their profession and rejected others based on information they could marshal before making this commitment. Stereotypes of professions and professional practice have a role in this...further along the journey of professional socialisation, the 'baggage' brought by established professionals and established teams to interprofessional and interagency learning or practice development, may limit*

participants' ability to imagine, consider or accept changed practice; even when collaborative practice is viewed positively'.
(Freeth and Reeves, 2004, p.49)

Students in different professions may demonstrate a lack of diversity of their perceptions towards each other's discipline and a demonstration of a lack of understanding of the roles and skills possessed by individual professional groups. This is an important issue since it has ramifications for the effective delivery of services within the context of multiprofessional teamworking in primary care.

The 'Skills Escalator' was set out within the NHS Plan (Department of Health, 2000) and provides a reference for employability and employment progression, grounded in the context of the common learning agenda and the 'Agenda for Change' framework for key skills competences. The essence of the Skills Escalator approach is that staff are encouraged through a strategy of lifelong learning to renew and continuously extend their skills and knowledge, and by doing so enable them to move up the 'escalator'. Meanwhile, efficiencies and skill mix benefits are produced through delegating roles, work and responsibilities down the 'escalator' where appropriate. The nurturing and ongoing development of primary care staff has the potential to assist in achieving service delivery aspirations. The focus here is upon existing staff already engaged in primary care provision that have shown a willingness to extend their professional skills and talents. There is the potential to utilise this process of skills escalation to engage staff into being ultimately recruited into primary care, whereby their prior learning, qualifications and experiences can be nurtured and harnessed appropriately. Skills escalator developments should include accessibility to training and developments that are agreed as part of the 'Individual Personal Development Planning' process that is currently only used ad hoc across primary care services. All staff should be encouraged to reach their potential and this process will send a powerful message about valuing staff together with their contribution towards primary care.

2.8 Conclusion to Chapter Two

The NHS and PCTs have undergone a number of structural and cultural changes over the past fifty years. Currently, there is an emphasis on teamwork and multiprofessional collaboration. This has significant implications for how PCTs deliver their services, and plan workforce and staff development initiatives. Therefore the focus of this study is:

- To establish 'key stakeholders' perceptions of the existing culture and change processes required for the delivery of effective multiprofessional education and teamwork in NHS primary care services;
- To gain 'key stakeholders' vision for the future of workforce and staff development to ensure effective teamworking for the delivery of patient care.

Specifically, the research questions that the study will address are:

1. How important is multiprofessional teamwork in Primary Care Trusts for the effective delivery of services?

2. What changes in organisational culture and processes are required to promote multiprofessional education in Primary Care Trusts?

3. What changes in workforce and staff development are required to promote multiprofessional teamwork in Primary Care Trusts?

Questions 1 and 2 are linked to objective one.

Question 3 is linked to objective two.

CHAPTER THREE – METHODOLOGY

3. Introduction

Chapter One and Two made explicit both the research objectives together with the research questions and provided a detailed review of the literature for this study and for ease of reference they are represented below:

Objectives

- To establish 'key stakeholders' perceptions of the existing culture and change processes required for the delivery of effective multiprofessional education and teamwork in NHS primary care services;

- To gain 'key stakeholders' vision for the future of workforce planning and staff development to ensure maximum benefits to patient care.

Questions

1. How important is multiprofessional teamwork in Primary Care Trusts for the effective delivery of services?

2. What changes in organisational culture and processes are required to promote multiprofessional education in Primary Care Trusts?

3. What changes in workforce and staff development are required to promote multiprofessional teamwork in Primary Care Trusts?

Questions 1 and 2 are linked to Objective One.

Question 3 is linked to Objective Two.

The purpose of this chapter is to present the methodology utilised during the study and provide a detailed analysis of the principles and procedures employed.

3.1 Combined Research Strategy

The research questions leading this study have spanned a number of foci ranging from cultural and change processes to teamworking and professional development within the context of multiprofessional NHS education. The researcher concluded that the most appropriate strategy to adopt was a combined strategy involving:

- Case study;
- Survey.

Where the case study involved in-depth interviews of staff working in the two Primary Care Trusts in the South East of England and the survey involved questionnaire responses from participants inside the case (two PCTs) and in-depth interviews of participants external to the case study.

Two Primary Care Trusts (PCTs) were chosen to be involved in the case study due to pragmatic reasons. At the time the research was undertaken, Trust B, was still the employer organisation of the majority of the primary care workforce. Trust A, had been recently established and was still in a transitional form. Trust B was disbanded several months after the fieldwork was completed in April 2002 (see section 1.7).

The benefits of utilising a combined research strategy is outlined by Robson (1999, p.41):

> *'It is important to note that the traditional research strategies do not provide a logical partitioning covering all possible forms of enquiry. They are more a recognition of the camps into which enquirers or researchers have tended to put themselves, signalling their preference for certain ways of working. However, they carry the danger of the enquiry being 'strategy driven' in the sense that someone skilled in, say, the ways of surveys assumes automatically that every problem has to be attacked through the survey strategy...it can make a lot of sense to combine strategies in an investigation. One or more cases might be linked to a survey'.*

3.1.1 Case Study

The study was rooted in the qualitative paradigm and followed an interpretative, naturalistic path to illuminating the case.

Robert Stake (1995, p.8) emphasizes that the foremost concern of case study research is to generate knowledge about the particular. The case seeks to discern and pursue understanding of issues intrinsic to the case itself. This framework was, in my opinion, the most appropriate vehicle to facilitate the handling of the variety of data that needed to be collected in this study. The case study can be defined as:

> *'an empirical enquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between the phenomenon and context are not clearly evident, and in which multiple sources of evidence are used'.* (Yin, 1994, p.23).

The purpose of the case study in this research was to:

1. Generally: provide detailed data that would enable all of the specific research questions to be answered;
2. Specifically: gain enlightenment into the processes engaged in delivering effective multiprofessional education and teamwork.

Specific research questions were to be the foci of the study and would enable the delivery of detailed data in this particular case. Gaining enlightenment into the processes engaged in delivering effective multiprofessional education and teamwork, in the context of the organisations studied, who were delivering primary care services, required the specific relationships and key linkages to be fully understood. The objectives and foci of this study required the research to consider the case as a whole and not in an isolated or piecemeal fashion. These primary care services were an entity at the time of the research study and are still in existence. The study did not introduce any artificial entities or situations. The benefits of using more than one method, has been set out in the triangulation section 3.15 of this chapter. The case

study strategy provides flexibility over the delivery of the most appropriate methods to be utilised in the research. Multiple sources rather than one research method.

The assumption that the case study is in some way typical of the broader phenomenon needs consideration. Stake and Trumbull (1982) introduced and expanded upon the concept of 'naturalistic generalisation', which can be defined as conclusion arrived at through personal engagement in life's affairs or by vicarious experience so well constructed that the person feels as if it happened to themselves. The concept of 'naturalistic generalisation' is most relevant for this study. Stake (1995) differentiates between the formal (scholarly, scientific) generalisation and naturalistic generalisation in the formalisation of knowledge and argues that:

> *'Naturalistic generalisations develop within a person as a result of experience. They form the tacit knowledge of how things are, why they are, how people feel about them and how these things are likely to be later or in other places with which the person is familiar. They seldom take the form of predicting but lead regularly to expectation. They guide actions, in fact they are inseparable from actions'.* (Stake, 1995, p.84).

It therefore falls to the reader of the case to make a personal judgement as to whether or not the findings are suitable to use within the context of their own situation:

> *'Often, this case will be as important to its readers as any other case they care about it; their interest in generalizing from this case to others is small. In other circumstances, this case will be studied primarily for generalizing to other cases...but people can learn much that is general from single cases. They do that partly because they are familiar with other cases and they add this one in, thus making a slightly new group from which to generalize, a new opportunity to modify old generalizations'.* (Stake, 1995, p.85).

The external validity issues and generalization concerns over case studies has presented problems. According to Yin (1994, p.36) case studies rely upon 'analytical generalisation' in as much as the researcher is seeking to generalize a particular set of results to some broader theory.

Ultimately case studies are carried out in order to seek to make the case understandable and people learn by receiving generalizations. In essence conclusions are arrived at through personal engagement in life and its array of experiences.

It has been the position of the researcher in this study, to describe the case in a manner by which the reader can make their own assessment and judgement as to the case's application to their own context. By doing this the researcher in this study support's Stake's position that it is left to others to take this particular case and to use it in other situations and at times yet to come.

3.1.2 Strengths and Weaknesses of the Case Study Strategy

Yin (1994) provides a helpful overview of the traditional prejudices against the case study strategy. In particular he states that although the case study is a distinctive form of empirical inquiry, many research investigators nevertheless have disdain for the strategy. Case studies, according to Yin, have been perceived as a less desirable form of inquiry than either experiments or surveys.

This perception, outlined by Yin (1994, p.9) can be placed in the context of three key concerns, which are:

1. Apparent lack of rigor when compared to more traditional research strategies. Yin suggests that on occasions the researcher has allowed ambiguous evidence or biased views to influence the findings and conclusions;
2. There is a commonly held concern that case studies provide little basis for scientific generalisation since frequently findings are based upon a single case;
3. A final complaint outlined by Yin relates to the concerns that case studies can be undertaken over long periods of time and consequently generate considerable quantities of unreadable documentation.

In consideration of the above concerns it must be borne in mind that good case study research requires the researcher to work extremely hard at avoiding any potential pitfalls. As suggested earlier in this chapter, the success or failure of the case study,

can be judged by the reader as to whether or not findings of the study, can be applied in their own specific situation and context. For my part as researcher, I have been obliged to ensure the provision of high quality input and robust interpretation to enable the reader to use from the case what is both transferable and enlightening for their own situation. This statement is upheld by Stake who argues that:

> *'Case study research is not sampling research. We do not study a case primarily to understand other cases. Our first obligation is to understand this one case'.* (Stake, 1995 p.4).

The strengths of the case study approach can be set out as follows:

1. The case study approach permits and supports the generation of theoretical propositions that may indeed be generalisable to other groups naturalistically (Hammersley, 1992, p.195) or analytically (Yin, 1994, p.36);
2. The holistic approach of the case study allows for the detailed focus of specific phenomenon (Denscombe , 1999, p30);
3. Case studies can provide powerful stories to illustrate particular social contexts (Grbich, 1999, p.193).

3.1.3 Survey Strategy

Colin Robson (1999, p.49) asserts that survey strategy is a term that commonly refers to:

> *'The collection of standardised data from a specific population, or some sample from one, usually but not necessarily by means of questionnaire or interview...survey data can be used to explore aspects of a situation, or to seek explanation'.*

The main rationale for utilising this research strategy in the study was to ensure that empirical information was obtained from as wide and inclusive coverage as possible within the time constraints of the study. The critical point, from my perspective, was not so much the number of people involved but the breadth of coverage that would provide further illumination of the case.

3.1.4 Strengths and Weaknesses of the Survey Strategy

My use of the survey strategy was to explore aspects of the research questions with respondents. Although some of the respondents were external to the bounded case study, nevertheless I felt that because of their positions and experience they had a valuable contribution to make in providing data to illuminate the study.

The strengths of the survey strategy, as depicted by Denscombe (1998, p.28) comprise several components. In particular surveys place an emphasis on providing empirical data directly from the real world and are associated with a proactive engagement in acquiring that information. The search for this information is purposeful and structured. Surveys can be used in small- scale studies such as this one. The crucial point from my perspective was not so much the number of people involved as the breadth of coverage gained through purposive sampling and interview. The amount of valuable and constructive data gleaned from this strategy was achieved relatively quickly and with a minimal cost associated with that collection. This assisted in adhering to the tight scheduling regime adopted. The researcher adopted the survey strategy within the context of a combined approach in order to employ the interview method and deliver the breadth of study that was believed to be important for the research and at the same time provide a snapshot at a given point in time. The strategy provided as wide and as inclusive data as possible.

According to Denscombe (1995, p.29) there are specific weaknesses involved in the use of the survey strategy which relate to the risk that the researcher could become obsessed with the data to the exclusion of an adequate account of the implications of the data in relation to specific issues or problems, thereby the significance of the data could have become neglected. In addition, there is the risk with large- scale coverage surveys over the degree to which the researcher can be assured of the accuracy and honesty of the data.

The prime rationale in selecting this aspect of the combined strategy was to obtain information from a representative selection that through analysis would provide patterns/themes to enlighten the case.

3.2 Research Approach

The study was based within an organisational and cultural setting that influenced behaviour and the qualitative inquiry is distinguished by its emphasis on the holistic treatment of phenomenon (Schwandt, 1994). In essence the nature of this research was substantially grounded within the qualitative paradigm.

However, the researcher adopted a 'combined approach' (qualitative-quantitative) in the study design in the collection of data and subsequent analysis. The viewpoint that it was reasonable to use both qualitative and quantitative data in this research study, was succinctly made by the following statement:

> *'We have to face the fact that numbers and words are both needed if we are to understand the world'.* (Miles and Huberman,1994, p.40).

The quantitative data to be collected would provide helpful background information to illuminate the case study. Salomon (1991) states that the issue is not quantitative-qualitative at all, but whether or not the researcher has adopted a systemic approach to understanding the interactions involved in a complex environment. This combined (qualitative- quantitative) approach assisted me according to Rossman and Wilson (1991) to:

(a) to enable confirmation or corroboration of each other via triangulation;
(b) to elaborate and develop analysis, providing richer detail;
(c) to initiate new lines of thinking through attention to surprises or paradoxes, turning ideas around, providing fresh insight.

As Firestone (1987) suggests, qualitative research persuades the reader through rich depiction and strategic comparison across cases, whereas, quantitative research persuades the reader through de-emphasising individual judgement and by stressing the use of established procedures.

Seale and Barnard (1998) point out that:

> *'Traditionally the two approaches to research have been presented as diametrically opposed. Depending on your viewpoint, one research approach is superior to the other. This is a polarised argument that has stemmed from the beliefs and traditions that people bring to research. There is currently a growing acceptance that both research approaches have their place. Furthermore, both approaches can be seen to complement one another. This has led to calls to combine the two approaches where appropriate or to mix methods'.* (1998, p.11).

Denscombe states that the crucial issues to ensure good research is that choices are reasonable and that they are made explicit within the context of the research report. This was a deciding factor in my decision to opt for analysis embracing a mix of both qualitative and quantitative data within the context of the case.

Miles and Huberman (1994, p.41) present a rationale for utilising a mix of qualitative –quantitative analysis and this mix can be seen to support and corroborate each other via triangulation and to elaborate or develop analysis providing richer detail. This mixed analysis supports the initiation of new lines of thinking through attention to surprises or paradoxes, turning ideas around, and providing fresh insight. A combined qualitative-quantitative approach can help overcome the 'abstraction inherent in quantitative studies' since qualitative research persuades through rich depiction. In addition, the combined qualitative-quantitative approach can also help by showing the generality of specific observations gained by the quantitative method and casting new light on qualitative findings.

Whilst the different epistemological heritages matter the differentiation between the qualitative and quantitative approach and subsequent data collection and analysis has been shown to be of minimum importance (Hammersley, 1992; Miles and Huberman, 1994).

The view upholding a combined approach within the same investigation is appropriate and further upheld by the work of Hammersley (1992) in which he outlines the ways

in which the differentiation between qualitative and quantitative methods has been shown to be of minimum importance. Hammersley argues, in particular, that both qualitative and quantitative researchers use each other's methods to a greater or lesser extent and that both types of researchers use terminology that both relate to numbers.

3.3 Research Study Design

The research design can be considered as the blueprint or action plan for the research. In particular the following questions needed to be answered prior to conceptualizing the design: what questions need to be studied? what data will be relevant? and how best to analyze the results? Chapter one is explicit in setting the historical context of the research. Chapter two provided a detailed review of the literature and it was through this process that the focus of research questions emerged:

> *'Design deals primarily with the aims, purposes, intentions and plans within the practical constraints of location, time, money and availability of staff. It is also very much about style, the architect's own preferences and ideas (whether innovative or solidly traditional) and the stylistic preferences of those who pay for the work and have to live with the finished result'.*
> (Hakim, 1987, p.1).

In deciding upon the design of the research the researcher was mindful of the absolute need to link the research questions to how best to achieve the data collection and ultimately the conclusions for the study. To assist in this process the term 'research' needed to be defined in order to ensure that the design of the methodology was both appropriate and robust:

> *'Research is best conceived as the process of arriving at dependable solutions to problems through the planned and systematic collection, analysis and interpretation of data'.* (Cohen and Manion, 1996, p.40).

In providing a description of the nature of this research the author of this study was influenced by the work of numerous academics and researchers:

'Yet no amount of caring for the case will ensure it's worth. It is interactive communication, first between a single researcher with the case, later with the reader. The exercise is partly commiseration, partly celebration, but always intellecturalisation, a conveying, a creating of meaning'. (Stake, 1995, p.136).

It is true to state that there are numerous dilemmas facing the researcher in the decision relating to the choice of strategy and methods. As Denscombe suggests:

'The social researcher is faced with a variety of options and alternatives and have to make strategic decisions about which to choose'.
(Denscombe,1999, p.3).

To assist the process of selecting the desired strategy and methods the researcher examined the possibilities with the assistance of the six parameters set out by Gill & Johnson (1997, p.13-16). These parameters were: access, achievability in the time available, symmetry of potential outcomes, student capabilities and interest, financial support and value and scope of the research.

The term 'gatekeeper' is a term often used to depict the person(s) having control over access to the research locations, for example, in the case of this research it was ultimately the NHS Trust Chief Executive. The parameters for the research were indicated in advance of commencement and full support and co-operation was achieved. It is true that the relationship between the researcher and 'gatekeeper' could present issues, for example, the 'gatekeeper' could perhaps place very stringent conditions on the research access or process, however, the access was not considered a problem at any stage of this research study and in fact was fully supported by all those that were approached at the outset.

All data for this study was to be collected in the course of twelve 'key stakeholder' semi-structured interviews and questionnaire survey to sixteen professional groups. The data collection phase lasted four months between July and October 2001. Each interview lasted up to 50 minutes and 166 questionnaires were returned from a total 220. This element of the research was scheduled and achieved within the time specified at the outset. The subsequent time for analysis and write up of the research

study was underestimated by the researcher in this study. The constraints of other 'life pressures' had the effect of causing slippage in the achievement of particular milestones/goals, that had been outlined at the beginning of the research project.

The research questions set for this study focus upon significant aspects of cultural change and the related educational needs and experiences of NHS primary care staff. As a consequence a contribution to the body of knowledge in the field will be delivered in seeking to answer these questions. Had this not been the researcher's perception throughout, it would have undermined the motivation required towards the completion of the thesis. The outcomes of the research will provide an increase in knowledge, regardless of whether they are perceived to be positive or not by particular individuals.

3.4 Sampling Techniques- Overview

Purposive sampling was the method of sampling used for both the case study and survey strategies of this research. Cohen and Manion (1996, p.88) regard 'purposive sampling' to be quite acceptable in circumstances where the findings are not going to be generalised too far beyond the case in question, having accepted that 'naturalistic generalisation' is being sought in this specific study. In relation to the interview stage of this case study research it was important to select 'purposefully' rather than on the basis of some random selection procedure. It has also been proposed by Creswell (1994) to purposefully select informants that will be best placed to answer the research questions.

Purposive sampling is the deliberate non-random method of sampling which aims to sample a group of people with particular characteristics (Bowling, 1997, p167). This was also the method of sampling adopted in piloting the questionnaire and interview questions.

It is my opinion that all participants were chosen in relation to their experience and role as opposed to any other aspect that could potentially be conceived as a bias within the sample selected.

The sample frame utilised is representative of the body of the people who are able to deliver information relating to the research questions set. In addition, this same sample of participants, were well placed to furnish a detailed understanding of the key issues under investigation. On reflection the researcher also now believes that the criteria set for the external interviewees was too subjective **(see Section 3.17).**

3.4.1 Case Study Interviewees

The seven case study interviewees were selected on the basis of their knowledge, experience and role they performed in relation to the context of the research questions. The following five explicit criteria was formed in order to ensure consistency in the selection process and relevance to the research:

1. Employed within the Primary Care Services from within the NHS Trusts being studied;
2. A minimum of five years experience at Senior Management/Senior Clinician grade;
3. Responsible for direct management/strategic direction of multiprofessional primary care services;
4. Responsible for completing Workforce Development documentation;
5. Ability to influence primary care training planning and delivery.

Interviewees*	Designation	Criteria Met
A	Director of Primary Care	1,2,3,4,5.
B	Primary Care Service Manager	1,2,3,4,5.
C	Continuing Care/Integrated working Manager	1,2,3,4,5.
D	Associate Director of Primary Care	1,2,3,4,5.
E	Assistant Director of Nursing	1,2,3,4,5.
F	Chief Executive	1,2,3,4,5.
G	Medical Director and GP	1,2,3,4,5.

3.4.2 Survey Interviewees

The five survey interviewees were also selected on the basis of their knowledge, experience and role they performed in relation to the research questions. The following three explicit criteria were formed in order to ensure consistency in the selection process and relevance to the research:

1. Holds a Senior Educational/Policy/Strategic position that has direct links to the delivery of primary care services;
2. A minimum of five years experience in the present post;
3. Not employed within the NHS Trusts being studied in this research project.

Interviewees *	Designation	Criteria Met
H	Director of Primary Care and GP	1,2,3.
I	Head of Primary Care	1,2,3.
J	Professor of Health Services Development	1,2,3.
K	Chief Executive-Commissioning	1,2,3.
L	Primary Care Lead Educationalist	1,2,3.

***Please Note:** For purposes on confidentiality and anonymity all twelve interviewees have been allocated a random code **(S1-12)** within the data analysis and discussion Chapters.

On reflection the researcher now considers that attributing the five external interviewees within the context of a survey has particular weaknesses and is discussed further in the **Section 3.17**. In particular, the decision made not to compare and contrast the three separate data sets more vigorously has been seen in hindsight to have been a flaw. Another weakness can be seen in relation to the criteria set for the

selection of the interviewees (both external and internal), for example , criteria 2, can be seen upon reflection to be too subjective.

3.5 Interview Process and rationale for both Case Study and Survey Strategies

The semi-structured interview process is a commonly used method in qualitative research (Dawson, 2002, p.28). The rationale for selecting this particular method was to acquire specific information in order to compare and contrast the data collected in all twelve interviews in the analysis stage of the study. In addition, it was important to allow flexibility within the context of the interview so that each respondent was able to develop their ideas and speak more widely on the issues raised by each question. The answers were open ended and the emphasis was allowing the respondent time to elaborate on any points of interest (Denscombe, 1998, p.113).

The key advantages of the semi-structured interview process in this study are as follows:

- Ability to probe fully for responses or to clarify any ambiguities;
- More complex and detailed questions can be asked and a greater depth of information was obtained;
- Inconsistencies or misinterpretations can be checked;
- The response rate will be high;
- Open- ended questions were asked which provided the opportunity for rich material to be gained through the process.

The main disadvantage related to the 'interview effect' and potential bias is considered here and later in **Section 3.17**. As a Senior Manager within the NHS primary care services within the organisations being studied, the researcher was known to many of the staff that had consented to be interviewed and indeed this may have been a contributing factor for their agreement to have been involved. The researcher's role, over those last three years, had changed and he was then more focussed upon strategic issues as opposed to day-to-day operational primary care management and therefore had limited contact with the participants.

It was possible that the researcher's role and position within the NHS organisations in which the study was undertaken, could have affected the responses received from participants **(see Section 3.17)**. For example, responses could have been provided in order to let the researcher hear what they thought he wanted to hear:

As Denscombe (1998, p.116) argued:

> *'Research on interviewing has demonstrated fairly conclusively that people respond differently depending on how they perceive the person asking the questions'.*

A strategy was adopted in order to ensure, as far as possible, the trustworthiness of the data received **(see also Section 3.17)**.

- The reassurances made prior to the commencement of the interview relating to the confidentiality would have allayed fears that no comments could be in any way attributed to individuals. It is also the researcher's belief that the cover letter originally sent to each participant detailing the objectives of the research, prior to their consent to become involved, was helpful in reducing any risk of potential bias. The cover letter and consent form also stressed the confidentiality aspects of the research;
- The question design avoided the potential of 'leading' questions and allowed for a full, frank and detailed discourse;
- During the interviews the researcher was careful to present a pleasant demeanour at all times, regardless of any comments being made and my dress was smart but informal;
- When the eleven semi-structured questions had been completed, the researcher was keen to afford the opportunities for the interviewee to discuss openly any further detail and other points of clarification or indeed to include other key issues that came to mind. This allowed a two-way dialogue to arise, which produced useful data on a couple of occasions;

- Once the transcripts had been prepared, the interviewees were forwarded a copy of each transcript under cover of a 'letter of thanks'. The request was made to each participant to confirm their approval of the contents of their interview and to make any adjustments on the transcripts, if required, and return back to the researcher in the stamped addressed envelope provided. No extra data was produced by the 'transcript validation' process **(see Section 3.17)**. There were no alterations to the texts.
  (See also Appendix One & Two for Transcript Validation Letter & Example of Anonymised Transcript).

The twelve participants were interviewed over a period of 4 months using a semi-structured interview schedule containing eleven specific questions with no pre-coded answers **(See Appendix Three)**. The question schedule had been set in order to ensure that the interview focussed upon all the areas under investigation and to keep the interview process on track (Seale and Barnard, 1998, p.61). At the end of the semi-structured component of the interview all participants were provided with the opportunities to provide any other further comments that they wished to make. At this stage the researcher was able to revisit particular areas previously considered and, if required, probe accordingly to gain further insight and reflection. Each interview lasted between 35 – 50 minutes.

The format of the semi-structured interview schedule was deliberately chosen in order to ensure focus and depth of response by allowing the respondents to answer on their own terms which would not have been the case had a standardised or structured interview method been selected. The working of each question, which was reviewed during the pilot stage, was critical in this respect.

The control over the wording of the questions, the order in which the questions occur and the range of answers that are potentially resultant have the advantage of ensuring that data collected is as focused as possible in answering the specific area of interest. However, although clearly focused, there was latitude if interviewees wished to spend more time on one particular question areas as compared to other areas.

The interviews were all tape-recorded using a professional pocket memo transcription machine and external miniature microphone, which was placed in a position to be as unobtrusive as possible. All interviews were subsequently transcribed into microsoft word for analysis using 'QSR N5' (NUD*IST) software. This process of transcription was extremely useful since it enabled review of the interview tapes for clarification during the data analysis stage.

Interviews were pre-arranged and held in the office of the participant without disruption thereby affording the most relaxed atmosphere for the interviewee. A set procedure was undertaken prior to each interview. Each participant's permission was sought to transcribe the interview and reiterated the fact that their comments would remain anonymised and not attributed directly to them individually. Their permission to be named in the research was also secured.

3.6 Interview Question Schedule and Explicit Links to Research Study

The schedule was developed from the research objectives and questions in order to provide prompts for in depth coverage of the topics under investigation in this study. This schedule was developed and facilitated in the pilot stage of the methodological process outlined in **Section 3.12**.

Interview Questions	**Explicit Links to Research Objectives and Questions**
In your view, how effective, in general terms, do you consider existing primary care teamworking across professional and organisational boundaries?	This question sought to identify the respondents' perception of the current state of teamworking. *Linked to research objective one and research question one.*
In your opinion, what key factors or attributes lead to good teamworking?	Further exploration of good teamworking concepts. *Linked to research objective one and research questions one and two.*
In your view, do you consider that shared learning opportunities encourage or hinder effective teamwork and	Development of respondents' views appertaining to shared learning. *Linked to research objectives one & two together*

professional development?	*with research questions two & three.*
What is your understanding of the term 'integrated working'?	Modernisation concept relating to effective teamwork. *Linked to research objective one and research question two.*
What is your understanding of the term 'culture' in relation to the NHS environment?	Introduction to cultural conceptualisation. *Linked to research objective one and research question two.*
What ways if any, do you consider the existing primary care culture supports or hinders the delivery of effective teamworking?	Further exploration of cultural concepts and its potential influence and ramifications. *Linked to research objective one and research question two.*
How effective do you consider the existing training and education processes for primary care staff in terms of career and professional development?	Introduction and exploration of the concepts of training, education and career & professional development. *Linked to research objectives one & two together with research questions two & three.*
How satisfactory and effective do you consider the existing NHS workforce planning process to be?	Further exploration of workforce development issues. *Linked to research objective two and research questions two and three.*
Within the context of primary care services, what improvements, if any, could be made in the ways staff are deployed to ensure maximum benefits to patients care delivery?	Identification of the key staffing issues and innovations required to maximise patient care. *Linked to research objectives one & two and research questions one, two & three.*
There has been an abundance of recent NHS policies and strategic guidance relating to the NHS modernisation, clinical governance etc. In what ways do you consider professional development in primary care is supported by these policies and guidelines?	Identification of respondents' views over the strategic direction of primary care services and the policy changes being introduced for delivering that strategy. *Linked to research objectives one & two and research questions one, two and three.*

Are there any other comments you wish to make?	To ensure flexible and inclusive approach adopted and to facilitate depth of data received. *Linked to research objectives one & two and research questions one, two and three.*

The questions were put to each respondent in a way that negated any reasonable possibility that I was leading the respondents down any specific route. No declaration of any views, potentially held by me, were at any time specified or discussed.

3.7 Strengths and weaknesses of semi-structured interview and questionnaire

The researcher considered in detail the strengths and weaknesses of the semi-structured interview prior to selecting this method for my research study. According to Blaxter et al (1999), Polgar and Thomas (1995), Denscombe (1998) and Robson (1999) the key strengths are:

- The semi-structured interview is a flexible and adaptable way of undertaking research together with the ability to ask respondents directly about specific issues is effective in seeking answers to our questions;
- The human use of language is fascinating both as a behaviour in its own right, and for the virtually unique window that it opens on what lies behind our actions;
- The achievement of a high response rate in relation to prearranged and scheduled appointments is very helpful to the process;
- The semi-structured interview provides a good balance between allowing the agenda to be set by the interviewer and affording the interviewee an active role in the conversation and the agenda of the research;
- The responses may be recorded in the 'own words' of the respondents, hence less bias through interpretation;
- The depth of information, detail and valuable insights by key informants acquired during the interview is extremely beneficial;

- The validity gained by the direct contact with informants is very positive since the data can be checked for accuracy directly with each respondent;
- In addition the process can be a rewarding and 'therapeutic' experience for the participants since it posseses a personal element that is not present in, for example, the questionnaire method.

The key weaknesses and disadvantages are:

- To make profitable use of this flexibility requires considerable skill and experience in the interviewer. I had many years of 'patient interview' expertise, but virtually no experience in field work research interviewing;
- Interviewing is time consuming and can be costly due to travel and other expenses incurred. It was possible that the proposed interviewees would not feel able to participate thereby potentially leading to biases in the sample I wished to secure (this was not the case in reality and all those approached were positive in their willingness to participate);
- Careful preparation is required in setting up and delivering the interview and requires attention to detail (for example: ethical and consent considerations);
- Post interview follow up is time consuming (for example: respondent transcript validation);
- The biggest time commitment in this research study was the typing up of all twelve transcripts from the 'dictaphone' tape recordings. Plus, of course the subsequent analysis data analysis stage as a result of the production of copious quantities of non-standard responses with a relatively open format;
- The 'interviewer effect' whereby people respond differently depending on how the respondent perceives the person asking the questions. In essence the personal identity of the interviewer is potentially relevant to responses that will be provided. From the perspective of this small scale research project there was a limit as to what I could do to reduce this potential effect and what limits I was able to disguise my 'self' during the interviews. I did, however, make a conscious effort during each interview to be punctual, polite, neutral and receptive at all times to the respondents' views so that the optimal environment was present to perform the interview;

- The impact of the interviewer and context of the interview needs to be considered. The data, which is collected, is to an extent, quite unique as a result of the specific context and the specific individuals involved. This will have an adverse effect on reliability. Reliability will have an effect, both in terms of objectivity and consistency, in the context of this study. This will be particularly relevant in the constantly changing environment of NHS primary care services. Reliability in terms of gaining the best data available at the time that this research was undertaken was the goal;
- There is the potential of inhibitions being present in the respondents because of the use of the tape recorder transcription equipment. Although the presence of the equipment probably wears off quickly this may not always be the case;

When people are speaking for the record this may also have an inhibitive bearing on the process. The issues of anonymity, confidentiality and consent need to be fully explained and agreed prior to the commencement of the process.

The researcher also considered in detail, the strengths and weaknesses of the questionnaire prior to selecting this method within the context of this research study. According to Oppenheim (1996), Sappsford and Jupp (1996), Robson (1999) and Denscombe (1998) the key strengths are:

- The questionnaires will provide relatively standardised answers and this has a bearing on the ease of data collection and subsequent analysis. However, the questionnaires also included several questions, which invited open written comment from respondents and needed to be analysed accordingly;
- Postal questionnaires are relatively easy and straightforward to dispatch and co-ordinate. Pre-dispatch consent to individuals is not a specific requirement plus I was able to widely distribute the questionnaire to an appropriate sample of professional groups and staff;
- Questionnaires are reasonably economical. Although the cost of stationery and postage was a relatively high personal cost in this research study but not in relation to the overall time resources for the study;
- There was no 'personal effect' as a result of interaction by the researcher.

The key weaknesses and disadvantages are:

- The response rate is a particular concern. However, I believed that the nature of the research was sufficiently high profile and important to achieve a good rate of response. The subjects under investigation had a clear interest to all those who participated. The researcher's 'self' plays a significant role in the production (subjects under investigation) and interpretation of the data **(see Section 3.17)**;
- Questionnaires can be frustrating to respondents and therefore deter them from answering. Whilst it is true that 'likert scale' tick boxes can be perceived by many as less demanding to complete, there potential frustration to some respondents, in not being able to be able to provide a fuller response. This was a key factor in the decision to also include several questions with the resultant opportunity for respondents to offer fuller explanation if they wished to;
- Incomplete, rushed or poorly completed questionnaires.

On balance the advantages for utilising both the interview and questionnaire methods far outweighed any disadvantages in terms of the clear potential to provide rich and highly illuminating material.

3.8 Interviewee Confidentiality and Consent

As part of the confidentiality agreements made with all twelve participants, the researcher has endeavoured to maintain anonymity with respect to their individual comments and views. All participants were pleased to be named as being involved within the research study, however, upon reflection, **(see Section 3.17)**, both the study setting and locations have been anonymised together with the names of the staff involved in the interview process. **(See Appendix Four & Five for: Initial Cover Letter, Consent Form and Ethics Form).**

3.9 The Questionnaire Sample- Case Study

The questionnaire sample was selected through a random process within the context of this case study. Sixteen Primary Case professional groups were identified, namely:
Chiropodist/Podiatrist/Podiatric Surgeon;
Clinical Psychologist;
Dentist/Dental Surgeon;
Dietician;
General Practitioner;
Health Visitor;
Nurse, Community (Mental Health or Learning Disability);
Nurse, District;
Nurse, Practice;
Nurse, School;
Occupational Therapist;
Pharmacist;
Physiotherapist;
Practice Manager;
Social Worker;
Speech Therapist.

The computerised payroll management information system (Pay Roll Electronic Management Information System-PREMIS) list used within the NHS Trusts contained details of the Primary Care staff working within the Trusts, together with a list of all their General Practitioners and Practice Managers. These were accessed under the strictest confidentiality arrangement.

In order to ensure that every member of each professional group had an equal chance of being selected in relation to their 'proportion' within the total professional group, the following 'Stratified Random Sampling' procedure was adopted:

- Full consent was agreed between the NHS Trust's involved and a list of each professional group and GP Practice lists were accessed;

- Each member of each professional group/ GP lists had a unique 7 digit payroll number. This number was written down on individual 'post it' notelets for each member of staff segregated into professional groups, then folded to secure anonymity, and then placed into a container, which was sealed and shaken vigorously;
- A 25% sample was selected from each of the sixteen primary care staff groups at random. For example, there was 32 Podiatry staff on the PREMIS list, which required 8 questionnaires to be randomly selected and sent.

The questionnaire survey was conducted at the same time that interviews were being arranged and conducted. In hindsight, the researcher now believes that it would have been more appropriate for questionnaire analysis to have been used to inform the interview process, specifically in relation to the semi-structured interview questions. **(See Section 3.17)**.

220 questionnaires were sent out and 166 completed questionnaires were returned which represented a response rate of 75% for this component of the research.

The sample randomly selected all grades of the staff within each professional group and therefore no bias was introduced. This also enabled the random sample of age, gender and part-time/full time employment and staff grade. Respondent cover letters and questionnaires were sent out by external post and contained a stamped addressed enveloped to be returned to my home address. Clarification was made with respect to confidentiality and purpose of the research in the context of the researcher's role as part time researcher and EdD student with the University of Southampton was explained within the cover letter sent to each respondent **(Appendix Six)**.

3.10 Questionnaire Structure

The questionnaire used in this research comprised four sections and was loosely based upon a questionnaire that was posted on the internet in relation to research undertaken by Owens et al (1999). The research questionnaire used in this study had been completely revised and rewritten, although, there was a basic complementary theme

in terms of some of the demographic and training data collected. However, the research undertaken by Owens et al., did not consider the objectives spanning existing primary care culture, change processes or workforce planning and development, which were the substantive areas under investigation in this study.

3.11 Questionnaire- Statements and Questions

The eight statements and four questions that were included in the questionnaire together with their justification are:

Statements	**Justification for inclusion in the questionnaire**
The existing culture within your organisation supports the best mechanisms for delivering multiprofessional primary care services.	This statement sought to identify the respondents' perception of whether or not the current culture supports multiprofessional service delivery. *Linked to research objective one and two and research questions one, two and three.*
Learning with members of my own profession is more worthwhile than learning in a multiprofessional group.	Exploration of the respondents' perception over the benefits of learning in multiprofessional groups. *Linked to research objective one and two and research questions one , two and three.*
There should be more opportunities for multiprofessional learning than there are at present.	This statement sought to identify whether or not multiprofessional learning was perceived to be worthwhile and helpful by the respondents. *Linked to research objectives one and two and research questions one, two and three.*

I consider that shared learning opportunities encourage effective health care delivery.	Further exploration of respondents' perceptions relating to shared learning. *Linked to research objectives one and two and research questions two and three.*
At present there is a good understanding of each other's professional role and function within primary care.	Identification of respondents' perception of role function spanning professional groups. *Linked to research objective One and research questions two and three.*
Multiprofessional training and development would assist in providing a greater understanding of the roles and functions of primary care professionals.	Further exploration of respondents' perception of role functions and how multiprofessional training and development could potentially influence the process. *Linked to research objectives one and two and research questions two and three*
The existing NHS workforce planning process is effective in delivering the right skill mix within primary care.	Introduction of workforce planning and skill mix processes. *Linked to research objective two and research question three.*
The existing primary care team working across professional and organisation boundaries is effective.	Identification of respondents' views over cross boundary working in terms of professional and organisational contexts. *Linked to research objectives one and two and research questions one, two and three.*

Questions	Justification for inclusion in questionnaire
What advantages, in your opinion, are there is learning with other professions besides your own?	Further exploration of respondents' views over the advantages in multiprofessional learning. *Linked to research objectives one and two and research questions one, two and three.*
What disadvantages, in your opinion, are there in learning in a multiprofessional group?	Further exploration of respondents' views over the disadvantages in multiprofessional learning. *Linked to research objectives one and two and research questions one, two and three.*
Please identify the professions that you most benefit from meeting in a multiprofessional group?	To identify specific existing multiprofessional learning opportunities in terms of perceived benefits. *Linked to research objective two and research question three.*
Do you have any further comments you would like to make about multi-professional education/developments or about any multiprofessional course you have attended?	Further exploration of respondents' views or perceptions appertaining to multiprofessional education or development issues. *Linked to Research objectives one and two and research questions one, two and three.*

Section one and two sought respondent's feedback on the frequency of professional education that they had participated in over the past 12 months.

Section three involved the use of two attitude statements and respondents were required to assess their agreement or disagreement on a five-point likert – type scale.

Section four provided the opportunities for respondents to complete a personal details section for age group, gender, professional background, grade/position, workbase setting, full/part time employment, how many years since qualification (career break details if relevant).

Notes were provided with the questionnaires, which defined, for the purposes of this research, the following:

- Multi-professional education can be defined as any event (course, seminar, study day, training session) at which members of two or more professions are present together. (Owens et al,1999);
- Culture can be defined as: *'the customary or traditional ways of thinking or doing things which are shared to a greater or lesser extent by all members of the organisation and which new members must learn and at least partially accept in order to be accepted into the service'.* (Mekk, 1988).

Serial number boxes were entered onto each questionnaire in order to identify the number of questionnaires sent per professional group. There was the facility, once each questionnaire was dispatched, to identify the individual recipient, since a master list was held. The response rate of 75% negated the need to send out reminder letters. In order to ensure anonymity and maintain strict confidentiality the master list was destroyed when the response rate triggered the benchmark that the researcher had set for 60%. The rationale for this decision is set out below:

- The response rate was very good and compared well with comparable surveys undertaken. For example, Owen et al. (1999), received an overall response rate of 43%. A judgement was made at the outset of the questionnaire distribution, that should an overall response rate of 60% or more be achieved then no 'chase' letters would be despatched;

- Actions were taken to seek to ensure that a good response rate was achieved, these actions included piloting the questionnaire for feedback over the flow and format of the questions and statements. In addition, the guarantee of confidentiality in relation to a subject area that was considered to engender personal commitment and interest from respondents was also perceived by the researcher to be helpful in achieving a high response rate. (Oppenheim, 1992 and Brown and Dowling, 1998).

Upon reflection, the researcher now believes that it was an error of judgement not to have sent out reminder letters to those two specific groups (General Practitioners and Physiotherapists), that fell below the 60% benchmark trigger **(see Section 3.17)**.

The questionnaire length presented a dilemma since it was a ten-page document. It was the researcher's belief that the topics under research would be of sufficient interest to capture the attention of the recipients in order to ensure a good uptake of respondents. The researcher, was however, conscious that the length of questionnaire could have had a negative effect in motivating respondents to spare the time to complete and return the questionnaire. To achieve the required response the researcher tried to ensure that the questionnaire was as concise as possible and only contained those questions that would collect data to enlighten my case. **(See Appendix Seven).**

3.12 Piloting

> *'There is a great deal in favour of piloting any empirical research. Advance planning and preparation is all very well but there is no complete substitute for involvement with the 'real' situation, when the feasibility of what is proposed in terms of time, effort and resources can be assessed'.* (Robson 1999, p.164).

The positive benefits accrued as a result of undertaking a small-scale pilot are considerable. The piloting of both the semi structured interview questions and questionnaire formed an integral part of the research and provided the flexibility to adjust in advance of the main study the content of the questionnaire and question

order for the structured interview component of the research. The semi structured Interview Pilot was undertaken on the same two colleagues that assisted with the questionnaire pilot phase purely to ensure consistency and the fact that they were willing to provide support. Both also had experience in Primary Care services. Originally there were had 12 questions, however, one question was perceived as duplicating the previous question to a large extent. This question was removed from the schedule.

In conclusion, the opportunities to fine-tune the research tools prior to the implementation of the main body of the research, was extremely helpful. The researcher's supervisor was also able to provide valuable advice over the structure and 'question flow' for both the questionnaire and interview schedule.

The Questionnaire Pilot was undertaken on two colleagues within my workplace setting prior to being utilised within the context of the 'real' data collection phase of the research study. The feedback received related to section 3 and 4 of the questionnaire. In essence there was a perception that two questions were incorrectly positioned and inhibited the flow of the questionnaire. Adjustments were made accordingly. In summary the piloting stage considered three key factors namely:

1. Will the respondents understand the questions as initially phrased?
   Has appropriate language been used and will it be understood by the research population being targeted?
2. Does the questionnaire take too long to complete?
   This was a cause for concern since my questionnaire was 10 pages in length. The piloting stage did not suggest that the respondents would show any signs of 'impatience'. Quite the contrary, the nature and contents of the questionnaire was perceived to be stimulating enough to capture the attention and interest of the respondents in order to take the time and trouble to complete and return.
3. What is the best order for the questions?
   If perceived sensitive questions appeared too early this potentially could hamper the likelihood of completion and return.

3.13 Data Collection

As previously stated the selected methods of data collection for this investigation was undertaken in two ways, namely:

- Semi-structured interview plus open discussion as part of the interview process;
- Questionnaire.

The forms of data collected have been gathered primarily through the qualitative route although quantitative data has also been received through the questionnaire method.

Whilst it is accepted that there are no 'general best methods' (Robson, 1999, p. 301) the data collection methods chosen for this research have been selected to provide the best opportunities to answer the questions posed. The researcher also had to make a judgement as to what is reasonable in relation to the time and other resources available.

The following questions were adapted from a process suggested by Robson (1999, p.305) were considered prior to the selection of the data collection methods:

Questions Posed	**Considered Answers**
Have you explored thoroughly the choice of method techniques?	A full exploration was undertaken to ensure the optimum fit for this research study
What mix of methods do you propose to use?	Three methods were initially considered: Semi-structured interviews, questionnaire and documentary analysis. Documentary analysis was rejected due to time constraints.
Have you thought through potential problems in using the different methods?	A strength and weakness analysis was adopted to review and consider potential problems
Do the methods have the flexibility that you need?	The semi-structured interview process and the questionnaire afford the flexibility required for the study.

In conclusion, the selection of methods were driven by the objectives and questions of the research and provided best fit in terms of the four parameters as set out above. In essence the choice was made purely on the basis of what will suit the requirements of the study bearing in mind the resources available to me, time being the most precious commodity. **(See Section 3.17 for a critique of the limitations of the study)**.

3.14 Data Analysis

> *'Data Analysis involves making sense of the information collected in order to obtain explanations. How we try to do that will depend on whether our data are of a quantitative or qualitative kind'* (Seale and Barnard, 1998, p.102).

A- Qualitative Data Analysis

There are many types of analytical procedures that can be adopted within qualitative research. According to Robson (1999, p. 370) there is no clear and accepted panacea or set of conventions for qualitative analysis corresponding to those observed with quantitative data. In relation to this study, the researcher utilized the iterative nature of the qualitative data collected to analyze the emerging themes as the data was reviewed and reflected upon these themes. This process was highly inductive, since the emerging themes, were not imposed by myself as the researcher (Grbich, 1999, p.231).

Miles and Huberman (1994, p.10) have stated that qualitative analysis has several key charecteristics. In particular qualitative designs cannot be taken 'off the shelf' and that there is a particular requirement for the design to be modified and adapted as the research proceeds. This is not to say that there is lack of structure to the research design but that they see the analytic selections that the researcher makes in particular situations as a form of 'anticipatory data reduction' giving direction and focus to the research. The concept of 'data reduction' can be defined as the process of selecting, focusing, simplifying and transforming the data that appears in the field notes or transcriptions. This data reduction will be a continuous process until the final report is produced. Fundamental to the process Miles and Huberman considers analysis as

requiring three processes to be utilised namely: data reduction, data display and conclusion drawing/verification (Miles and Huberman, 1994). Data reduction refers to the initial task whereby data collected was reduced on the basis of an emerging conceptual framework. Data display refers to the organised, and compressed assembly of information that was produced. This enabled me to display the data in a fashion which afforded ease of identification and interpretation. Conclusion drawing and verification referred to the procedure whereby broad interpretations were gleaned from the data.

The framework described above has been utilised in this research strategy to analyse the qualitative data collected through the methods employed. The interview data in this study has been reduced by the adoption of a coding, memoing and review process placed within the context of the QSR-N5 (NUD*IST) computer analysis programme. The NUD*IST program (Non-numerical Unstructured Data with powerful processes of Indexing Searching and Theorizing) has been developed to provide a toolkit for assisting the categorizing and coding of qualitative data. The key aspect from the researcher's perspective was that it did not displace the researcher in any way, it supported the study in analyzing the data into themes and assisted in the iterative process linking ideas together (Gahan & Hannibal, 1999).

The codes used have supported me to link material and flag up potential themes contained within the data. The content of the interviews and the written responses to the questions contained within the questionnaire were read and scrutinized line-by-line and identified segments or concepts illuminating the content of the data. The researcher initially manually produced seven 'first level' codes that provided the working set of 'bins' which were simply based upon descriptive terms and served the purpose of 'attributing a class of phenomena to a segment of text' (Miles and Huberman, 1994, p.57).

These initial codes were decided at the beginning of the study and were based upon the conceptual design of the research, namely:

(ch)...Change processes;

(cu)...Cultural issues;

(sd)...Staff development;

(wp)...Workforce planning issues;
(elt)...Education/ learning/ training;
(tw)...Teams/ teamworking;
(pc)...Patient /care issues.

The code list was subsequently revised as the data was analysed to produce 88 sub-theme codes **(see Appendix Eight)** that relate to the themes that have emerged as a direct result of the analysis and not as a result of any preconceptions. The analysis process was iterative and involved constant comparison and review of data and produced a saturation of categories. There was a constant moving back and forth between the analytic phase and empirical material (Willumsen & Hallberg, 2003, p.393). The end result of the process was a refinement of the themes.

> *'Computerisation removes barriers to scale and complexities of analysis. There are virtually no clerical limits to how much stuff you can get now, and few to how complex it is'* (Richards and Richards, 1993, p.40).

The 'QSR-V5 (NUD*IST) software was invaluable in the process to enable me to conceptualise the data by breaking the data down into discrete bits/creating names for categorizing and themes (known as nodes in the software jargon), and to undertake the iterative analysis required to produce the resultant conclusions that have been drawn from the analysis and to assist in the filing and storage of data. The Initial Text Search for Anonymised Transcript-S3 using QSR-V5 (NUD*IST) Software is attached as **Appendix Nine**. The computer aided analysis of qualitative data can be referred to as 'theory building' packages

> *'They usually include code-and –retrieve capabilities, but also allow you to make connections between codes (categories of information); to develop higher order classifications and categories; to formulate propositions or assertions, implying a conceptual structure that fits the data; and/or to test propositions to determine whether they apply'* (Miles and Huberman, 1994, p.312).

According to numerous researchers in the field of qualitative analysis there are several essential criteria that need to be adopted for the task of efficient and effective qualitative data analysis (Lofland and Lofland, 1995; Delamont, 1992; Tesch, 1990) the researcher sought to follow these rules in this research study and has summarized them below:

Essential Criteria to Effectively and Efficiently Analyze Qualitative Data	**How Applied in this Study**
Analysis should commence as soon as the data is collected to avoid being overburdened	The questionnaires were methodically analysed for their qualitative data components upon receipt from respondents. After each interview, the transcript was typed up and validated by the respondents, then the initial analysis was undertaken
Generate themes, categories, codes as the research moves forward	This process began as soon as the validated transcripts and questionnaires were received by the respondents
Data handling should be through reflection and iteration in order to move the data to a conceptual level	The whole process was essentially an iterative one. Initial coding with the emergent of primary themes was constantly reviewed and revisited
There is no' right' way to handle this type of data therefore it is even more important to be organized and systematic in the approach	I endeavoured to adopt from the outset, a systematic and organized approach. The process of data analysis was considerably more time consuming than I originally thought it was going to be
Set up appropriate 'filing' systems for the data generated	I had put aside a large four drawer filing cabinet in my home office for all the research documentation and articles. The filing system was most beneficial in the retrieval and organization of research data and information. In addition, the QSR*

	NUD.IST was helpful in this regard
Keep abreast of the data and ensure that it is indexed	I adopted a manual indexing system that equated to the themes that emerged
Keep alert to the need to compare and contrast the data at all times	The iteration involves in the process was essentially one of comparing and contrasting through reflection .

B- Quantitative Data Analysis

The inclusion of quantitative data was introduced as a way of providing helpful background information to this research study by offering initial insights in relation to the research questions. The quantitative data retrieved from the questionnaire survey, in relation to the likert-type scale statement analysis (ordinal data), enabled the formation of rank order summary data to be produced. In addition, section four of the questionnaire has been analysed to provide (nominal data) summary data for the categories stipulated.

The quantitative data was retrieved and analysed manually without the use of a computer package such as SPSS for Windows, Minitab or Statview. The researcher's choice was based on the fact that he could appropriately summarise the data as each of the completed questionnaires was received without any difficulty. The decision to use a quantitative analysis package would probably have been different had the researcher not specifically allocated time on a daily basis to manually summarise data collected.

All the summary quantitative data has been reproduced in the next chapter in the form of tables, line graph and bar charts, dependant upon the most appropriate format thought suitable. In reproducing the data the researcher was mindful of specific criteria that needed to be applied to ensure comprehensive presentation and description of the data adapted from Denscombe (1998, p.191):

Quantitative Data Presentation	How Applied in this Study
Is the choice of table or chart appropriate for the specific purpose of the data?	18 bar charts were incorporated along with 50 tables
Does the table or chart contain enough information to provide significance and avoid information overload?	Each Chart and Table provided specific background detail to illuminate the case
Has the information been provided in appropriate 'units', properly titled and labeled?	Personalised descriptors and labels were applied in each case

3.15 Triangulation

> *'Triangulation, or the use of multiple methods is a plan of action that will raise social scientists above the personal biases that stem from single methodologies. By combining methods and investigators in the same study, observers can partially overcome the deficiencies that flow from one investigator or one method'* (Denzin, 1989, p.67).

The triangulation protocol used in this study was 'methodological triangulation' and according to Stake (1995, p.114) is the protocol most recognized. Multiple approaches within a single study is likely to illuminate or nullify some extraneous influences. Triangulation can involve the use of multiple methods of data collection related to the research project. Semi-structured interviews and questionnaire survey have been used as the main components for triangulation in this research. The comparisons made between the different data collected have been an important element of this study's research methodology. Todd (1979) also advocates the use of both qualitative and quantitative methods of data collection to aid triangulation of the research study. Todd points out that triangulation is not an end in itself but an imaginative way of maximizing the amount of data collected. According to Robson (1999, p.383) triangulation is:

'...an indispensable tool in real world enquiry. It is particularly valuable in the analysis of qualitative data where the trust-worthiness of the data is always a worry. It provides a means of testing one source of information against other sources. Both correspondences and discrepancies are of value. If two sources give the same message then, to some extent, they cross-validate each other. If there is a discrepancy, its investigation may help in explaining the phenomenon of interest'.

The main benefit, in my opinion for the use of triangulation in this study has been in the development of converging lines of enquiry, since the findings of the study have been based upon different types of information/data collected and has followed a corroboratory pathway. Upon reflection, the inclusion of the 5 interviewees beyond the case study was limited in delivering triangulation for the following reasons, namely:

- The interview data sets were not appropriately compared and contrasted;
- The failure in testing one source of information against another source weakened the process of triangulation by not affording robust cross-validation. **(See Section: 3.17)**.

3.16 Validity, Generalizability and Reliability

'Validity' is concerned with whether findings are 'really' about what they appear to be about. Are any relationships established in the findings 'true' or due to the effect of something else?

'Generalizability' refers to the extent to which the findings of the enquiry are more generally applicable, for example in other contexts, situations or time, or to persons other than those directly involved. (Robson, 1999 p.66)

'Reliability' is based upon the judgement as to whether or not it is capable of being replicated by another inquirer. There has been an assumption in Social Science that although not all repeatable or replicable observations or accounts are necessarily valid, all valid accounts (at least in principle) are replicable. (Schwandt, 1997, p.137)

Trustworthiness of the claims of research is of fundamental importance and will be assessed not just in terms of the evidence but also in relation to its credibility. It is therefore of prime importance that the research is subject to robust verification. In a study such as this one the key processes of validity and generalization does indeed present difficulties. The main purpose of using interviews in this research has been due to the fact that in an interpersonal encounter people are more likely to disclose aspects of themselves, their thoughts, their feelings and values, than they would in less human situations. At least for some purposes, it is necessary to generate a kind of conversation in which the 'respondent' feels at ease. In other words, the distinctively human element in the interview is necessary to its *validity*.

As detailed in section 3.6 interview transcripts have also been subject to 'transcript validation' and has provided a limited mechanism to authenticate the narrative. This form of validation in qualitative research provides the opportunity for participants to consider further comments and views they originally forwarded and if required the opportunity to make adjustment and to 'sign off' their transcript once they had the revisited it and then reflect upon what they stated in their interviews.

Reflexivity is held to be a very important procedure for establishing the validity of accounts and the process of 'respondent validation' of the analysis to enable member checking of the analysis in hindsight should have been undertaken. As a result of this failing the validation is limited **(see Section: 3.17)**.

With these concepts in mind, the researcher has endeavored to bring to bear particular verification processes to evidence the achievement of validity, generalisability, and reliability within the context of this research inquiry. It needs to be borne in mind that the research questions were developed from a detailed study of the research literature together with background knowledge of research undertaken in other studies. This process can be described as learning by receiving generalisations, explicated generalisations, from others.

Stake (1995) describes this as 'naturalistic generalisation' the definition of which has already been set out in section 3.2.1 of this chapter. The concept of 'naturalistic

generalisation' has been used in this study to evidence generalisation. Essentially the generalizations evidenced in this study are conclusions arrived at through personal engagement in reading the study and providing the opportunity for the reader to form their own generalizations. It has therefore been my responsibility as the researcher to assist the reader in arriving at high-quality understandings:

> *'The analyses and interpretations of researchers need to be paralleled by those of the readers. For this, the researcher has an obligation to provide high-quality input for the readers' study. If the importance of naturalistic generalization is accepted, the rules for analysis are preceded by rules of data gathering, which in turn are preceded by rules for preparing research questions, all taking the circumstances of the reader into consideration'.*
> (Stake, 1995, p.88).

In terms of *validity* the researcher's focus has been upon ensuring that my findings and recommendations would be entirely consistent with those of another researcher walking within a similar context. The overarching link between the theoretical issues and the findings should match the empirical reality. Validity of data has been subject to the benchmark of 'participant confirmation', which according to Carr and Kemmis (1986, p.91) is signified by ensuring that contributors to the data collected would recognise the account as a valid description. This factor was considered, amongst others to be most significant prior to theorising about the data. The process of 'respondent validation' used in the interview transcript process exemplifies this particular point in case.

In addition the reliability of the procedures adopted in this study for data collection were critically examined at the outset to assess to what extent these methods were likely to produce reliability and validity. For example, asking the same questions in the same order assisted the process of reliability during the interview stage of the research together with the design of the questionnaire.

3.17 Reflexivity, Self and Bias

A. Reflexivity

In qualitative research the researcher is positioned centrally and therefore this positioning demands a high degree of reflexivity on the part of the researcher, and to this end reflexivity and 'self' has been addressed in this chapter and at various stages throughout this thesis. The origins of the term 'reflexivity' has been derived from the latin word 'reflectare' which means to bend back. For the purpose of this study the term can be defined as being the analysis adopted which:

> *'interrogates the process by which interpretation has been fabricated: reflexivity requires any effort to describe or represent to consider how that process of description was achieved, what claims to 'presence' were made, what authority was used to claim knowledge'.* (Fox, 1999: p.220).

Reflexivity affects the relationship between the researcher and the social world and emphasizes an awareness of the researcher's own presence and subjectivity in the research process. Reflexivity proposes that there is no expectation of the qualitative researcher attaining an entirely objective position from which to study and interpret the social world. The sense that we construct of the social world and the subsequent meaning we attribute to the events and situations are fashioned from our own experiences as social beings. The sense that we create is therefore shaped by our own values, norms and concepts that have been learned throughout our lifetime. (Denscombe, 1998, Taylor and White, 2000, Finlay and Gough, 2003).

Since reflexivity highlights an awareness of the researcher's own presence or 'self' in the research process, the researcher can be seen to create worlds or lenses through which the questions have been framed and asked. The issue of the researcher's own subjectivity, therefore, has to be seen as central to this thesis because he was also intrinsically involved in the changes that have been described in the study and consequently unable to be explicitly objective. It is also argued by Henwood et al (1993) and Denzin and Lincoln (1994) that, due to the nature of naturalistic research,

the process will of necessity shape the object of the enquiry and that a reflexive approach must be adopted.

This argument, for undertaking a reflexive approach, is challenging and requires an acknowledgement, and sometimes painful reminder, that interactions and interpretations of the data must be subject to continued self awareness in order to seek to deliver as high a degree of confirmability and subsequent trustworthiness as possible in the study. As suggested by Alvesson and Skoldberg (2000):

> *'There is no one way street between the researcher and the object of study; rather, the two affect each other mutually and continually in the course of the research process'.* (Alvesson and Skoldberg, 2000, p. 67).

B. Positioning the Self: Researcher's Story

The process of interpretation of the data in this study lends itself to the temptation to seek to present the interpretations as pure and untouched by the process of research. For example, in presenting a quote from a respondent as though it can be taken at face value requiring no commentary. This would not be a stance supported as best practice in qualitative research since:

> *'the researcher's self plays a significant role in the production and interpretation of qualitative data'.* (Denscombe ,1998, p.208).

The involvement of self in this study has been acknowledged as inevitably playing an integral part of the research design, data analysis and interpretation. The researcher believes that whilst there was a conscious effort on his behalf to seek to exert sufficient control over his inherent values and beliefs in the production of the analysis and interpretation of the data, on reflection, the author does not believe that it has been entirely possible to suspend personal prejudices or beliefs sufficiently within the context of this research study. The reflexive analysis process has highlighted, at stages throughout this thesis, weaknesses in achieving the desired adequacy and transparency of the research process and relationship of the role of the researcher. These stages will be discussed shortly.

The researcher qualified as a Podiatrist 25 years ago and has had a direct 'team leadership' and 'staff development and training' role for the past 24 years within the NHS. Whilst continuing to practice as a clinician, the researcher has held several operational and strategic positions, including a twelve- year period as Deputy Operational Director (Head of Primary/Community Care Services). Currently the researcher's role is Professional & Strategic Head of Podiatry Services for four NHS Trusts (three Primary Care Trusts and one Acute Trust) in North East London.

These posts and inherent responsibilities have required the author to develop and naturally implement his own framework for multiprofessional staff development and team building processes within the context of a changing environment with all the cultural nuances incumbent within the NHS.

Upon reflection, it is certainly the case that the researcher has a personal belief that it is in the best interest of patients that multiprofessional, collaborative working and learning is the optimal mechanism to deliver high quality care. It is also true, upon reflection, that the researcher has held these views for a very long time during his professional working life. Having been a general manager for many years within primary/community care services, the researcher has been in a fortunate position to have a acquired, in his opinion, a reasonably detailed and in depth knowledge of the competences of a range of health care professionals within the context of the study, and this will have had a bearing on the researcher's beliefs, personal experiences and values of staff development and possible innovations to practice.

C. Confirmability and Bias through Reflexivity

Confirmability relates to the determination made about the openness and fairness of the research process and the relationship of the role of the researcher to the process. Prosser (1998) states that the reflexive account is best suited to interpreting the nature of this relationship.

There are a number of areas in this study where the self has been particularly intertwined with the research process:

- Possible 'unresolved baggage' in relation to the researcher's historic and current allied health professional/senior management positions in the NHS;
- The decisions made in the selection criteria and subsequent data set interpretation of the 5 interviewees external to the case study merged with the data gained by internal case study interviewee process;
- The simultaneous nature of data collection across the three data sets and subsequent simultaneous data analysis;
- The quality of the questions/statements/introductory letters addressed to the participants and its relationship to the data/themes generated;

I will discuss each of these areas in turn and reflect on the extent to which they have limited the rigour of the research methodology:

Possible 'unresolved baggage' in relation to the researcher's historic and current allied health professional/senior management positions in the NHS

The researcher's experiences and commitment to multiprofessional teamworking, development and learning needs to be acknowledged. Past experiences in developing these interactions and models of service development have on occasions met with negative attitudes. There may be issues appertaining to 'unresolved baggage' since the GP professional group has, in the researcher's experience, been on occasions the most difficult to engage in multiprofessional training and development opportunities. Conversely, the researcher has found GPs that he has worked with in general, particularly in the days of GP Fundholding, to be extremely innovative and supportive in introducing new roles such as Consultant Podiatric Surgery posts within primary care. However, the 'twin hat' role of researcher and NHS manager affords the risk of the interaction between self, participants and data to be influenced. In hindsight, the researcher would have benefited from keeping a 'field note diary' throughout the research process in order to assist in the understanding of his personal biases. The ability to reflect and make a conscious attempt to understand the 'self' in interpreting the data would have been helpful and appropriate.

Peshkin (1988) provides clarity over the potential for subjectivity to introduce biases:

> *'personal characteristics could filter, skew, block, transform, construe and misconstrue what transpires from the outset of a research project to its culmination in a written statement'.* (Peshkin, 1988, p.17).

The decisions made in the selection criteria and subsequent data set interpretation of the 5 interviewees external to the case study merged with the data gained by internal case study interviewee process

Selection criteria set for the external interviewees was, in hindsight, too subjective. The relevance of the specific interviewees selected would have been better served had it emerged through the course of the analysis of the questionnaires and internal case study interviewees. The researcher now believes that he had already formed a preconceived view that the selected interviewees would be appropriate from the outset of the research, even before any data had been gained through the survey or internal case study interviews.

The decision made to integrate the data acquired through both the case study interviews and the external interviews has, in effect, limited the value and contribution of the case. This approach, upon reflexion, was a built in weakness and has lessened the ability of the interview data sets to illuminate the study overall and negated to some extent, the process of triangulation that was gained from obtaining data relevant to the study from several informants situated outside the case.

The simultaneous nature of data collection across the three data sets and subsequent simultaneous data analysis

It would have been more appropriate to have phased the data collection schedules in order to allow and support the developing and emerging nature of the research, as opposed to predicting/setting the personnel and questions at the outset. On reflection this was a weakness in the approach adopted it would also have been pertinent, to this study, to have compared and contrasted the three complementary data sets fully.

In this particular study, the adoption of the research practice, on a broadly similar basis to a 'grounded theory' approach (Glaser and Strauss, 1967), would on reflection have supported a more flexible emergent design. By doing so it would have improved the research focus during its course rather than working to a rigid preordained schedule decided at the outset. However, the weakness of undertaking a looser more flexible, emergent approach, is that it could fail to deliver the methodological rigour originally established by Glaser and Strauss (Denscombe, 1998, pp. 217). On balance, the researcher now believes that improvements could have been made to the study, by phasing the data collection schedules more appropriately with a phased data analysis procedure, which supported improved opportunities for critique of the three data sets.

The quality of the questions/statements/introductory letters addressed to the participants and its relationship to the data/themes generated

The questions/statements for both the interviews and questionnaires were piloted and after feedback amended prior to field utilisation. Despite this process the subsequent continued inclusion of potentially 'leading' statements in the questionnaire may have led to respondents being prompted to provide a particular answer. For example: Section 3, *Statement 20 of the questionnaire: 'There should be more opportunities for multiprofessional learning than there are at present'. Followed by a 'likert scale' response format.* . This can been seen to introduce a form of bias that had been built into the statement, albeit unintentionally, and has an influence on the validity of the data generated. Another example of a quality flaw relates to *Statement 21 of the questionnaire: 'I consider that shared learning opportunities encourage effective health care delivery'.* On reflection this would have benefited from seeking 'qualitative follow up data' in order to gain valuable respondent feedback. Also 'section one' of the questionnaire produced data over respondents' involvement in CPE. It failed, however, due to a design fault, to produce data in relation to whether or not low scoring groups undertook unguided CPD instead.

On further critical reflection some themes that emerged from the study may have been 'designed in' by the questions/statements posed. For example, respondents' were asked to score the following statement: *' The existing culture within your organisation*

supports the best mechanism for delivering Multidisciplinary Primary Care Services'.
The quality of this question is flawed on two counts:
Firstly, it fails to provide definition over the meaning of 'best mechanism' and secondly, it can be seen to introduce a leading statement for respondents to perceive 'cultural conflict' as a likely response.

The use of an extended pilot beyond that which was applied in this research study would have provided the opportunity for improvements in the designs of both the semi-structured interview process and questionnaire. The pilot would have benefited from a more detailed 'peer review' process specifically focussing upon reflection upon how the questions and statements in both the questionnaire and interview stages were interpreted and to minimise the risk of introducing 'leading questions' into the research process. This would have significantly reduced the potential for themes to have been 'built into' the study as opposed to purely emerging from the research process. In addition the failure in not applying a 'Respondent Validation' process, to enable member checking, in hindsight should have been undertaken. As a result of this failing the validation is limited.

The content of the introductory letters to interviewees **(Appendix Four)** and questionnaire respondents **(Appendix Six)** would also have 'set the scene 'by introducing 'self' into the context of the respondents' perceptions of my position within the study. Again, in hindsight, a piloted review of the most appropriate wording and content of these letters would have been beneficial in seeking to eliminate, as far as possible, any bias.

Complementary themes have been drawn from both the questionnaire and interview stages of the research process. The questionnaire data provided insights into the respondents' participation and commitment to multiprofessional education together with important evidence over the existing organisational cultural shortfalls **(see Section: 4.1)**.Upon reflection, however, the researcher believes that the data analysed from the interview stages of the research process has provided the richest sources of evidence, in order to have been able to deliver the specific conclusions and recommendations, as set out in Chapter Five and Six.

D. Reflection on the findings and conclusions of this study that was undertaken during a period of rapid change

In view of this research study was carried out during a particularly rapid period of change for NHS primary care services, it is important to apply a reflexive approach in considering which aspects of the findings and discussion may have durability and those that purely represent a 'snap shot' in time.

It is likely, bearing in mind the history and development of primary care services that further organisational changes, will be introduced by the present and successive governments. It is worthwhile reflecting upon these potential organisational changes and how these may influence the conclusions and recommendations made within the context of this research.

As suggested in **Section: 1.7**, the introduction of new organisational structures will have had a bearing on both the culture and the perception of team working relationships. The direction of change, during the time this research was undertaken, was towards locally driven services (Primary Care Trusts) alongside a patient centred, partnership and collaborative approach (patients and professional staff) to this service delivery model.

At the time of finalising the writing of this thesis (May 2005), the New Labour government had been re-elected and it is therefore probable that recent policy directions in the NHS and primary care will continue for at least the next 5 years.

Foundation Trust status is presently being introduced within the secondary care (Hospital) NHS settings and it would seem reasonable to propose that a similar concept of structural change, with the continuation or enhancement towards locally based commissioning of services, would be introduced within the primary care arena. As a consequence there will, in all probability, need to be another restructuring process for all existing PCTs together with a 'revised' remit for their direct provision of services. The concept of these free standing (free from direction by the Secretary of State for Health) Foundation Trusts is that they are to be protected against privatisation in order to ensure that all assets are maintained within public ownership.

The government also states that the governance arrangements for Foundation Trusts will allow patients and the public to play a more effective part in the running and management of their local NHS Foundation Trusts whilst still being still be part of the NHS and will deliver treatment to NHS patients according to NHS principles and standards. The following rationale has been set out to represent the key aspects of the NHS Foundation Trust model:

- Controlled locally and have as their members local people who have been patients, members of staff or appointed from previous NHS Trust/PCT organisations;
- Retain proceeds from land sales to invest in new services for patients;
- Use the flexibilities of the new (agenda for change) pay system to modernise the NHS workforce, including additional rewards for those staff who are contributing most effectively;
- Decide locally over what can be borrowed for investment in services and to have their own local decision making process relating to capital funding.

(Wellard's NHS Handbook, p.18, 2003)

The concept and culture of locally driven, locally commissioned, patient centred NHS primary care service philosophy fully supports the discussions, conclusions and key recommendations of this research study.

E. Concluding Comments to the Reflexivity Section

Participants were selected to be involved in this research based upon their experience within the context of the case study. The researcher had, as far as he was able to tell, no preconceived views about their knowledge or strategic views in relation to the research objectives or research questions and believed that this factor helped to minimize any potential bias at the outset.

It was the researcher's intention throughout this research to be as objective as possible and to maintain a stance that can be referred to as a 'passionate neutrality' (Hedge, 1985). By electing to seek to ensure the maintenance of an objective approach, the

researcher believed this enabled the research participants to deliver their own views without feeling threatened by any perspective they felt the researcher might have held. It is accepted, through process of reflexivity, that it was not entirely possible to avoid an element of bias or subjectivity when undertaking research within the researcher's own professional area and including personnel who were known to the researcher as a result of his operational position. As Popper (1969) insisted, there is no secure starting point for knowledge, since nothing can be known with absolute certainty, and that future revisits can always result in change. This leads to the view that if no knowledge is certain, then can objective research techniques, based upon clear definitions and controlled processes of inductive logic, be any closer to the 'truth' than a 'subjective' approach, which can be clouded by bias? The arguments around subjectivity and objectivity, has led to ongoing debate within the research field. Habermas (1972) has also argued against objectivity by stating that mutual understanding should substitute the presumption that there are inseparable links between, methodology, knowledge and human interest that makes objectivity an impossible aim.

In this study the researcher has sought to adopt a philosophical approach suggested by Weber (1949), which argues in favour of trying to achieve objectivity. Weber asserted that the truth of factual propositions can indeed be established in an objective fashion despite the fact that evaluative judgements have impacted on the study. This view is also supported by Philips (1990) by stating that objectivity is possible in qualitative research if there is evidence that there is a robust critique of the way bias has been avoided as far as reasonably possible. It is doubtful, however, that subjectivity and bias can be entirely avoided:

> *Perhaps the most practical way of achieving greater validity is to minimize the amount of bias as much as possible. The sources of bias are the characteristics of the interviewer, the characteristics of the respondent, and the substantive content of the questions'.* (Cohen and Manion, 1996, p.281).

Throughout the process the researcher believed that he was conscious that his explicit role was to produce the best opportunities for the respondents to reproduce their own views and comments within a framework of open and safe dialogue. The sample selected for the questionnaire was also subjected to a random and unbiased selection

process as outlined above in **Section: 3.9**. The weaknesses highlighted in the reflexive analysis process has been helpful in formalizing where improvements could have been made to reduce bias and subjectivity further. In particular the use of a field note diary, where reflexive accounts could have been made throughout the study, would also have been valuable at the stage of writing up the thesis. An extended pilot stage to review and revise more appropriately both the questionnaire and interview statements/questions .In addition the utilization of 'respondent validation' not merely 'transcript validation' would have provided a greater degree of objectivity with the data.

3.18 Ethics

The researcher is charged with the responsibility to undertake his/her processes in an ethically acceptable way that takes into account the interests of the participants who have consented to assist in this particular research study. Conscious of these responsibilities, the researcher was acutely aware of the need to explain these rights on an individual basis to each participant prior to commencement of their involvement in the research. Initially this was carried out through the delivery of a cover letter for the interview and questionnaire. As a precursor to each interview these rights were reiterated. Each interviewee was informed that confidentiality with respect to their comments and views would be maintained. The researcher also supplied each interview participant with a summary sheet, which outlined the ethical procedures I have followed in this research together with the confidentiality agreements that were made together with the authorization of a consent form with respect to the interview **(see Appendix Four)**. The questionnaire cover letter and questionnaire itself made explicit reference to confidentiality of the process **(see Appendix Three)**.

3.19 Conclusions

This chapter has provided a review of the methodology used within this study and has focused upon the study design, sampling, piloting and subsequent development of the interview and questionnaire research tools, together with the procedures involved with the collection and analysis of the data. The key purpose of this chapter has been to provide justification for the use of the qualitative and quantitative procedures

undertaken within the context of the case study /survey strategy. Chapters Four, Five and Six will summarize the data collected and provide a detailed analysis together with a description of the conclusions drawn from the data.

CHAPTER FOUR

QUESTIONNAIRE RESULTS AND DISCUSSION

4 Introduction

This chapter provides the results and discussion of the data that was collected through the questionnaire stage of the research process. The results of this stage of the analysis has both a quantitative and qualitative component.

4.1 Questionnaire-Quantitative Data

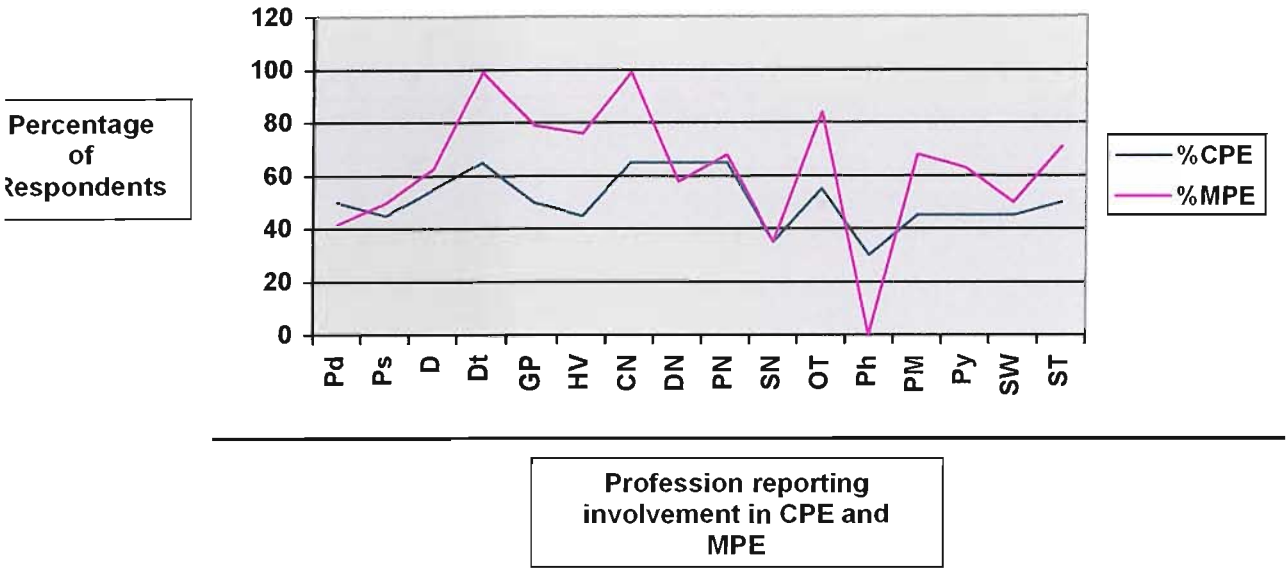
In total 220 questionnaires were sent out and 166 completed questionnaires were returned which represented a response rate of 75% for this component of the research study. Sixteen primary care professional groups were represented **(see Section: 3.17)**. The response rate ranged from 100% for District Nursing and Dieticians to 55% for Physiotherapists **(see Table 1)**.

Table 1. Response Per Professional in Percentage Order

Professional Group	Questionnaires Sent	Number of Respondents	% Response
Nurse, District	23	23	100
Dietician	4	4	100
Health Visitor	24	22	92
Chiropodist/Podiatrist	8	7	88
Dentist/Dental Surgeon	16	14	88
Occupational Therapist	14	12	86
Pharmacist	4	3	75
Social Worker	4	3	75
Practice Manager	22	12	72
Speech Therapist	16	11	69
Clinical Psychologist	3	2	67
Nurse, Schools	6	4	67
Nurse, Practice	20	13	65
Nurse, Community	8	5	63
General Practitioner	30	17	57
Physiotherapist	18	14	55

The following results, presented in graphical and table formats, provides an overview of the total Continuing Professional Education (CPE) and Multiprofessional Education (MPE) activity reported across the professional groups and purely reflects that some form of CPE or MPE had been undertaken within the 'last twelve months' at the time the study data was collected **(see Graph 1 and Table 1a)**:

Graph 1. Professional Group Involvement in CPE and MPE



Key

Pd= Chiropodist/Podiatrist/Podiatric Surgeon	**PN**= Practice Nurse
Ps= Clinical Psychologist	**SN**= School Nurse
D= Dentist/Dental Surgeon	**OT**= Occupational Therapist
Dt= Dietician	**Ph**= Pharmacist
GP= General Practitioner	**PM**= Practice Manager
HV= Health Visitor	**Py**= Physiotherapist
CN= Community Nurse	**SW**= Social Worker
DN= District Nurse	**ST**= Speech Therapist

Table 1a. Response Per Profession in Percentage Order of Reported Involvement in CPE and MPE Activity

Professional Group	% CPE Activity	Professional Group	% MPE Activity
Nurse, District	65	Dietician	99
Dietician	65	Nurse, Community	99
Nurse, Community	65	Occupational Therapist	84
Nurse, Practice	65	General Practitioner	79
Dentist/ Dental Surgeon	55	Health Visitor	76
Occupational Therapist	55	Speech Therapist	71
General Practitioner	50	Nurse, Practice	68
Speech Therapist	50	Practice Manager	68
Chiropodist / Podiatrist	50	Dentist/ Dental Surgeon	63
Physiotherapist	45	Physiotherapist	63
Health Visitor	45	Nurse, District	58
Social Worker	45	Clinical Psychologist	50
Clinical Psychologist	45	Social Worker	50
Practice Manager	45	Chiropodist/ Podiatrist	42
Nurse Schools	35	Nurse, Schools	35
Pharmacist	30	Pharmacist	0

Summary- Continuing Professional Education (CPE):

- The response ranged from 65% in District, Community, Practise Nursing and Dieticians to 30% in Pharmacists;
- This reflects all CPE training undertaken, both uniprofessional and multiprofessional.

All the professions stated that they had been involved in some form of CPE. Surprisingly, Pharmacists, who have an integral part to play in the context of primary care and the government's strategic agenda had the least CPE activity, closely followed by school nurses. *Upon reflection, it would also have been helpful and appropriate to have sought to discover whether or not the low scoring groups undertook either guided or unguided CPD* **(see Section: 3.17).**

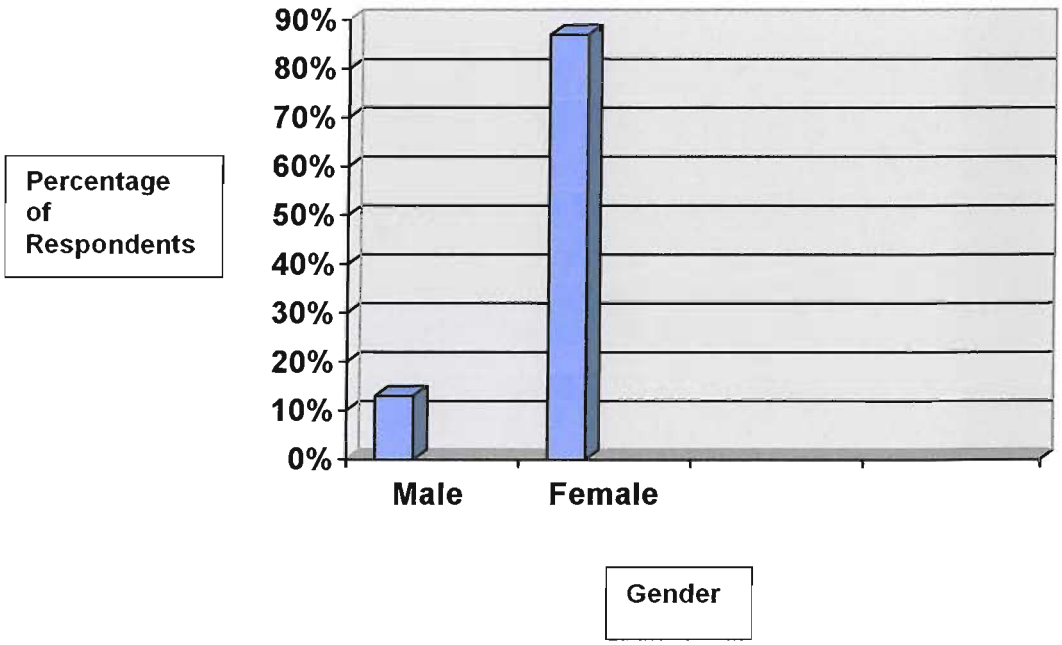
Summary- Multiprofessional Education (MPE):

- All professional groups (94%), with the exception of Community Pharmacy, reported some involvement in multi-professional education during the 12 months proceeding the questionnaire completion date;
- The percentage range varied considerably from 0% (Community Pharmacy) to 99% (Dieticians and Community Mental Health/Learning Disability Nursing);
- Ten professional groups reported receiving more than 60% involvement in multi-professional education. The lowest involvement (less than 50%) were for Physiotherapy, School Nursing, Social Work, Clinical Psychology and 0% for Community Pharmacy.

This presents a concern over the diversity of access to MPE across the range of primary care professional groups, particularly since Community Pharmacy is seen to be at centre stage in delivering aspects of the Primary Care led agenda.

Graph 2.

Gender of Respondents



Summary:

- Male= 13% representing 21 respondents;
- Female= 87% representing 145 respondents.

Evidence from the literature also suggests that a move towards part time working is favoured by the increasing population of women in healthcare (Taylor and Leese, 1997, Carlisle and Johnstone, 1996). Therefore the evidence in relation to the gender of respondents may be supportive of the view that 'family friendly and flexible working practices' would potentially be beneficial in the employment of staff.

4.1.1 Location of Multiprofessional Training Events and Distance Travelled

The majority of MPE training events were undertaken in NHS training facilities in and around the local county setting in which this research was undertaken. In particular the two Primary Care Trusts had their own training facilities that were able to cope with up to 50 staff at any time. The co-operation between local NHS Acute units facilitated access to post-graduate medical an nursing training facilities on an 'ad hoc, pre- booked' arrangement. The local community hospital settings also provided opportunities to utilize their group meeting/training rooms on occasions. This type of location was utilised in 51% of the activity reported by respondents. These locations and travel distances were not highlighted by respondents as being beyond the requirements that were needed to undertake their normal duties.

- 28% of the training events reported were provided in settings within central London in and around a 30 mile parameter of the employees work location. The facilities utilised were primarily commercial settings that were hired through the 'course organiser' and not part of the NHS estate. The majority of respondents had to travel slightly further (64%) in order to attend this type of training location;
- A further 21% of respondents reported that their MPE training location was undertaken at locations outside of the immediate local county or London settings. For example: Leeds, Birmingham and Warwick. These related to

University and commercial settings that required distances to be travelled in excess of 150 miles;

- 94% of respondents stated that they were prepared to travel considerably further than their normal travel distance to work in order to access Multiprofessional Education (MPE) training events (More than 50 miles);
- Only 3% stated that they would not be prepared to travel to attend and a further 3% stated that they would be prepared to travel up 50 miles.

The evidence gained suggests that the majority of staff have a willingness to travel 50 miles or more to access MPE training events, should that be required. It can therefore be suggested that the distance is not a relevant barrier in staff's motivation to participate in MPE.

4.1.2 Course Payment

The majority (60%) of respondents made no payment or contribution towards their MPE attendance. There were 10% who contributed £45 or more and a further 10% who paid between £15 and £45. However 20% of respondents did state that the cost was a prohibitive factor in their non-attendance.

This evidence suggests that, whilst on the whole, access to funds to attend these courses were largely provided through the employing organisation there were a substantial percentage (20%) who could not attend due to lack of funding. A further 20% of those that attended had to contribute towards the cost individually.

4.1.3 Qualifications Gained

The evidence confirmed that 17% of those that attended the MPE contributed towards either a degree or other accredited qualification. The courses highlighted included the following:

Qualifications

- BSc (Hons);
- MSc;

- Basic Counselling;
- Continence Advisor;
- Basic Food Hygiene Certificate;
- GP Post Graduate Accreditation.

Summary-Courses highlighted:

- 83% of respondents stated that the courses they attended did not contribute towards any accredited or recognised academic or professional qualification.

Historically the majority of uniprofessional courses are accredited and make a contribution towards staff portfolios, for example; Post Registration Education Programme (PREP) portfolios, Post Graduate Education Allowance (PGEA) or Individual Development Review (IDR) training needs. There appears, from the evidence gained in this study, to be a clear gap in how the MPE events and programmes are coordinated and planned in order to ensure that some aspect of formal accreditation is achieved.

4.1.4 Professional Groups Involved in Multiprofessional Education

In response to questions 15 and 16 of the questionnaire the following responses were provided in this study:

Q.15. Which professions, besides your own, were present on the course that you were attending?

Summary- Professional groups attending MPE courses:

- The majority (41%) of respondents stated that they were training alongside 2-3 professions besides their own;
- 19% of respondents were present alongside 3-5 other professional groups and 14% of respondents were present with between 5-8 other professional groups;
- A further 26% of the responses received did not specify any other professional groups that had been present at training events that they had attended.

The inference that can be made is that the study has shown that there is a variation of between 2-8 multiprofessional groups that have been engaged at any one time in MPE training events. Most events were of limited multiprofessional input (41%) and a substantial number of respondents were unable/unwilling to specify which groups were also present in specific MPE events. It could be that individuals were unable to remember who was present or that other professional disciplines were invited to attend but they did not. There appears, on this evidence, to suggest that a further reaching net could be spread in order to engage more widespread MPE input, so that training programmes more accurately reflect the nature of primary care team membership and service delivery. This process would also need to stipulate the relevance and the nature of the MPE training programme to ensure interest of professional groups across a broader team catchment.

Q. 16. Did you actively engage with other professionals in group work or other activity?

Summary- Interaction with other professionals:

- The majority of respondents to this question (86%) stated that they did actively engage with other professionals involving group work or other programme.

This interaction would have been helpful in ensuring that there was greater opportunity to deliver more appropriate communication and co-operation between professional colleagues involved at MPE events.

4.1.5 Respondents Involvement in Assisting in the Teaching of a Multiprofessional Course

Summary- Involvement in assisting in teaching of the MPE course:

- 24% of respondents stated that they have had involvement in assisting in the teaching of a multiprofessional course(s);
- Out of the 16 groups that responded the only group not to have had involvement was pharmacy;

District Nursing, Health Visiting, Speech and Language Therapy, Physiotherapy and Occupational Therapy all had reported considerable involvement (30-40%) of respondents from these professions recording input.

4.1.6 Work Base of Respondents

All questionnaire respondents, with the exception of social workers , were based within a primary care setting.

Summary:

- Community Hospital;
- GP Centre;
- Health Centre;
- Trust Headquarters-Business Park.

Social workers in this study were based within the local acute unit.

4.1.7 Employment Status, Grades and Years Since Qualification and career Breaks

Summary-Employment status:

- 68% of respondents worked on a full time basis;
- 32% of respondents had a part time role of 4days or less per week.

Summary-Grades:

There was a wide span of Medical, Nursing and Allied Health Professional grades and Senior Manager grades taking part in this study.

Summary-Years since qualifying:

- 40% of respondents had been qualified for 10-20 years;
- 21% of respondents had been qualified between 20-25 years;
- 17% of respondents had been qualified between 5-10 years;
- 10% of respondents had been qualified between 1-5 years;
- 2% of respondents had been qualified for 35 years plus.

Summary-Career breaks:

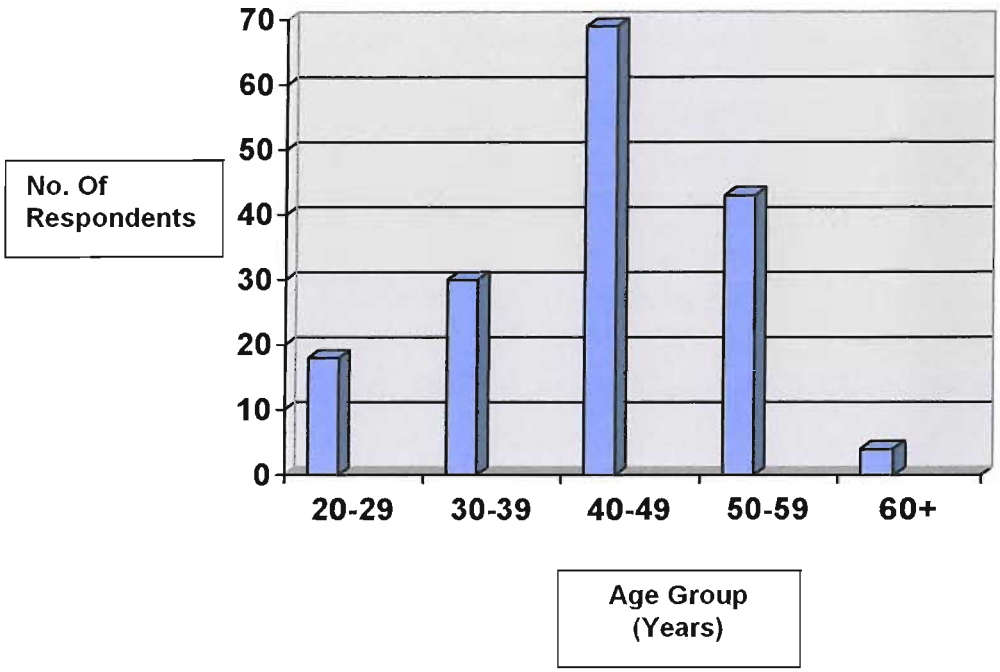
- Maternity leave was recorded in 18% (29) of the respondents involving between 5-9 months;
- 3% of respondents recorded career breaks for the following lengths of time:
- 2 years (Physiotherapist);
- 4-5 years (Podiatrist);
- 7 years (Physiotherapist);
- 11 years (Occupational Therapist);
- 16 years (District Nursing);
- 25 years (Dental Team Member).

Evidence gained from this aspect of the study, whilst not able to evidence 'good employment policy' practices and 'return to work' support policies and practices, does depict wide ranging 'career break' data.

4.1.8 Bar Chart and Table Presentation of Data

Graph 3

Number of Respondents in each Age Group Reporting Involvement in Multi-professional Education

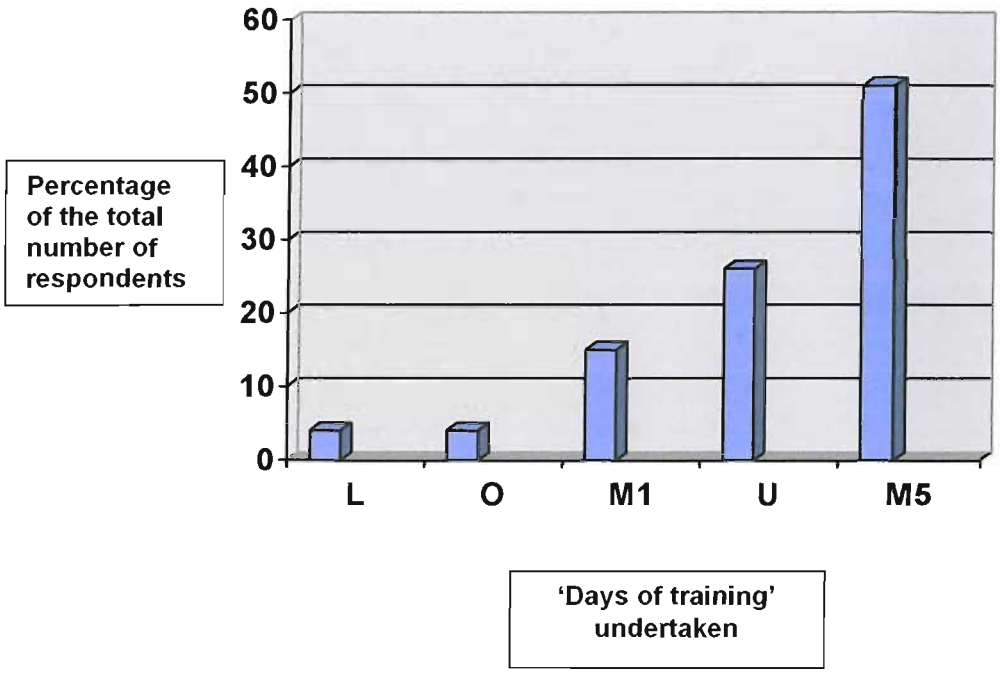


The majority of respondents (69) fell within the 40-49 years age group:

- 4 of respondents were bearing retirement age (60 years or over);
- 16 of respondents fell within the 20-39 years.

Graph 4

The percentage of the total number of respondents who have taken CPE in terms of the 'days of training' undertaken.



Key

L= Less than one day
O= One Day
M1= More than one full day*
U= Up to five days*
M5= More than five days

***Category error:** Upon reflection, there are specific errors in the way in which these two categories were set out in the questionnaire. The U category will include all the preceding categories. The M1 category also presents an ambiguous description that may have also caused confusion to respondents. In hindsight the category descriptions should have been more focused and explicit. **(see Section: 3.17).**

Summary:

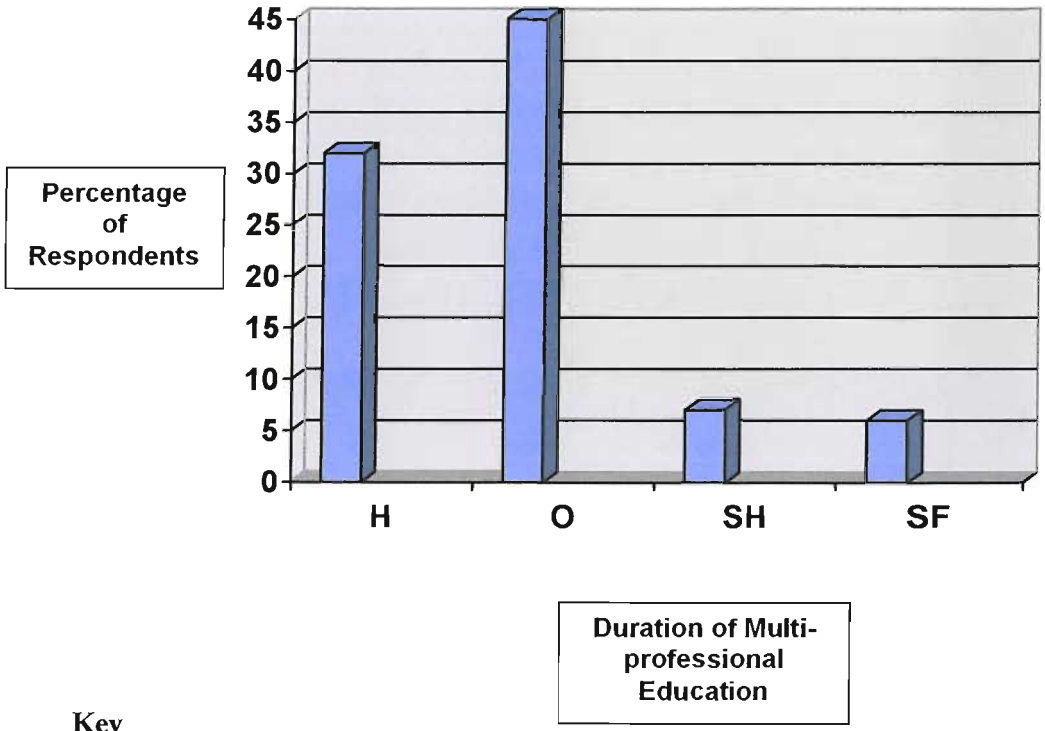
- The majority of respondents (51%) was for those respondents that had received more than five days CPE training (both uni-professional and MPE). 26% of respondents had received up to five days training and 15% receiving more than one full day;

- 4% received only one full day and 4% of respondents stated that they had received less than one full day.

Evidence from this component of the study supports the view that CPE, in general terms, has been established for the majority of respondents, however, there is a considerable variation in uptake in terms of days of CPE delivered.

Graph 5

How long did the Multiprofessional Education last?



Key

H= Half a day or less
O= One full day
SH= Several Half Days
SF= Several Full days

Summary:

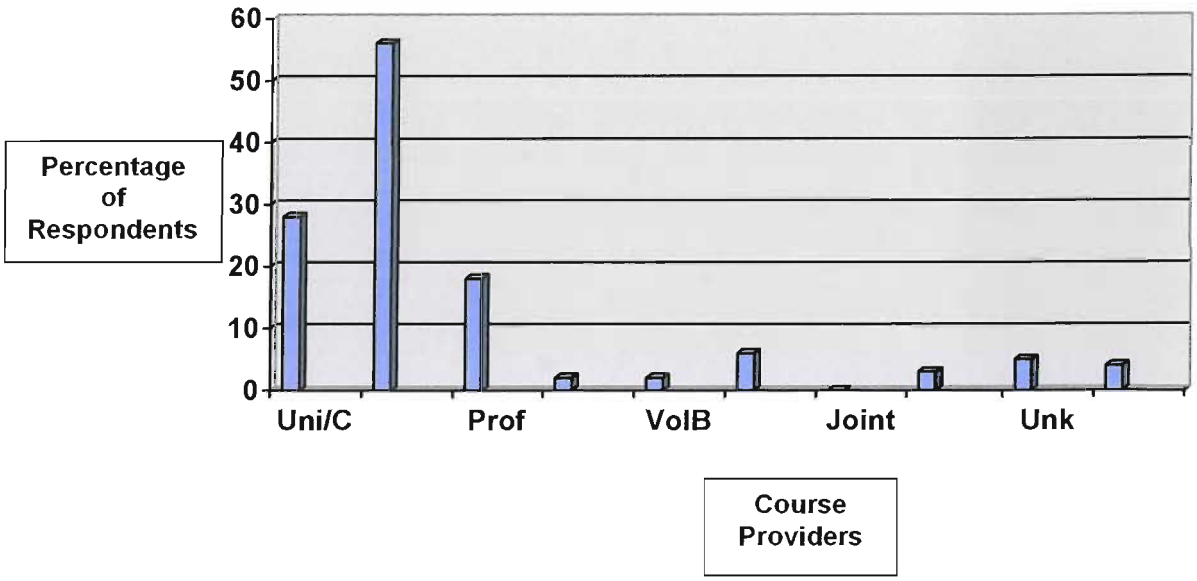
- The majority of respondents (45%) stated that the Multi-professional education they attended lasted one full day. 32% of respondents received

MPE lasting half a day or less. 7% of respondents received MPE lasting several half days and 6% of respondents received MPE lasting several full days;

- Evidence from this component of the study supports the view that the majority of respondents in this study (77%) received MPE lasting one day or less.

The interpretation of this finding is that there appears to be minimal opportunities, in terms of time set aside, for staff to engage in MPE training events.

Graph 6. Course Providers of Multiprofessional Education



Key

Uni/C= University or College
Emp= North Kent Community Trust or North Kent Primary Care Trust
Prof= The Professional Regulatory Body
Com= Commercial Company/Drug Company/Computer Company
VolB= Voluntary Body
LA/SS= Local Authority/Social Services
Joint= Joint Agency
Oth= Other Government Organisations/NHS Regions
Unk= Unknown
Sch= School/Education Authority

Summary:

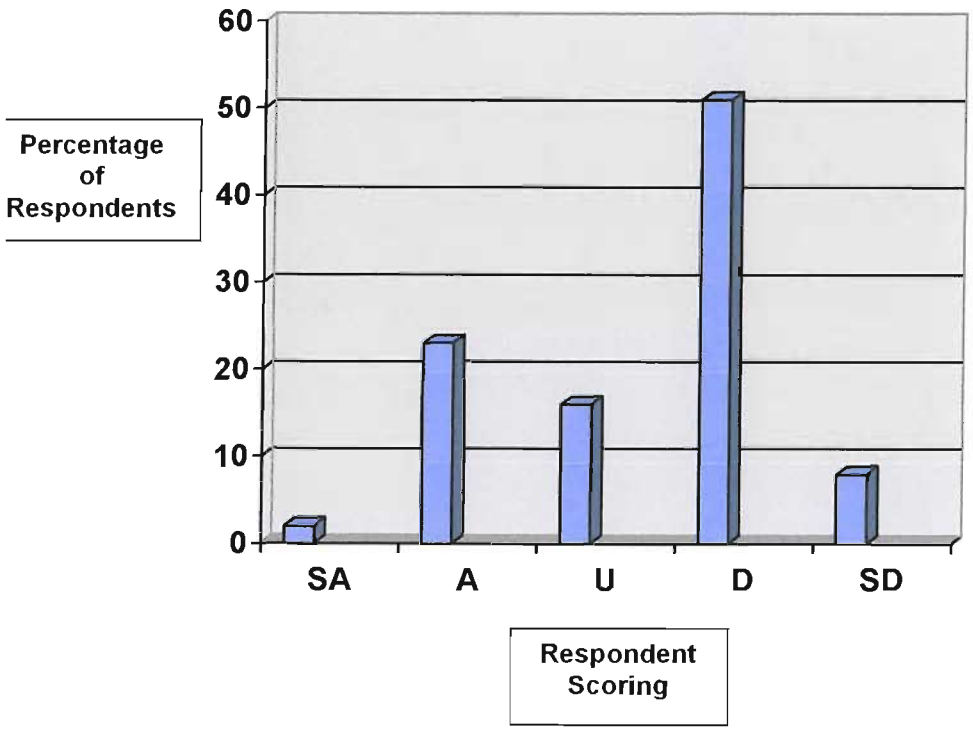
- Multi-professional Education (MPE) providers identified by respondents' written comments retrieved from the questionnaire amongst those that reported to have has involvement in MPE;

- 56% of respondents stated that their employing organisation provided the MPE;
- 28% of respondents stated that the MPE was provided through their University or College;
- 18% of respondents stated that the MPE was provided via their Professional Body;
- <5% of respondents stated that the MPE education was provided through commercial Company/Drug Company/Computer Company or Local Authority/Social Services;
- 5% of respondents reported an unknown origin for their MPE that was provided;
- No 'joint training' between two or more organisations are reported.

A key finding is that the NHS primary care employers in this study are providing the majority of MPE training opportunities.

Graph 7

The existing culture within your organisation supports the best mechanism for delivering Mulidisciplinary Primary Care Services.



Key

SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

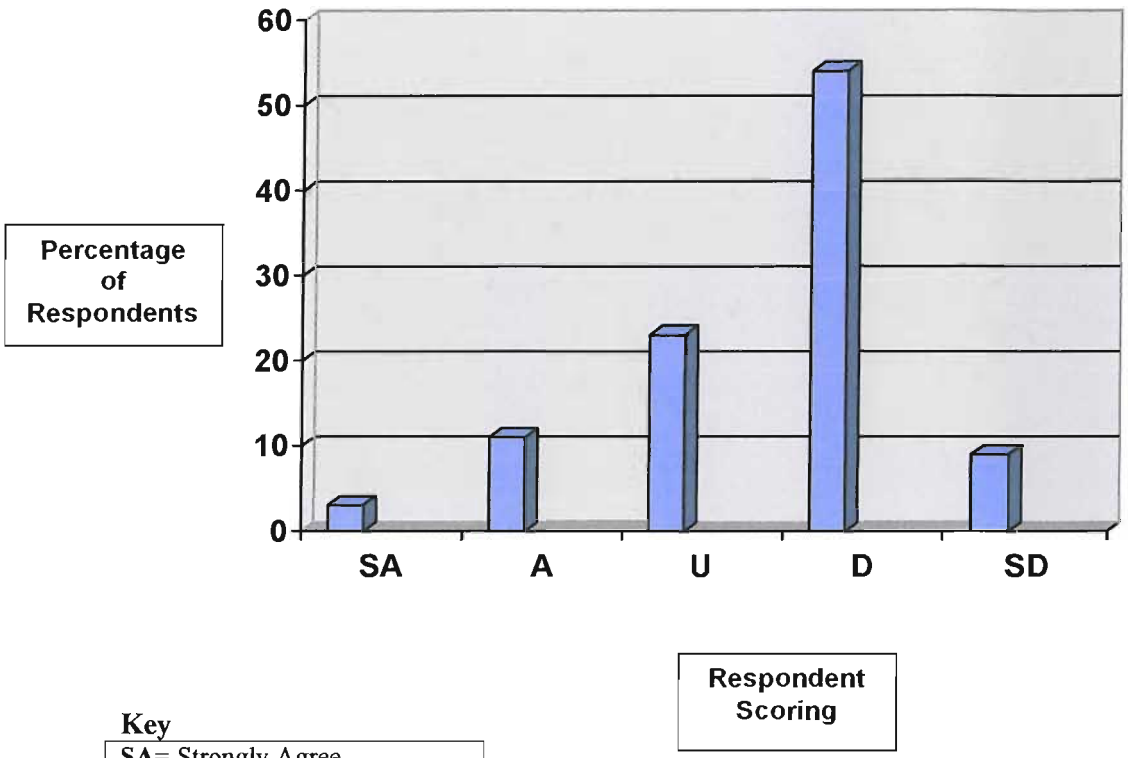
Summary:

- 51% of respondents stated that they disagreed that the existing culture intheir organisation supports the best mechanism for delivering MPE;
- 8% of respondents stated that they strongly disagreed that the existing culture in their organisation supports the best mechanism for delivering MPE;
- 23% of respondents stated that they agreed that the existing culture in their organisation supports the best mechanism for delivering MPE;
- 2% of respondents strongly agreed that their organisation supports the best mechanism for delivering MPE;
- 16% of respondents stated that they were uncertain whether or not their existing organisational culture supports the best mechanism for delivering MPE.

There is evidence therefore to support the view that the majority of respondents involved in this study (59%) do not believe that their existing organisational culture supports the best mechanism for delivery of Multi-professional Education. **(see Section: 4.2).**

Graph 8

Learning with members of my own profession is more worthwhile than learning in a Multiprofessional Group



Key

SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

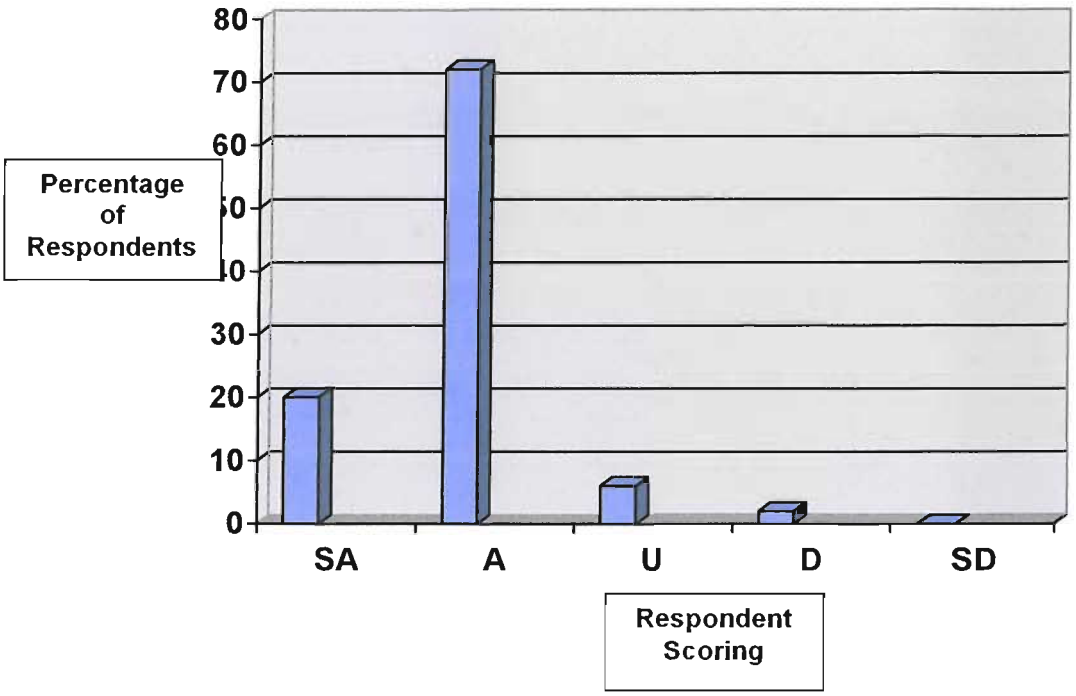
Summary:

- 54% of respondents stated that they disagreed with the statement that learning with members of my own profession is more worthwhile than learning in a multi-professional group;
- 9% of respondents strongly disagreed with the statement;
- 11% of respondents stated that they agreed with the statement that learning with members of my own profession is more worthwhile than learning in a multi-professional group;
- 3% of respondents strongly agreed with the statement;
- 23% of respondents were uncertain whether or not learning with members of my own profession is more worthwhile than learning in a multi-professional group.

There is evidence therefore to support the view that the majority of respondents involved in this study (63%) either disagree or strongly disagree that learning with members of their own professional group is more worthwhile than learning in a multi-professional group. **(see Section: 3.17).**

Graph 9

There should be more opportunities for Multiprofessional learning than there are at present.



Key

SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

Summary:

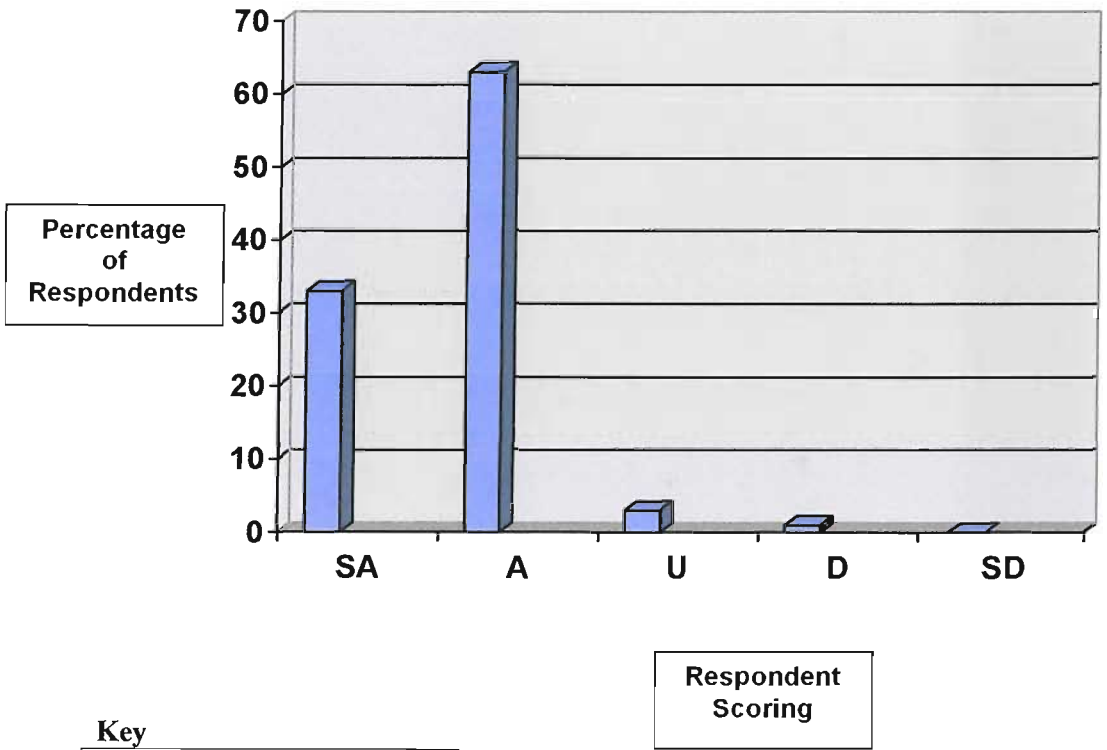
- 72% of respondents stated that they agreed that there should be more opportunities for multiprofessional learning than there are at present;
- 20% of respondents stated that they strongly agreed that there should be more opportunities for multiprofessional education than there are at present;

- 2% of respondents stated that they disagreed that there should be more opportunities for multiprofessional education than there are at present;
- 6% of respondents stated that they were uncertain whether or not there should be more opportunities for multiprofessional education than at present.

There is evidence therefore to support the view that the majority of respondents involved in this study (92%) either agree or strongly agree that there should be more opportunities for multiprofessional learning than there are at present. It can also be concluded that there is willingness by the majority of primary care professional staff to engage in more multiprofessional educational training programmes or opportunities.

Graph 10

I consider that shared learning opportunities encourage effective health care delivery.



Key

SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

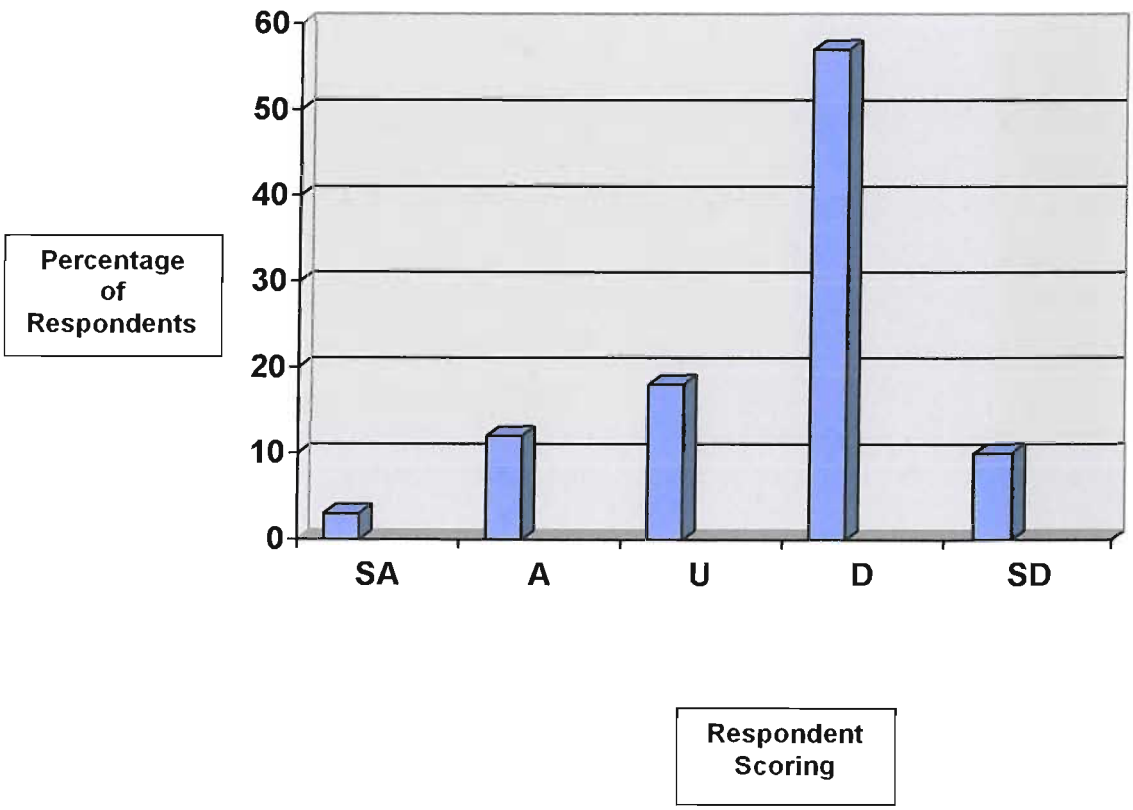
Summary:

- 63% of respondents stated that they agreed that they considered that shared learning opportunities encourage effective health care delivery;
- 33% of respondents stated that they strongly agreed that they considered that shared learning opportunities encourage effective health care delivery;
- 1% of respondents stated that they disagreed that they considered that shared learning opportunities encourage effective health care delivery;
- 3% of respondents stated that they were uncertain whether or not they considered that shared learning opportunities encourage health care delivery.

There is evidence therefore to support the view that the majority of respondents involved in this study (96%) either agree or strongly agree that they considered that shared learning opportunities encourage effective health care delivery.
Upon reflection, opportunities should have been provided for further qualitative data collection from respondents in relation to this question. **(see Section: 3.17).**

Graph 11

At present there is a good understanding of each other's Professional role and function within Primary Care.



Key

SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

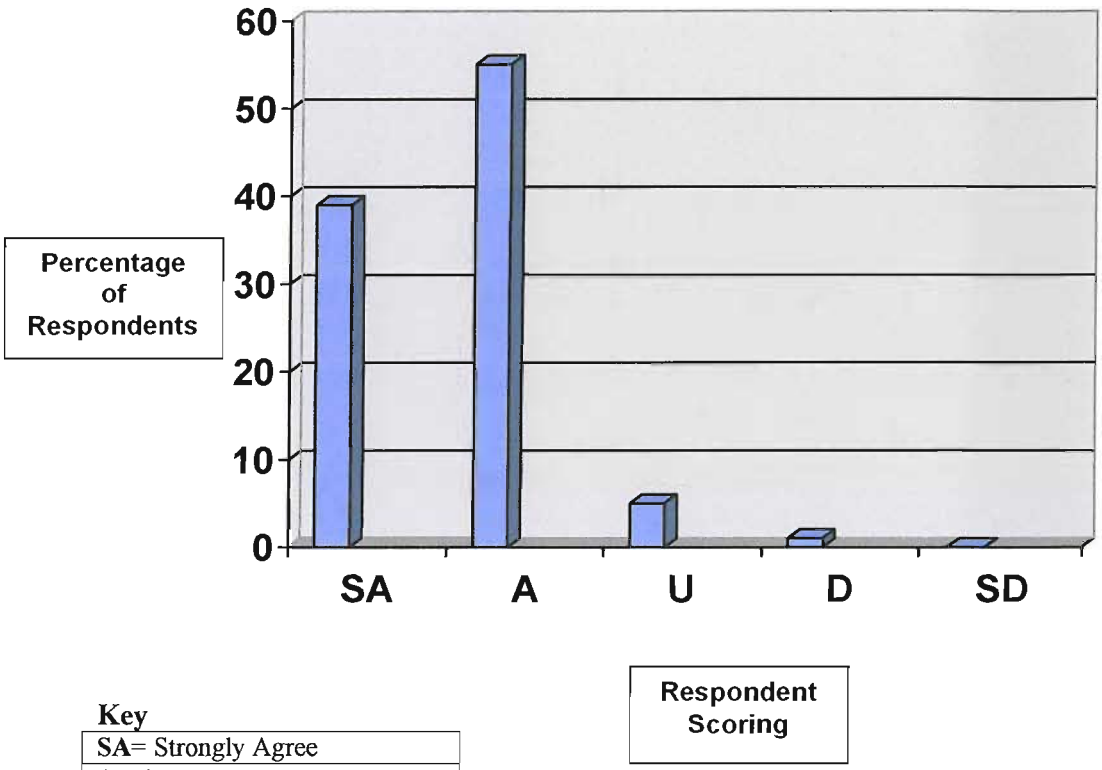
Summary:

- 57% of respondents stated that they disagreed with the statement that at present there is a good understanding of each other's Professional role and function within Primary Care;
- 10% of respondents stated that they strongly disagreed with the statement that at present there is a good understanding of each other's Professional role and function within Primary Care;
- 12% of respondents stated that they agreed that at present there is a good understanding of each other's Professional role and function within Primary Care;
- 3% of respondents stated that they strongly disagreed that at present there is a good understanding of each other's Professional role;
- 18% of respondents stated that they were uncertain whether or not at present there is a good understanding of each other's Professional role.

There is evidence therefore to support the view that the majority of respondents involved in this study (67%) either disagreed or strongly disagreed that at present there is a good understanding of each other's Professional role or function within Primary Care.

Graph 12

Multiprofessional Training and Development would assist in providing a greater understanding of the roles and functions of Primary Care Professionals.



Key
SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

Summary:

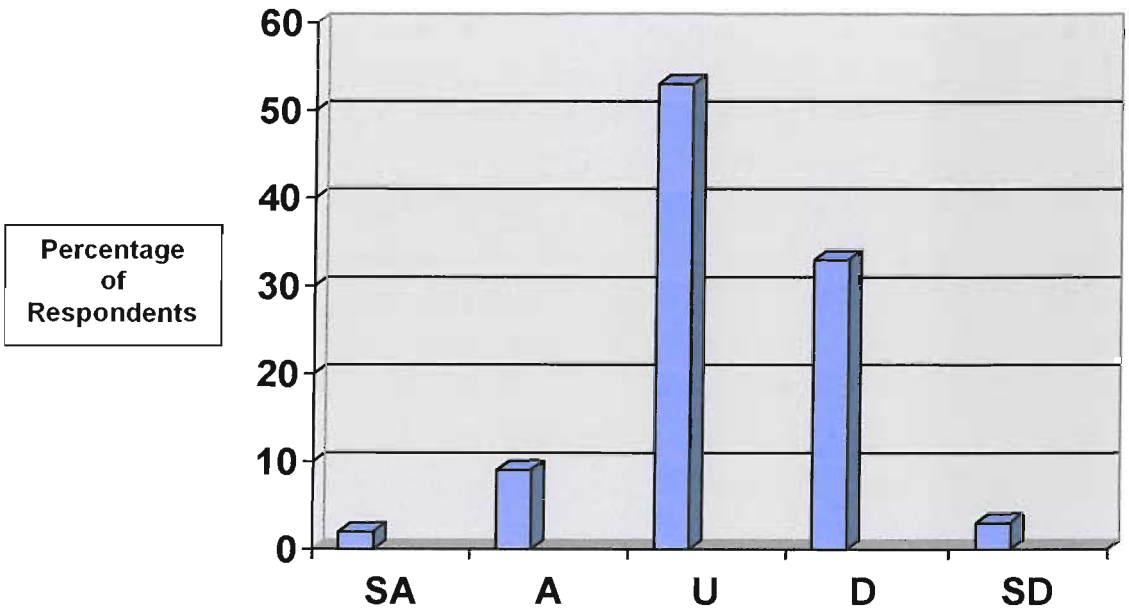
- 55% of respondents stated that they agreed that Multiprofessional Training and Development would assist in providing a greater understanding of the roles and functions of Primary Care Professionals;
- 39% of respondents stated that they strongly agreed that Multiprofessional Training and Development would assist in providing a greater understanding of the roles and functions of Primary Care Professionals;
- 1% of respondents stated that they disagreed that Multiprofessional Training and Development would assist in providing a greater understanding of the roles and functions of Primary Care Professionals;

- 5% of respondents stated that they were uncertain whether or not Multi-professional Training and Development would assist in providing a greater understanding of the roles and functions of Primary Care Professionals.

There is evidence therefore to support the view that the majority of respondents involved in this study (94%) either agreed or strongly disagreed that Multi-professional Training and Development would assist in providing a greater understanding of the roles and functions of Primary Care Professionals.

Graph 13

The existing NHS workforce Planning Process is effective in delivering the right skill mix within Primary Care.



Key
SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

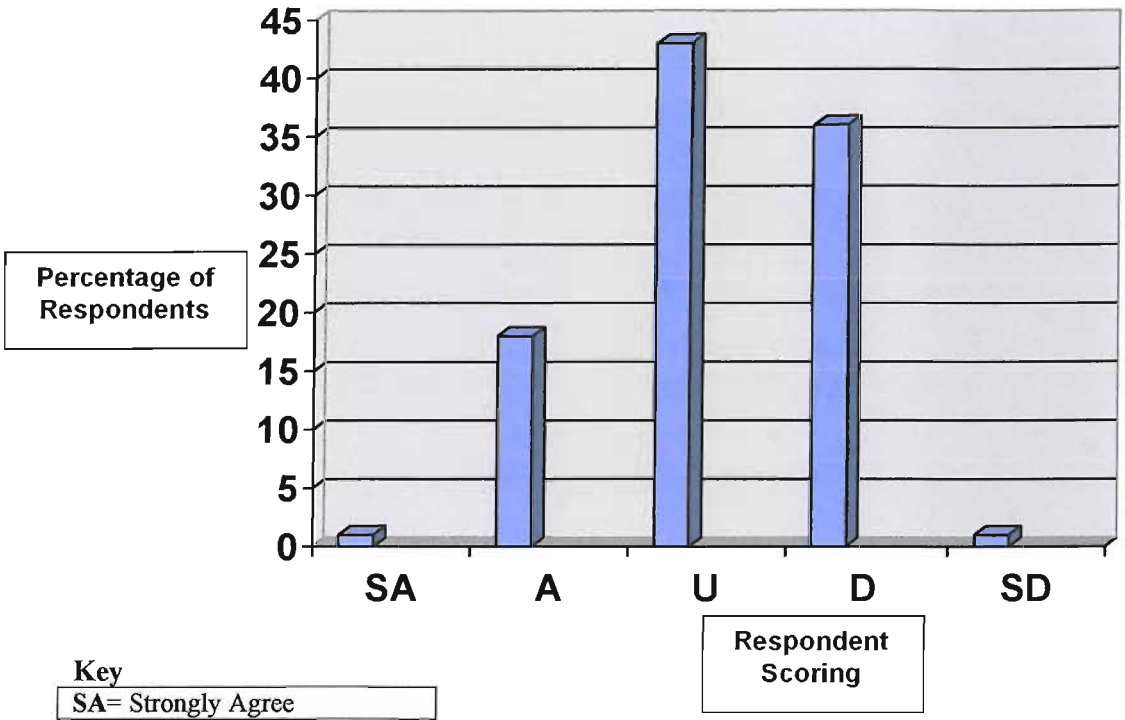
Summary:

- 53% of respondents stated that they were uncertain whether or not the existing NHS workforce Planning Process is effective in delivering the right skill mix within Primary Care;
- 33% of respondents stated that they disagreed that the existing NHS workforce Planning Process is effective in delivering the right skill mix within Primary Care;
- 3% of respondents stated that they strongly disagreed that the existing NHS workforce Planning Process is effective in delivering the right skill mix within Primary Care;
- 9% of respondents stated that they agreed that the existing NHS workforce Planning Process is effective in delivering the right skill mix within Primary Care;
- 2% of respondents stated that they strongly agreed that the existing NHS workforce Planning Process is effective in delivering the right skill mix within Primary Care.

There is evidence therefore to support the view that the majority of respondents involved in this study (53%) were uncertain whether or not the existing NHS workforce Planning Process is effective in delivering the right skill mix within Primary Care, and a further 36% either disagreed or strongly disagreed with its effectiveness. It is reasonable to make the assumption that since only Senior management/Head of Service staff are currently involved in collecting data for submission of NHS workforce Planning and that Primary Care staff do not have the necessary background knowledge or involvement to make a definitive judgement, therefore communication to front line staff over this planning process has not been effective.

Graph 14

The existing Primary Care team working across professional and organisational boundaries is effective.



Key

SA= Strongly Agree
A= Agree
U= Uncertain
D= Disagree
SD= Strongly Disagree

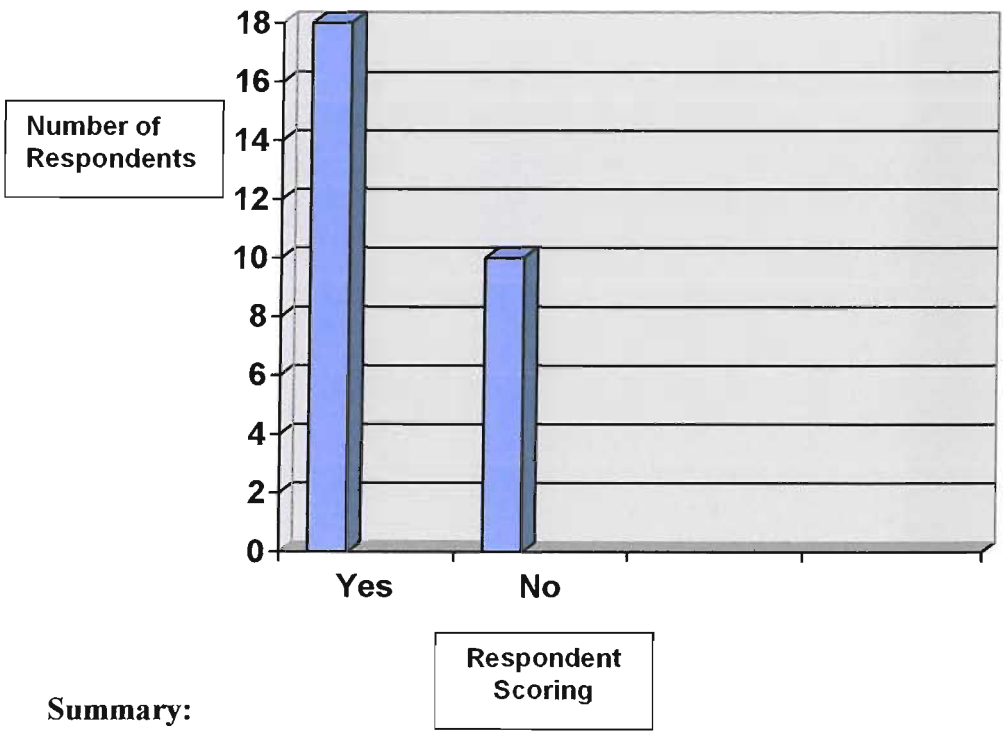
Summary:

- 43% of respondents stated that they were uncertain whether or not the existing Primary Care team working across professional and organisational boundaries is effective;
- 36% of respondents stated that they disagreed that the existing Primary Care team working across professional and organisational boundaries is effective;
- 1% of respondents stated that they strongly disagreed that the existing Primary Care team working across professional and organisational boundaries is effective;
- 18% of respondents stated that they agreed that the existing Primary Care team working across professional and organisational boundaries is effective;

- 1% of respondents stated that they strongly agreed that the existing Primary Care team working across professional and organisational boundaries is effective.

There is evidence therefore to support the view that the most common score, modal category of respondents involved in this study (43%), were uncertain whether or not the existing Primary Care team working across professional and organisational boundaries is effective and a further 37% either disagreed or strongly disagreed with its effectiveness.

Graph 15
Respondents who did not attend any Multiprofessional Education Training Event were any opportunities for Education available to you?



Summary:

- 18 respondents who had not undertaken MPE stated that there were opportunities available to them;
- 10 respondents stated that opportunities were not available to them to participate.

(See Table 2)

Table 2. Reasons for not attending Multiprofessional Training Events

If yes, what prevented you from attending?	Number of Respondents
Cost	5
Timing	8
Not interested in content of course	3
Too busy at work	4
House/Family Commitments	3
Distance	1
Course Booked	2

Summary:

There is evidence to support the view that distance is not a particularly relevant factor in non-attendance, whilst, scheduling of course and family and work commitments appear to have a more important bearing on ability to attend. Over subscription of courses is also a factor that could influence capacity planning for course organisers, as indeed would course content relevance spanning a range of professional groups **(see Table 3).**

Table 3. Respondent interest in attending Multiprofessional Training Events

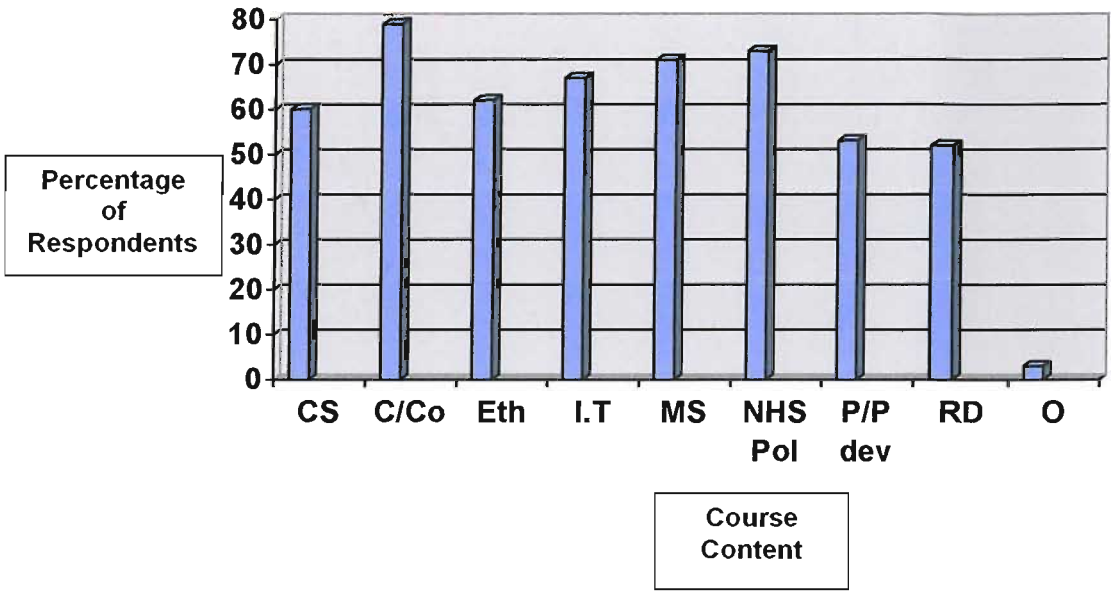
If no, if an opportunity for multi-professional learning had been available how interested would you have been in attending?	Number of Respondents
Definitely not interested	0
Not really interested	1
Uncertain	1
Moderately Interested	9
Extremely Interested	4

Summary:

There is evidence therefore to support the view that the majority of respondents involved in this aspect of study (13) would either have been moderately or extremely interested in undertaking multiprofessional learning had the opportunity to participate been available to them.

Graph 16

Course Content of Multiprofessional Education Undertaken by Respondents



Key

CS= Clinical Skills
C/Co= Counselling/Communication Skills
Eth= Ethics
I.T=Information Technology
MS= Management Skills
NHS Pol= NHS policy issues
P/P dev= Personal/Professional Development
RD= Research and Development
O= Mandatory Training, Clinical Student issues/projects, Child Protection

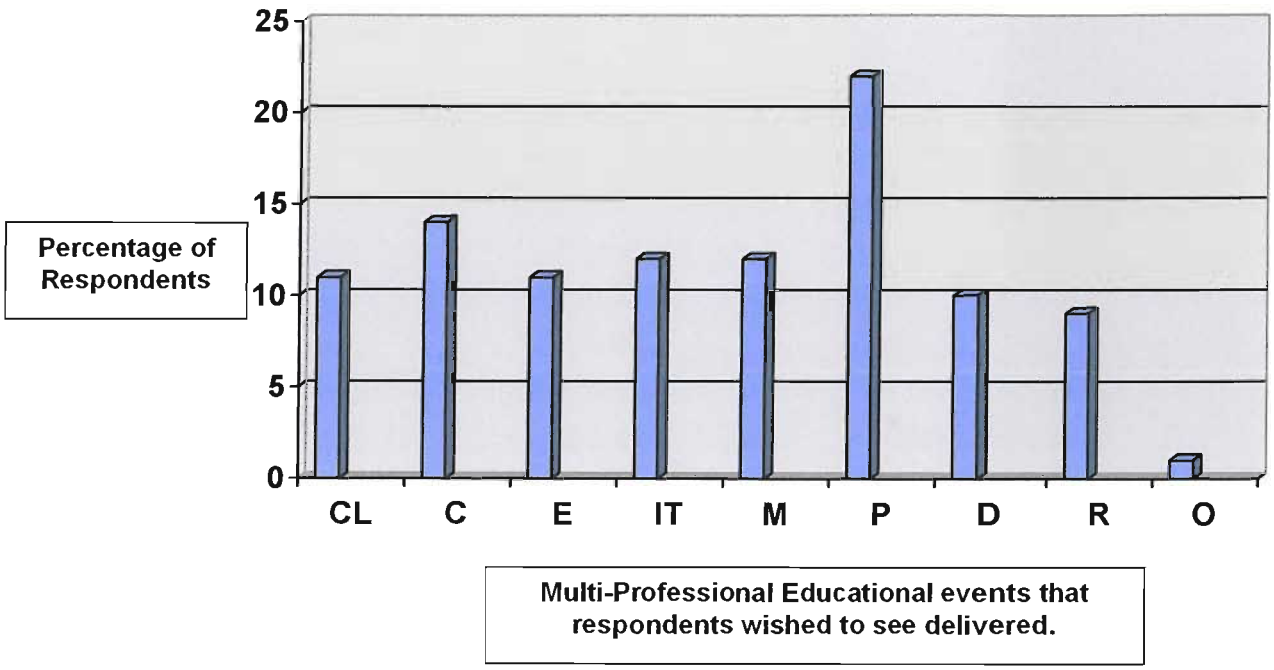
Summary:

The MPE course content information was retrieved from respondents comments entered onto the space provided on the questionnaire. This implies that respondents are attending several courses on a range of topics:

- 79% of respondents stated the course content to be Counselling/Communication Skills;
- 73% of respondents stated the course content to be NHS Policy Issues;
- 71% of respondents stated the course content to be Management/Leadership Skills;

- 67% of respondents stated the course content to be Information Management Skills;
- 62% of respondents stated the course content to be NHS Ethics/legal skills;
- 60% of respondents stated the course content to be Clinical Skills;
- 3% of respondents stated the course contents to be related to mandatory, child protection or clinical student project related subjects.

Graph 17
Multiprofessional Educational Training Events that Respondents wished to see delivered.



Key
CL= Clinical Skills
C= Counselling/Communication Skills
E= Ethics
IT= Information Technology
M= Management Skills
P= NHS Policy Issues
D= Personal/Professional Development
R= Research Methods and Associated Issues
O= Other (not specified)

Summary:

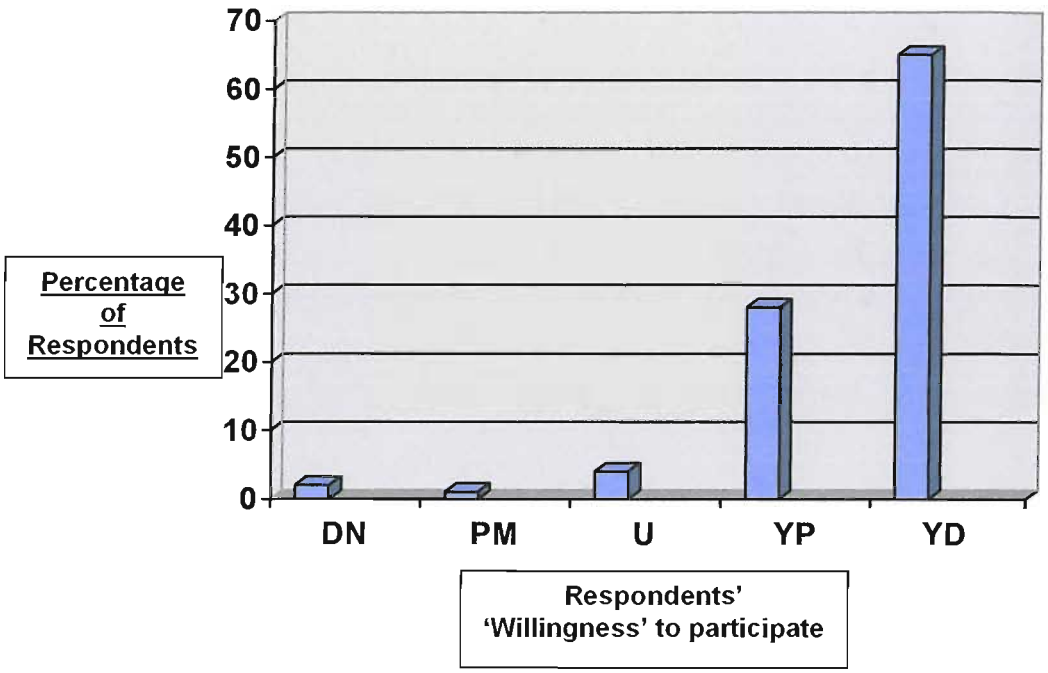
The question asked of respondents was 'which of any of the following professional issues would you be interested in learning about in a Multiprofessional group setting?' There was no limit to the number of 'ticks' each respondent could apportion. The majority of respondents entered multiple selections:

- The highest selection appertained to NHS Policy Issues that achieved 22% of the total;
- 14% of the total selection was for MPE in relation to counselling and communication skills followed by 12% for both Information Technology and Management skills;
- Clinical Skills and Ethics was selected by 11% of the total with Personal/professional development achieving a 10% response;
- Research and Development skills was selected by 9% of the total;
- 1% of the total were for other MPE training initiatives for the following that were entered onto the comment section of the questionnaire: clinical audit, project planning, child protection and management development.

There is evidence to suggest that a wide range of training programmes has been made available for the respondents engaged in this study.

Graph 18

'Willingness' to Participate in Follow Up Multiprofessional Training Events.



Key

DN= Definitely Not
PN= Probably Not
U= Uncertain
YP= Yes-Possibly
YD= Yes-Definitely

Summary:

- The majority of respondents in this study (65%) stated that they would 'definitely' participate in a follow up MPE training event;
- 28% of respondents stated that they 'probably would' participate in a follow up MPE event;
- 4% of respondents in this study stated that they were 'uncertain' whether or not they would participate in follow up multi-professional education;
- A further 2% of the respondents in this study stated that they would 'definitely not' participate again and another 1% stated that they 'probably would not' participate in follow up 'MPE' training events.

There is evidence therefore to support the view that the majority of respondents involved in this aspect of the study (93%) probably or would definitely be willing to participate in follow up multiprofessional education (MPE) training events and that the experience that respondents have already had of multiprofessional education is positive.

4.1.9 Conclusions

The data provides an insight into the respondents' participation and commitment to multiprofessional education across the primary care settings involved in this study. The general trend pictured is that employee support and willingness for shared learning opportunities is very positive and that the majority of respondents were supportive in participation in more structured shared learning opportunities with a range of professional groups. Involvement in multiprofessional education was non existent in Pharmacy and poor in School Nursing **(see Section: 4.1)**, and this 'isolation', which may of course only be representative of the local picture, does nevertheless present a case to undertake further research into whether or not this scenario is more generalisable of the national situation. The need to ensure equality and equity in the delivery of shared learning opportunities is a key aspect of government policy and therefore this anomaly should be seen as significant, particularly in view of the widening role of Community Pharmacy in the 'New NHS'.

Existing training processes do not facilitate sufficient opportunities or involvement in multiprofessional education or working **(see Sections: 4.1 & 4.1.8)**, although the main provider of multiprofessional education as delivered by the NHS employer **(see Sections: 4.1.,4.2 & 4.1.8)**.This is an important finding that reflects well in the context of the future delivery of MPE opportunities for NHS staff and shows that at the very least a positive commitment to the achievement of ongoing MPE for the workforce.

From an organisational perspective, the data from the questionnaires **(see Section: 4.1.8)**, provides important evidence over the existing 'organisational cultural'

shortfalls. The majority of respondents did not believe that their existing organisational culture supports the best mechanism for the delivery of multidisciplinary primary care services. Alongside this fact it was clear from the study that the majority of respondents currently did not have a good understanding of each other's professional role and function and that there is ineffectual team working across organisational boundaries.

Also, shared learning opportunities is thought, by the majority of respondents, to encourage effective primary health care delivery and teamwork which assists in providing a greater understanding of the roles and functions of primary care professionals **(see Section: 4.1.8)**.

Existing NHS Workforce Planning processes was viewed to be ineffective by the majority of respondents in delivering the right skill mix of staff within the primary care setting **(see Section: 4.1.8)**.

The highest level of multiprofessional educational activities were focussed upon counselling, communication, NHS policies, ethics and clinical subjects together with management and leadership skills. Respondents wished to see a similar range of MPE courses delivered in the future **(see Section: 4.1.8)**. The evidence provided supports the concept that the existing MPE, whilst limited, did seek to deliver the appropriate training agenda that staff wished implemented.

4.2 Questionnaire -Qualitative Data

Analysis of the comments made by respondents in relation to the following three statements, together with additional comments entered onto the questionnaire was undertaken:

- Whether existing cultures provide effective mechanisms for delivering multiprofessional primary care services;
  (Five themes emerged: collaboration and mutual understanding of roles, communication & shared language, organisational structure and processes, shared learning and tribalism).

- The advantages of learning with other professions;
  (Four themes emerged: collaboration and mutual understanding of roles, communication & shared language, shared learning and tribalism).

- The perceived disadvantages in learning in a multiprofessional group.
  (Three themes emerged: collaboration and mutual understanding of roles, shared learning and tribalism).

The five themes identified were:

1 Collaboration and mutual understanding of roles;
2 Communication and shared language;
3 Organisational structure and processes;
4 Shared learning;
5 Tribalism.

Each theme will be considered individually as follows:

4.2.1 Collaboration and mutual understanding of roles

According to these respondents, spanning several professional groups, the obstacles to involvement in multi-professional collaboration is widespread. Evidence gained from

this part of the study also suggests that there is confusion over roles together with a limited understanding over what multiprofessional working means:

> *'The trend is not towards patient-centred groupings but toward professionally focused groups i.e. there is a major move towards multitasking of the various Community Nurses described as 'integrated care' whereas I believe that professions skills, multi/interdisciplinary services should focus on the needs of patients'. (Health Visitor).*

> *'My Clinical Director only understands multi-professional as meaning all the Therapists he has to manage – not Education, Social Services and others'.* (Speech and Language Therapist).

> *'There are not enough opportunities to mix and learn with other multi-disciplinary and Primary Care team members. We don't know what they all do really'.* (Podiatrist).

Individuals and teams need leadership and encouragement from their managers (Martin and Rogers, 2004). The development of integrated care will only advance when joint learning occurs, and the team understands and values shared beliefs, perspectives and individual roles, which are focused on the requirements of the patient. The development of a culture that actively encourages and supports integration appears to be absent in the environment in which these respondents are working. This culture essentially needs to be a shared philosophy of patient centred and 'joined up' learning and working. Lack of encouragement and opportunities to work multiprofessionally are seen as particular obstacles by these respondents:

> *'Multi-professional mixing is not encouraged'.* (Physiotherapist).

> *'Collaborative working is not encouraged because of constraints of time, resources etc. The system does not encourage active communication and information sharing between disciplines and services'.* (District Nurse).

'There should be more interprofessional working to give more effective treatment'. (Social Worker).

The changing intraprofessional boundaries and relationships are seen by several respondents to be problematic. This creation of tension within a profession, let alone a team of professions illustrates well the cultural change experience felt by nurses caused by failed engagement and collaboration:

'As yet the Primary Care Trust has failed to engage the Practice Nurse in any meaningful way. There is no opportunity for multprofessional teams and meetings. Our District Nurses have been taken away to large health centres as have the Health Visitors'. (Practice Nurse).

'I frequently feel isolated as a health visitor and I am aware that many of my colleagues in health visiting feel likewise. There is no real sense of belonging'. (Health Visitor).

The goal should always be to improve collaboration through improved awareness of each professional group by achieving a greater understanding and respect for each other's skills. In achieving these objectives it will be necessary to provide a common framework of knowledge, which commences at the inter-professional education level. As researchers such as Della Freeth have commented (2001, p.37):

'Whilst there is a common sense reasonableness about the idea of interprofessional collaboration, an impetus is required to realize the ideal'.

Just simply placing members of different professions together will not by itself lead to collaborative or multiprofessional team working. There is an onus of responsibility for NHS Trust Managers to support the culture that delivers the interdependent team, within an appropriate structure with a shared philosophy. This support will include resources of finance, time and policy. In shaping these changes educational processes as well as NHS operational policies will need to be considered in harmony with each other. The following respondents' comments are helpful in understanding this need more fully:

'To gain a more holistic view of clients and to learn new ways of working with our patients. (District Nurse).

'Helps to provide better integrated seamless care which helps in the achievement of multi-professional goals. Provides different viewpoints and perspectives to discuss with our patients'. (Physiotherapist).

The concept of patients being passive recipients of care has long been the overriding situation in NHS service delivery. This has been termed *'patronising paternalism'* (Starey, 2003). The new primary care led NHS places the patient at the centre and through patient 'user groups' and 'expert patient' forums they will now have greater opportunity than ever before in the collaboration, communication and development of their own health planning and care systems. Multiprofessional goals and delivery of integrated and seamless care pathways, providing the baseline challenges will support the delivery of these overarching aims. A positive stance to working with and through other professions was taken by these two respondents:

'Better understanding of how our profession can inter-link with others for single assessment and seamless working'. (Occupational Therapist).

'Problems we see in our patients are often multi-factorial with more than one aetiological factor. Other Primary Care workers can help with these problems and causes if they know'. (Speech and Language Therapist).

A multi-professional approach is required for the care of the whole person, not just the immediate problem or condition. The building of relationships between professionals also enhances the build up of expertise specific to the individual patient or patient group. These sentiments are further enlightened by the following respondent views:

'Different backgrounds bring different knowledge, perceptions and viewpoints to acquire a fuller picture and prevent problems falling through the gaps in knowledge and expertise'. (Speech and Language Therapist).

'To gain experience and views from other perspectives through networking and liaising with other professions'. (Dietician).

'To look at where boundaries cross and *identify and improve joint working'.* (Community Nurse).

'Greater understanding of each others roles and skills and introduce new ways of delivering our services'. (Health Visitor).

Also, the multiprofessional approach acts as a 'safety net' for individual patients since a team member can often judge another team member's ability at delivering effective patient care and between them implement ways of managing any shortfall in the care or delivery of effective therapeutic outcomes. These respondents believed that learning with other professions besides their own also provided opportunities to reflect on how enhanced joint working and innovative working could be achieved. In essence, by taking an holistic view this facilitated a 'root and branch' reappraisal of their patterns of working and supported the introduction of potentially new ways of working that transcended historical professional barriers. This position was aptly summed up by the following respondent's comments:

'To gain a rounded view, become more aware of other professions everyday working problems and expertise they have to offer and to develop an understanding of the role of others in the primary health care team and a feeling of where you fit in the whole and how new roles could fit in'. (Practice Manager).

A coherent vision of the role of primary care will only be achieved if sufficient attention and focus is afforded to the professional roles and capacity for the future change of primary care and the emergence of new roles. Relationship building between professionals adds to team stability and enables strengths and weaknesses in delivering specific aspects of care to individual patients/patent groups to be highlighted. This learning process is very positive since understanding of each others roles will greatly assist patient care management in the context of the team, since

strengths and weaknesses will be better understood, and therefore appropriate actions taken to address any clinical imbalances or shortfalls.

The following respondents highlight the difficulties encountered with entrenched beliefs surrounding professional groups and how it can impinge on the effective delivery of multiprofessional learning:

> *'Some may have entrenched beliefs, which leads to the disruption of group'.* (Health Visitor).

> *'Tendency to bring your 'old baggage' and this can prevent looking forward'.* (Practice Manager).

> *'Boundaries and ring-fencing around various professions, self imposed or imposed by beaurocracies, people protecting themselves from new responsibilities'.* (GP).

The need to 'unlearn' is also a requirement that can be supported in the environment of multi-disciplinary collaboration, particularly in a training or teamworking environment. Davies and Nutley (2000) suggest that profound change requires a fundamental question of existing custom and practice in the context of moving services from secondary to primary care, and the ways in which there is a requirement to critique deeply held assumptions about specialist roles. The process of 'unlearning' can be an extremely hard process for many to successfully achieve. It may be that this is one of the prime reasons, that despite policy support for particular reforms, as is the case in the delivery of a primary care led NHS, there are still enormous barriers to overcome. In essence maintaining the status quo is easier than undertaking change and reform. This area has been highlighted as an area that could benefit from further research **(Section: 6.3.13)**.

The benefits of multiprofessional education are seen to be thought provoking and helpful in gaining a mutuality of understanding over different roles. The definition by CAIPE (1997) of MPE is when 'two or more professions learn side by side for

whatever reason'. Clearly 'collaboration in practice' goes beyond this definition and is best reflected more appropriately in the term of 'interprofessional education or working'. There is evidence to suggest that the respondents believe this also. For example:

> *' We should learn to enjoy multi-professional education, it can be very thought provoking'.* (Health Visitor).

> *'It is always easier to talk to someone you know. Multiprofessional courses provide a great opportunity to get to know people and understand their roles and how to collaborate more effectively'.* (Community Nurse).

4.2.2 Communication and shared language

Inappropriate referrals have their basis in either a lack of understanding of professional knowledge or a failure in interpreting subsequent treatment philosophies. A shared language around treatment philosophies (for example: Integrated Care Pathways or Joint Assessment tools) highlight the positive benefits accrued by a shared language/improved communication processes. Existing problems, in the area of communication, were highlighted by the following three respondents:

> *'We do have problems with referrals especially to Podiatry plus inappropriate referrals from GP's and Consultants'.* (Physiotherapist).

> *'Poor Communication links between some sections of Primary Care make referral to or from rather tenacious'.* (Community Nurse).

> *'Lack of communication exists which does not reduce the confusion over roles. More joint training and learning is needed'.* (Dietician).

This supports the concept that inter-professional or multi-professional working and education would be beneficial in providing greater opportunities for clarification and improved communication between professional team members.

The NHS Executive's (1996, Annex B, p.6.) 'Education and Planning Guidance' document requests that Professional Bodies should use common or shared languages across occupational standards to improve individual and multiprofessional competencies.

Meads and Ashcroft (2000) has suggested that certain elements of conflictual relationships can indeed be extremely robust and are effective in resolving often difficult and key issues. The view that a relationship is termed as 'good' can, according to Meads and Ashcroft, be misleading since it could imply complacency or collusion. Clearly, conflict can lead to thoughtful rationalisation and hence agreement over the best treatment to deliver and thereby reducing the risk of passing on inconsistent messages or inappropriate referrals. The process of clarification of roles in order to provide optimum feedback to patients, so that they are able to make an informed choice, has also been highlighted as necessary and important by the following respondents:

> *'It can highlight conflicting areas of clinical and professional opinion'.* (Dentist).

> *'Sometimes we give conflicting views to patients, if for example dentists and dieticians learn together they will deliver a clearer message to patients'.* (Dentist).

> *'To improve referral systems between professionals instead of between GPs and Consultants. When I refer to other agencies e.g. physiotherapy, OT, I need to know what they do so that I can give the patient information in order that they can make an informed choice'.* (Practice Nurse).

Professional to professional relationships have a better chance of success if there is a spirit of collegiality, support and trust (Northouse and Northouse, 1998, p.93). The basis of this view is founded on the principle that health professionals should cooperate openly with one another in order to help patients resolve complex health problems. The interference of this effective communication and support framework will ultimately lead to the delivery of a sub optimal quality of service. Compromised

professional to professional relationships also make it less likely that the primary care service will be delivered in a seamless/coordinated way with appropriate referrals being made based upon knowledge and understanding of each others roles. The following quotes made by three primary care professionals highlights the need for improved communication for the benefit of improved patient care:

> *'All involved need to be willing to address and discuss issues openly and accept new ideas and practice'.* (Practice Manager).

> *'Breaking down barriers in communication and a well supported team are the two main advantages of multi-professional education and development'.* (District Nurse).

> *'It is essential for the development of services. If you do not know what each other do, then how can we plan services. Also prevents inappropriate referrals if other professionals can give base line information'.* (Dietician).

4.2.3 Organisational structure and processes

The problems associated with teams working across two or more trusts can be considerable, not least as a result of the need to work with different policies, operational procedures and philosophies. This can also offset the focus of patient centred care delivery. The following comment is helpful in understanding how organisational structures can act as barriers to collaborative working and education:

> *'Two professions within Primary Care settings are situated within different Trusts, so this makes collaborative working and education very difficult and acts as a barrier'.* (Podiatrist).

Equally professional staff must be aware that all organisational environments will not be the same. A professional clinician may well work within many organisations in their career and will need to 'adapt' within each setting accordingly. Education needs to be aware of this predicament in order to deliver training strategies that provide

appropriate 'tools' for professionals to understand the nuances of organisational 'politics' and culture. The requirement to place multi-professional learning and working high on the agenda of the organisation is paramount. This will then lead onto the necessity to ensure that structural changes and processes are suitably adjusted to support its effective delivery. The view that the constant climate of structural change is problematic is appropriately highlighted by the following respondent:

> *'It is a constant challenge to determine what 'customary and traditional' as defined above, means in my organisation. I am well satisfied that some of my professional development and training needs are being met. However, putting what I learn into practice can be frustrating when partnerships, which have taken time and effort to establish, are constantly disrupted. The present complex infrastructure of overlapping Trusts with different geographical boundaries, in which I currently work doesn't lend itself to effective multi-professional delivery of primary care services. This is compounded by the constant climate of change such as merging Trusts and Management Structure with it's accompanying red tape and bureaucracy'*.(Dental Assistant).

The idea that complex infrastructure and organisational structures can act as a barrier to collaborative working is not a new concept. Work undertaken by Giddens (1979) and further developed by DiMaggio and Powell (1983) employs the concept of 'structuration' at the organisational level to explain the process by which an organisation creates a coherent structure of interactions along with communication of information and shared governance. This work has also been built upon by Scott et al. (1998), in the context of the American field of healthcare is of benefit in understanding this concept. According to their research the breaking down of traditional organisations and behavioural patterns together with governance structures can be termed 'destructuration'. Interestingly a form of 'restructuration' or attempts to merge, introduce new posts and new cultural processes can be seen to support innovation, together with new Clinical Governance systems is helpful in considering how the New Primary Care services in the United Kingdom may develop **(see recommendations for future research in Section: 6.3.12)**.

'Financial Constraints –who pays? is a constant difficulty'.
(Practice Manager).

The preceeding respondent suggests that these financial tensions need to be seen in the context of the service prioritisation by Primary Care Trusts, local Commissioning and team members who are budget holders or have a responsibility for balancing the books.

The relatively high part time component of the work force also lends further support to implementing 'Improving Working Lives' and the adoption of 'Flexible' approaches to employment of staff. Lack of perceived support and development by management can lead to low staff morale and a poor staff retention rate, not to mention high sickness levels as a result of work related illnesses such as stress. This respondent describes the tensions experienced by part time members of staff in terms of processes in place for training opportunities:

'I am a part time Nurse and I feel I am greatly undervalued by my manager plus I do not receive as many training opportunities as my full time colleagues'. (District Nurse).

National policy and legislation in primary care makes a request for service users, local clinicians and managers to engage with as many stakeholders as possible in the planning of services. There are great opportunities, if the right leadership and champions are in place, to influence the multiprofessional and interprofessional education and working processes for the future. The following respondents' views reflects the problems encountered:

'Staff are never given the opportunity to question or challenge policy makers'.
(District Nurse).

'It means taking risks for careful planning and processes. If it goes well – great benefits are achievable for service developments, if it goes badly – stereotypes and prejudices can be reinforced'. (Health Visitor).

4.2.4 Shared learning

The appropriateness of joint professional education is most pertinent and should be considered in the context of each individual's personal development plans, and agreed training objectives, prior to attending training events, in order to be clear that specific courses have relevance and purposeful learning outcomes that not only support individual staff but also supports the strategic/business objectives of the NHS Primary Care Trust. Existing problems in the area of shared learning was described by the following respondent:

> *'The only training event I have attended with other professionals (last year) was a lifting and handling course and it was obviously geared for hospital nurses, to be honest I did not feel it was worth going'.* (Dentist).

The nature of primary care service delivery is that it is the first point of contact for the individual seeking help or advice about a health-related problem or condition. Sharing best practice, which is evidenced based, will assist in delivery of optimal quality of care and a positive stance to sharing best practice was held by the following two respondents:

> *'By attending courses together knowledge of attitudes can be brought home and shared in order to assist in problem solving for patients as we are often their initial contact and advice point in the system'.* (Pharmacist).

> *'To share best practice, update knowledge and gain insight into recent research'.* (Practice Nurse).

Training and development, with the widespread introduction of Continuing Professional Development (CPD) for all professional groups in primary care, is a major proactive step forward and according to this respondent will reduce unnecessary duplication of courses:

'Help us to work towards multiprofessional goals and development, which are focused upon patient centred care and avoids duplication of courses'. (District Nurse).

The following five quotes by respondents illustrate the barriers that occur in implementing shared learning. The acknowledgement of the benefits to shared learning, whereby professions are willing to contribute insights, information and reasoning gained from their own professional body of knowledge is critical (Miller et al, 2001, p.105):

'Doctors attitudes – unwilling to listen to others'. (Practice Manager).

'Individual educational personnel may have an agenda'. (Dietician).

'One or more groups may not get enough 'air time' – one group could possibly take over'. (District Nurse).

'If those of higher occupational status don't leave that status at the door and learns as equals then others are intimidated and their learning is hampered'. (District Nurse).

'Intimidation – if dominant group members talk down to others – other group members may be afraid to offer their point of view'. (Practice Manager).

Medical dominance and the current power base of General Practitioners has been seen by respondents as a hierarchical block or barrier to multi-professional learning. This perceived hierarchy also has prominence in the other professional groups, where 'air time' for equitable dialogue, could be hampered by individuals feeling intimidated. The preservation of the 'medical dominance model' across both the primary and secondary care services in the UK only fuels the ongoing belief that the GP or Consultant is the prime decision maker for each patient. It is clear that there are still many members of the medical profession who wrongly believe that they ultimately have absolute legal responsibility for individual patients. This misplaced elusion of absolute 'leader' still presents a major cultural obstacle that needs to be overcome in

order to provide appropriate multiprofessional delivery of primary care services for the 21st Century.

Respondents held the view that common learning opportunities had to achieve the correct balance to ensure relevance in the post-graduate setting. This is supported by the workforce planning document 'A Health Service of all the Talent: Developing the NHS Workforce' (Department of Health, 2000b) where modern education and training needs to support team working, and flexible working to make the best use of skills and knowledge:

> *'May not deal with some issues with enough detail and depth –maybe too broad and may not be able to address the subject sufficiently to satisfy the needs of all the group. Also the group size for training can be too large and impersonal'.* (Occupational Therapist).

> *'Sometimes there are courses specifically for physiotherapy, for example an out-patients course such as 'McConnell Course' will have minimal advantage to another profession. Sometimes things take a lot longer to explain to other members that are not familiar with the terminology and techniques'.*
> (Physiotherapist).

Achieving a balance to receive the added value of the learning episode and networking opportunities, needs to be factored into the objectives and learning outcomes of the training event. Whilst it is no doubt true to state that Higher Educational establishments wish to develop multiprofessional education and shared learning opportunities, the University agenda may not be so much focused upon the benefits to patients that is derived by effective teamwork, but more upon finance pressures and curriculum scheduling issues and this could adversely affect the capacity of specific events. The balance needs to be addressed by partnership working with all stakeholders to ensure all agendas are successfully delivered.

Good facilitation together with active involvement and collaboration with educators will be a critical imperative in order to influence future developments in these areas as suggested by the following respondents:

'Needs good facilitators and course organisers to ensure all participants are actively engaged in the process'. (District Nurse).

'It's difficult to involve everybody with different levels of responsibilities of care'. (GP).

All staff at all levels of responsibilities must be participants, as far as reasonably possible, through individual development frameworks. Curriculum change will require commitment from all the stakeholders involved, and not least the professional bodies that may be perceived to have a vested interest in continuing with the uniprofessional training processes currently in place. The changes required in scheduling and logistics alone are not to be underestimated. However, the perceived values and benefits to patients has to be the main driver for change to occur.

Protected time requires to be set- aside for MPE so individuals place the training in the context of a strategic fit with their own and their team's development which ultimately supports continuous improvements in their patients' quality of care. This is further enlightened by the following respondent comment:

'Multi-professional education is happening on 'ad-hoc' occasions at grass roots level – not as part of an overall strategy, there is always the feeling that we should be actually treating patients instead'. (Podiatrist).

The following quote made by a Physiotherapist is helpful in clarifying the rationale as to why 'shared learning' opportunities deliver benefits to the multiprofessional team. It is suggested by this respondent that multiprofessional courses would lead to improved trust and role understanding together with improved communication processes:

'With the complex needs of patients being increasingly addressed in primary care there is a greater need for cohesive team working which is addressed via multi-professional courses and which hopefully will lead to more trust and

understanding of each others roles and effective joint working/inter-team referral'. (Physiotherapist).

4.2.5 Tribalism

Within professional group settings 'tribal' associations express the desire or indeed need to reconcile the continuation of existing, often hard fought, cultures and provide to members of that 'tribe' a secure strategy for dealing with their day today situations and encounters. Resistance to change and protectionist viewpoints, were suggested by these two respondents:

'Tribalism, resistance to change from some staff group'. (District Nurse).

'Professionals get protective over their roles. Higher management structures are not functioning well therefore staff at grass roots level have difficulty'. (Occupational Therapist).

A central theme is the requirement of a 'joint responsiveness' of the primary care professions in putting aside their professional 'baggage'. Individual confidence, as opposed to feelings of being threatened, will promote a greater willingness to train, learn and work together with clarity of vision and a shared philosophy, which negates tribalistic behaviour. These positive benefits were made by respondents in relation to seeking to reduce tribalistic tendencies in the primary care setting:

'To reduce stereotyping, reduce tribalism and develop new ways of addressing issues with fresh eyes'. (Health Visitor).

'To work smarter, not harder and to crack down professional barriers and snobbery'. (Practice Nurse).

The relevance of the following respondent quotes has a specific focus upon the 'balance' of delegates attending multiprofessional courses. The view is taken that unless this balance is achieved then there is potential for 'tribal' bias.

'Unless the ground is well balanced it can become very biased in favour of the profession who have the greatest numbers, particularly in workshop sessions'. (Health Visitor).

'A disproportionate number of one particular agency will put an unfair balance to the course'. (Dietician).

'Staff still cluster in professional/tribal groupings'. (District Nurse).

These preceding respondents suggest that the professional allocation of delegate places should provide a balance so that there is less likelihood of skewing power in favour of the predominant 'tribe' or individual hidden agendas. Acknowledgement is made that this has ramifications for the success or otherwise for successful 'shared learning' opportunities.

4.3 Please identify the professions that you most benefit from meeting in a multiprofessional group?

The following respondent comments provide a selection of those received from various professional groups from the qualitative section of the questionnaire in relation to Question 28:

'All, but not too often'. (GP).

'All medically orientated professionals'. (District Nurse).

'Social workers, midwifes, practice nurses, police, voluntary services, GPs, health promotion advisors and public health'. (Health Visitor).

'Health visitors, school nurses, dieticians, speech therapists, adult special needs, community development workers, pharmacists, radiographers'. (Community Dental Surgeon).

'GPs, podiatrists, health visitors, district nurses, practice administrators,

all therapy staff'. (Practice Nurse).

'Nurses, physiotherapists, psychologists, GPs, Chiropodists and other primary care staff'. (Occupational Therapist).

There was considerable evidence to support the view that all staff groups have a desire and willingness to meet in multi-professional settings in order to benefit their own professional development. All professional groups taking part in this study were highlighted as being important to meet in the multi-professional group setting. In addition other key community stakeholders such as the police, voluntary services, health promotion advisors, public health and community development workers were flagged up as integral players that needed to be worked with and through to achieve added benefits to individual role

4.4 Summary

This qualitative data from the questionnaires provides insights into the respondents' participation and commitment to multiprofessional education and teamwork across the primary care services involved in this study. There is considerable support by the respondents, for improved collaboration, multiprofessional learning and team development. Lack of multiprofessional learning and working opportunities has been cited as a key attribute for this situation, however, the evidence cited in this study does suggest that the NHS Trusts are providing opportunities for the delivery of MPE. Resistance to change, based upon tribalistic tendencies and poor communication between professional groups, was also felt by respondents, to be another factor in inhibiting shared learning and multiprofessional teamworking developments. Rapid organizational structure changes, together with a lack of appropriate planning was suggested by some respondents to have undermined the potential success of collaborative working and education.

CHAPTER FIVE

INTERVIEW RESULTS AND DISCUSSION

5 Introduction

This chapter provides the results and interpretation of the data that was collected through the semi-structured interview process with twelve key stakeholders. For each question a thematic analysis was undertaken **(see Appendix Ten)**. Where a specific quote has been included in the text, this has been anonymously coded to reflect the range of responses gained from each of the 12 interviewees (S1-S12: allocated randomly since part of the confidentiality agreements made with each respondent was to ensure that their identities would not be attributed to their transcript text). Then, all themes were collated together and from this, eleven overarching themes emerged: collaboration and a mutual understanding of roles, communication and shared language, cultural dissonance, flexible team working practices, leadership and innovation, modernisation and policies, organisational structures and processes, professional boundary changes and new roles, quality and accountability, shared learning, tribalism.

5.1 Collaboration and a Mutual Understanding of Roles

It was identified by several interviewees that collaboration presented a key challenge that must be overcome in order to deliver a more constructive approach to joint working. The need to ensure collaboration also has it basis in involving patients in their care. The ability to involve professionals in multiprofessional education and teamworking will support the requirement to 'collaborate externally' with patients and the public at large. The culture of collaboration needs to replace the culture of competition:

> *'I think that individuals are beginning to remodel away from the competitive environment that we were working in for many years into a more open,*

transparent, collaborative and I hope more positive approach to joint working which involves communicating with our patients'. (Interviewee S5).

Professional and Agency 'isolationism' was considered by the following interviewee to be contributing to the barriers, which prevent effective collaboration. Another interviewee also considered that collaboration was central to everything in Primary Care and a precursor to the introduction and further development of integrated teams:

'I know of people who have said that they already have integrated teams but I do integrated working and I dispute that. I think that we work collaboratively but we still remain in our own boxes, professional and agency. I think that we are very protective about where the line is drawn. I would say that there are a lot of barriers to overcome'. (Interviewee S9).

'Collaboration is the key to everything in Primary Care and that is very much from my own perspective and I know that is shared by a lot of people. We do a considerable amount of collaboration with other agencies, other disciplines and I think as far as Primary Care is concerned that is the way that it is going to be developed in the future. Integration and integrated teams'.
(Interviewee S2).

The view taken by the following respondent relates to a general (non technical) understanding that by integrating clinical care (for example, between community hospital and the home setting), the patient's health care needs can be more appropriately and flexibly achieved:

'Truly integrated clinical care in the community will provide bring the best service to our patients'. (Interviewee S4).

Despite models of 'good practice' evidence collected in this study suggests that there is a lack of collaboration and considerable tension towards inter-professional working. In particular a lack of understanding of different professional roles within the context

of the primary health care team has prevented interprofessional and cross boundary advancement:

> *'My reading of the situation would be that there is considerable tension between awareness and probably enhancement of interprofessional working in terms of the different disciplines of nursing, general practice and social care, alternative therapies and so on and perhaps the research literature hasn't quite caught up with that'.* (Interviewee S12).

The inter-dependence of team members requires a clear understanding of each other's roles. In particular this is necessary to avoid conflict and confusion so that individual team members gain a clear understanding of what is expected of each other (Parker, 1990). The views taken by the following two interviewees highlights these concerns:

> *' The usual situation is that it is often led by a nurse who is leading the education cycle. So you have the Nurse there, the physio, sometimes a podiatrist, GP's and it seems to me that first of all they don't know that they don't work together. They don't know what each other can do and they don't know what each other's requirements are'.* (Interviewee S7).

> *'I don't think it is effective I think everybody retains their disciplines differently and professional boundaries are not crossed. Although there might be times of information sharing I wouldn't say that is working, that is just communication it's not integrated working which is effective'.*
> (Interviewee S4).

Team members from all professional disciplines in this study must have a sense of confidence in their own roles and professional identity so that they can share and yield their professional autonomy to aid effective working. This enables the development of multi-professional working, which is patient focused, with the necessary pooling of ideas and the sharing of expertise although each professional continues to retain their core expertise. The need to cross professional boundaries is a helpful concept in this context as is the term 'professional adulthood' (Laidler, 1991), whereby the premise is

that lack of 'professional adulthood' leads to interprofessional jealousy which in turn gives rise to conflict with the subsequent effect that patient care is put at risk. This is further enlightened by the following respondent's comment:

> *'Whenever we get together to talk at primary trust education meetings for example it is quite clear that no-one talks to each other'.* (Interviewee S11).

There is considerable evidence within the study to support the concept of 'mutuality' as being a sense of ownership and shared responsibility. This is not to suggest that it requires uniformity moreover it suggests a shared philosophy and respect for each other's roles, and a clear understanding of each profession's strengths within the context of the team setting. This was aptly summed up by the following comment:

> *'That they are willing to support their team members and be a bit flexible and to maybe be open to change. There should be a mix of 'we know what we are here for' and probably some shared beliefs and values must be important'.* (Interviewee S1).

Shared beliefs and values provide the team it's identity and character. This perspective is robust, as long as the dynamics of culture are considered. For example, the way in which these shared beliefs and values are interpreted by individual professional team members, will be critical and will be determined by both historical and present day influences. Management has a valuable role in ensuring that the prevailing culture is supportive to effective team functioning. There is evidence to suggest that the interviewees believe this too. For example:

> *'I think a clear sense of what the team is all about. If you've got this very discreet practice organisation that you are dealing with then it means that you can have quite a clear vision as to where you are taking those services. It would certainly involve management acting as supportive rather than a directive role so that the Primary Health Care team could develop it's own culture and agenda to a degree'.* (Interviewee S9).

The understanding of each other's contribution leads to positive beliefs about valuing the skills that team members use to perform their tasks and also to value the distinct professional knowledge that underpins a particular patient treatment regime for that professional team member. The following comments are helpful in considering this position:

> *'I suppose it's about individuals within the team understanding, their own and other roles and responsibilities, their strengths and weaknesses and having a common aim and common focus or common goal. Value for each other, and respect, that is something we have really got to build on. We really are into reconstructing teams, reconstructing practice, reconstructing models of care and giving people support'.* (Interviewee S7).

The willingness to share and learn from each other has a twofold advantage, firstly, it produces a pool of team knowledge and skills, thereby supporting individual professional development. This facilitates the second advantage, which is the delivery of the best possible outcome for their patients, and the following respondent's comments reflects this:

> *'The word vision I don't like, but a shared ambition, and sometimes a shared guilt, that they are not doing the best work they could do for the patient'.* (Interviewee S8).

The lack of clarification over roles and responsibilities can be seen historically in context to have been mythically enshrined in professions and these myths have been proactively maintained to offer protection against 'outsiders'. The 'club culture' or 'professional protectionist' culture of the events surrounding the Bristol Royal Infirmary tragedy is a point in case. The following respondent's perspective supports the concept of avoiding a protectionist attitude whilst developing a sense of shared responsibility:

> *'It's a recognition of your own roles and responsibilities, a recognition of where the boundaries exist for other staff and that includes recognising their*

capability, their training background and a sense of shared responsibility. So it's about sort of giving up and being able to sort of give up the traditional and mythical stuff. But also about supporting the people that are doing the work and avoiding a protectionist attitude'. (Interviewee S6).

The Bristol Royal Infirmary Inquiry recommends that the requirement to understand each other's professional role be a key element in the path towards multiprofessional shared education and training:

'One of the most effective ways to foster an understanding about and respect for the various professional roles and the value of multi-professional teams is to expose medical and nursing students, other healthcare professionals and managers to shared education and training'. (DoH, 2002a, p.435).

There is considerable evidence gained from this study that shared learning opportunities maximize the understanding of individual professional roles and thereby maximize the use of peoples' skills and expertise which encourages a collaborative approach within the context of the team setting. The following two comments are representative of numerous similar comments made by respondents in the interview stage of this study:

'A lack of planned and focused multiprofessional educational opportunities is the norm and this needs to change if teams in primary care are to perform truly as a team'. (Interviewee S7).

'I feel that shared learning is rare and consequently effective teamworking is also rare'. (Interviewee S5).

To successfully achieve 'mutuality' and the cultural shift towards 'professional adulthood' there needs to be a reduction in the insecurities experienced and felt by the individual Health & Social Care Professional Bodies and Royal Colleges. This view was highlighted by the following interviewee:

'But it is also about confusion about peoples' roles out there and what their professional bodies have got to contribute isn't adding clarity either'. (Interviewee S2).

Gaining a clear understanding and knowledge of all primary care team member roles and responsibilities is seen here to be important. Work undertaken by Cannon-Bowers et al.(1993) also suggests that this 'role uncertainty' undermines shared understanding of the task, which can only be achieved when professionals have an awareness of the expertise of their colleagues. There is evidence to suggest that the interviewees believe this too. For example:

'Clearly it is the importance of a clear understanding of each other's roles and backgrounds, training skills and contribution that different members make in coming together in a team and avoiding duplication. It is absolutely paramount and it always astonishes me that in primary care teams how little for example GP's may know about the training of other people that are team members'. (Interviewee S8).

The preceding quote from a respondent has resonance to the work undertaken by Ovretveit (1997) who suggests that duplication, mistakes and delays can occur when professionals do not understand each other and refrain from working together. West and Pillinger (1996) propose that training and education is needed by professionals in team- working, since it will provide valuable insight into professional role function. The following respondent considers that there is a need 'to let go' of professional boundaries in order to maximise the skills and expertise of the team:

'Because I think the idea of multidisciplinary team working is around maximising the use of peoples' skills and expertise and for the team to be more than the sum of it's parts. So the better understanding that people have of one another's role. The more people will be able to use the expertise of their colleagues more flexibly. Removing professional boundaries is easy to suggest but much harder to put into practice. Letting go is a particular requirement'. (Interviewee S6).

The evidence derived from interview data has also referenced social identity as a construct that enlightens group membership:

> *'Members of a team should have identity. This identity has a social element and goes beyond the parameters of the professional team boundaries'.* (Interviewee S8).

Social identity theory as cited by Tajfel and Turner (1979) states that individuals can derive a sense of identity through belonging to a group or profession. This can also influence issues appertaining to stereotyping and seeking to understand how concerns over 'blurring of boundaries' can potentially lead to fear and anxiety by individuals that the distinctiveness of their valued professional group can be undermined or diminished:

> *'Some people use it in a way that implies no overlap of roles. So you have got a variety of professional people working together but they are working in an integrated way so that there is no duplication. I think that the most important aspect is the latter in that there is no overlap or duplication of roles between various professional groups'.* (Interviewee S5).

Avoidance of duplication and bringing services together in the NHS is considered a critical factor by the preceding respondent and places a particular emphasis on the duty of partnership and collaboration, in order that there is a seamless patient care system in place. This concern for overall integration is broad-based and involves the relationships not just within primary care settings but spans the relationships between the NHS, Social Services, Local Authorities and the Voluntary Sector:

> *'One example I quote would be within the YOT [Young Offenders Team] we have a health worker within that team that works alongside professionals on probation, Social Services so on and so forth. This is an equal power sharing opportunity and it works well. Although we employ the health worker, they are managed by someone within Social Service and that seems to work quite well. Accomodation space is always a problem area'.* (Interviewee S9).

This preceding interviewee's view is supported by work undertaken by Dingwall and McIntosh (1978) who suggest that interprofessional collaboration without the apportionment of equal power, prestige or status to the different healthcare professionals is futile and prone to problems. As Elston and Holloway (2001) suggest, a lot has changed in terms of nurse education, but not enough progress has been made in achieving the balance. Innovations in shared management opportunities has proved to be effective in selected areas and can establish a benchmark for future models of management that underline the partnerships required for collaborative working. Recognition that inter-agency and professional collaboration can reduce fragmentation in service delivery is an important concept. Since the early 1990s NHS policies (The White Paper-Primary Care: Delivering the Future, DoH, 1996) have encouraged the movement of diagnostic and treatment related services from hospitals into primary care settings. New developments in primary care will also place demands on premises to be able to accommodate a range of professionals who have previously often worked in a separate single-handed practitioner locations. The size and integration of the premises and services does indeed matter for optimum service delivery that is responsive to the individual needs of patients in their locality setting.

5.2 Communication and Shared Language

> *'Well good communication is the start and good understanding of each others roles and responsibilities and where the grey areas are so that they merge and crossover, plus having a philosophy that is shared by all'.* (Interviewee S10).

> *'The Hospice and the Care Managers from Social Services need to look at things like transfer of care, pathways, and at setting a standard language. I have moved away from the term discharge to demonstrate a seamless approach to care in that way'.* (Interviewee S7).

Good communication was considered by numerous interviewees in this study to be integral to understanding individual professional roles and responsibilities together with a 'Mutuality' of shared philosophy. Communication can be seen as the process

whereby information can be shared using a set of common rules (Northouse and Northouse, 1998). Good communication processes in multi-professional groups was also seen to be a key factor in successful team and organisational professional working.

The following comment by the respondent evidences that a 'shared language' is essential to ensure the ongoing development of joint planning and continuous liaison:

> *'There is a lot of professional jargon, this is not helpful, we need to work towards a shared language that crosses professional boundaries'.*
> (Interviewee S1).

Professional jargon can compromise communication and therefore needs to be kept to a minimum. This view was highlighted by the following respondent:

> *'I do not feel that there is particularly good communication with my colleagues within other areas of primary care. The jargon gets in the way and hampers collaboration and teamwork'.* (Interviewee S4).

The introduction of the 'Single Assessment' tool will hopefully improve inter-professional communication and begin to produce positive benefits in the use of a shared language for the benefit of inter-professional and inter-organisational groups, which will hopefully lead to less duplication and better targeting of resources. Pietroni (1992) has provided a description of the complexity of professional languages and where they are used in various aspects of health and social care namely:

- Medicine/molecular/material;
- Psychology/psychosomatic/psychoanalytic;
- Epidemiology/social/cultural;
- Anthropology/ethnology/ethology;
- Symbolic/metaphorical/archetypal;
- Natural/energetic/spiritual;
- Prevention/promotion/education;

- Environmental/ecological/planetary;
- Legal/moral/ethical;
- Research/administration/political.

Each professional and organisational language will often have a different interpretation and meaning within that particular context and conceptual setting which does not aid effective communication. The evidence from the interview data supports the necessity that individual team members need learn about each others' roles, clearly effective communication is critical. The integrated team must engage in detailed discussion of their patient's focus of care and that discourse must provide patient problem solving opportunities. This requires a high level of team trust and support together with an increased confidence in the skills and competences of fellow team members. In an attempt to facilitate enhanced communication, the Department of Health produced a consultation document in August 2001 around the 'Single Assessment Process' for implementation from April 2002. The Single Assessment process was first outlined in the National Service Framework for Older People and applies to both Health and Social Services. It recognises that many older people have health and social care needs, and that agencies and professionals need to work together so that assessment and subsequent joint care planning is both effective and co-ordinated. The future evaluation of this joint planning process could provide interesting recommendations implementation within the context of improved communication within primary care settings.

5.3 Cultural Dissonance

It was identified by several interviewees that key cultural issues need to be addressed to support good and effective teamwork. The 'cultural dissonance' was viewed as involving closer integration of the undergraduate curriculum for the Health Care Professions which will address, in the long term, the lack of collaboration and lack of role understanding that has already been established in this study as a central barrier to effective team-working across professional and organizational boundaries:

'I would go for a long run strategic answer that if we had a common Bachelor of Medicine degree so that everybody had a couple of years together in the first instance, for example, medics, pharmacists, professions allied to medicine, you know it wouldn't be purely medicine but it would be about professional lives. Then I think that that is a long runner. The short term is very difficult. So I think that we have to do many things. I think we have to continue to address the cultural dissonance'. (Interviewee S3).

In an organization that is as risk averse, as the NHS, the negative implications and implementation of a 'blame culture' has been established. This has been made more apparent by the trends towards higher litigation risk. The potential consequence of this has been for scape-goating and defensive practices to be undertaken by practitioners. This behaviour has consequences in terms of staff's emotional feelings and vulnerability and can produce a culture where individual members of the team can feel personally vulnerable and blamed when adverse incidents occur. The support of staff through engaging concepts such as 'learning through mistakes' (DoH, 2000c) as opposed to blaming and disciplining, is still thought to be rhetorical rather than a reality by many in the NHS. The 'blame culture' for the following respondent is seen as a particular hurdle to be overcome:

'There is a common feeling I think that people feel that the NHS is still embedded in a blame culture and again I think that everyone has to wake up from that and stop looking at blame and start talking responsibility and accountability. We have got to start using those kinds of terms and not blaming people and where there are things that go wrong, whether it's an incident, a complaint, we need to support the individuals in improving their practices and mean it. To mean what we say'. (Interviewee S12).

In describing the culture of the organization in which they worked, some interviewees gave descriptions reminiscent of the culture defined by Scholz (1987) whereby the bureaucratic 'dinosaur' culture of the NHS is typified, according to Scholz (1987), by how organizations function and work. Three culture types were described, namely: production, bureaucratic and professional. These were then distinguished by their

degree of routineness, standardization, skill requirements and variety of property rights:

> *'I think that we have a very old fashioned culture. I think we have a lot of bureaucracy, which hinders. That is being very negative, but I think that it is those kind of visions and we have quite a lot of plans and strategies that are in the NHS that say that we should be forward thinking, that we should be doing things differently. We should be integrated services. We should be working in better ways. We have a lot of written and verbal expectations of us. The historical patterns of the NHS and the way in which a lot staff still think within the NHS, hinders ambitions. The NHS culture is a bit of a dinosaur'.*
> (Interviewee S10).

The preceding respondent likens the NHS to a bureaucratic culture. This is reminiscent of Scholz's bureaucratic 'monolithic' typology and would explain why innovation can be stifled and blocked. Interviewee descriptions of culture can also be contextualised through the intellectual basis of Quinn and McGrath's typology (1985) in relation to the idea that any interaction between groups or individuals will require the exchange of facts, ideas, permission and other values. The four generic cultures being: market (rational), adhocracy (ideological), clan (consensual) and hierarchical. All these exchanges are important for primary care staff since they can determine the status of individuals and groups together with the power they can wield. These exchanges or transactions will in turn be governed by rules, norms and beliefs that reflect the prominent belief and values:

> *'The culture I would think is generally hierarchical and uniprofessional in the main at the moment* so, *there is a strong hierarchy between Primary and secondary care, Medical Clinicians and that's quite clear. There are hierarchies within other clinician groups, particularly nurses, but also I think professions allied to medicine or AHP's as they are called now. So there is a whole mish mash of different uniprofessional groupings and the goal really is for everyone to understand each other's position really. And then having done that, move the culture towards a multi-disciplinary approach'.*
> (Interviewee S8).

The preceding respondent's view that 'hierarchical' and uniprofessional is the predominant culture would assist in explaining that the hierarchical culture exists to execute regulations while remaining stable and controlled. In these circumstances authority is vested in the rules and is exercised by those with technical knowledge. This is also true of 'uniprofessional' cultures in as much as professional technical knowledge is part of the 'closed shop' viewpoint and only those of 'our' profession have the technical knowledge and expertise. The values and beliefs of the existing primary care organizational culture are part of the cognitive sub-structure of the organizational culture:

> *'Its about the way that we do things and our primary care leaders do things that is influenced by values and beliefs and if you like some history'.*
> (Interviewee S10).

According to Schein (1997) the beliefs of an organizational leader can be transformed into collective beliefs through the medium of values and norms. Norms can be seen as rules for behaviour and set the scene as to what is considered appropriate or indeed inappropriate for particular staff behaviour in selected situations. These norms develop over time as individuals seek to negotiate between each other in order to reach a consensus on how to deal with specific issues within the organizational setting. This following respondent's comments are helpful in considering this, namely:

> *'It's the philosophy and the environment that the NHS organisation has performed as it has developed so you refer to that particular organisation in comparison to another such as Social Services or the Police. That it is purely formed by the norms within the NHS'.* (Interviewee S4).

> *'Culture in broad terms I suppose I would say first of all is a reflection of feeling towards individual selective values, attitudes and beliefs. I think in relation to the health service, that also links to historic practices as well'.*
> (Interviewee S6).

The preceding respondent considers that culture reflects the attitudes, values and beliefs with a sense of feeling. This involves making an evaluation of a particular circumstance in terms of a feeling towards that specific circumstance. Attitudes evolve over time and can be the foundation upon which stereotypes and prejudices arise:

> *'I think that culture is a term that is loosely used, little studied and extraordinarily important. I think it is perfectly possible to argue that the NHS of the last decade has been shaped by it's subculture, it's secret culture,* and *continues to be so'.* (Interviewee S11).

The terms 'subculture', and 'secret culture' are used by the preceding respondent to confirm his/her belief that the NHS organisational culture comprises an aggregation of subcultures, secret by the fact that these subcultures are difficult to decipher and explain and are frequently occupationally or technically based (Scott et al, 2003).

Secret subcultures are often cultivated, according to Deal & Kennedy (2000), and hark back to more satisfying, comfortable and meaningful times. The overall result of this is a 'hodgepodge' of secret subcultures. The fear of change and perceived threat of change can reinforce individual and groups anchorage to the safety of their subcultures:

> *'Culture is like every organisation has character. It's just like human beings, we all have a particular character except we call it in an organisation, it's culture. Again we tend to be a bit blasé about culture. We either prize it highly or we see it as a tremendous barrier. The worst form of culture is a static culture. Most cultures are all evolving and changing and it is quite interesting to reflect on what culture means but the real issue is about the way we do things and the way we want to do things and the difference between the really successful culture and an unsuccessful one is that the successful one always says this is the way we want to do things in the future and the other one says this is the way we have always done it. Those are the two different ones'.* (Interviewee S1).

The success of a culture is seen by the preceding interviewee in terms of its ability to change and adapt. This can either be through the need to engage in radical change or via an incremental change process. The success of a culture is critical for most change processes, and it is the experience of success that leads to values and beliefs being subscribed to on the basis of emotional as opposed to rational grounds, thereby being transformed into new assumptions. The cultural aspects of the multi-disciplinary team arise from the differing professional rationales of the individual membership, and the presenting tensions between the individual values of their professions:

> *'I think it's the attributes and nuances around the way things are done, together with the structures and processes, protocols and procedures. I think that the culture of a team will be around how people work together, how committed they are to the team's identity. It's the glue or lack of glue that determines the type of culture that you are working with'.*
> (Interviewee S3).

The interpersonal aspects of multi-disciplinary working can also arise from our similarities or differences as humans. The difficulties or otherwise that arise from the structural or cultural dimensions may be wrongly attributed to someone being awkward to work with:

> *'There is no doubt about it. The NHS is bedevilled with pilots and beacons. What is a beacon? The one example of a beacon is that it flares brightly and then goes out. Beacons represent tremendous achievements by individual practices and individual people within those practices or elsewhere but before you go and see a beacon, the thing to ask yourself is, has that particular good practice rolled out to the rest of the practice, let alone has it rolled out to other practices locally, has it rolled out to other specialities, has is started to embed, has it started to change culture and 9 times out of 10 the answer is no'.*
> (Interviewee S1).

The example, provided by the preceding respondent, of Culture Change in relation to NHS Pilots and Beacons is a good example of the need for individuals and organizations to work together towards shared goals and shared responsibilities and hence a sense of 'Mutuality'. According to Meads and Meads (2001,p.62) a shared culture reduces the risk of misunderstanding, difficulty in articulating shared objectives and a lack of a basis for resolving differences. The sense of common identity can only reflect the strength of the relationship but also provide a basis for development.

The aspirations of the Department of Health's document 'An Organisation with a Memory' (2000c) was aptly highlighted in the following respondent's comment:

> *'I think that teams need to have support and they need to have the opportunity to make decisions and to take risks and to seeing things go well but also when things don't go so well to avoid a blame culture'.* (Interviewee S5).

The 'Organisation with a Memory' (DoH, 2000c, p.6) document was produced by an expert working group and was chaired by the Chief Medical Officer. The four key areas looked at the changes required in the NHS to move away from a blame culture towards a culture of lessons learnt through near misses and adverse incidents:

- Unified mechanisms for reporting and analysis when things go wrong;
- A more open culture, in which errors or service failures can be reported and discussed;
- Mechanisms for ensuring that, where lessons are identified, the necessary changes are put into practice;
- A much wider appreciation of the value of the system approach in preventing, analysis and learning from errors.

The following respondent believed that a 'huge cultural leap' was required to support the delivery of effective teamworking. There is a need for health professionals in multi-professional teams to become adept at minimizing any potential impact of

practice boundaries, tribalism and be able to move towards a culture of harnessing conflict in a positive way:

> *'In Primary Care we have got to work more effectively alongside practice nurses, GPs and some of the other professions that are transferring with us and my understanding is in terms of looking at integrated teams, we will be looking at integrated nursing, PAMS teams and perhaps even including social services. There is a huge challenge there for people and I don't think at the moment that staff are ready to take that huge cultural leap'.* (Interviewee S9).

Boaden and Levis (2000) believe that it is unlikely to see this become reality unless the focus is given not just to interprofessional dynamics, but also to the impact of culture and interprofessional communication in determining the function of health care teams in the organizational setting. Organizational structure and transition of organizational structures lead to uncertainties and a degree of cultural flux. It is difficult to separate culture from organisational structure embedded in the rapid changes that are going on at the moment, as the move into Primary Care Trusts has become established. Uncertainties get in the way of building new approaches to effective teamworking and integrated working, because there is confusion as to where people are going to be, how they are going to be managed and who they are going to be supported by:

> *'I think one of the good things about Primary Care culture is that general practices are very distinct identities and they provide a good environment to develop teamworking within the organisation if you did it right. It is at a level where it is very visible. Teamworking is about small groups of people working together effectively with the patient pathway'.* (Interviewee S6).

The preceding interviewee describes the 'team work' culture in terms of developing the culture within an environmental setting, such as a GP practice, with a distinct identity, thereby allowing the small group to work together effectively, supported by good communication in the form of a 'patient pathway':

'If you are taking the NHS on a macro level, I think it hinders it and by that I mean things like the Royal Colleges and professional bodies and professional boundary alignments such that the UKCC may have a particular definition of professionalism and appropriate protocols to be working to. Conversely the British Dietetic Association covers a different viewpoint so that if you have a District Nurse looking to give dietetic advice in order to facilitate integration, then you have this sort of Royal College and Professional Body conflict so that you do not actually facilitate any integration actually happening. I think on a micro level the culture of the NHS is actually open to integration. I think if you can get teams working together around a particular agenda and have individual clinicians open to the skills that other people are able to bring to the table then it can work very well. The culture should, in theory, give people the tools that they may need to grow and fit well within the team'.
(Interviewee S3).

The macro and micro cultures, described by the preceding respondent, is an interesting concept. The 'club culture' mentioned in the Bristol Royal Infirmary disaster and the failure of the Royal College of Surgeons (macro level) to set and monitor appropriate standards is again relevant. In the Bristol case, the inquiry stated in its findings that there was a lack of leadership and of teamwork (micro level). There was a 'club culture', an imbalance of power with too much control in the hands of a few individuals, professional groups or tribes. (DoH, 2002a):

'The doctors in primary care have a particular culture and so do other professional groups and if you are looking at teams they have different cultures that are driven by their leaders or whatever. I think that there is a thing about general practice and because they are independent organisations there are many cultures as there are practices'. (Interviewee S12).

The Independent Practitioner status of GPs can be viewed as hierarchical in cultural terms. This can often be problematic for the development multi-professional team work where the GP has historically undertaken the role of gatekeeper for initial assessment and onward referral:

> *'I think the culture of Primary Care really is all about teamworking, I don't think Primary Care would function without good team working'.* (Interviewee S4).

> *'Culture comes down very much to teams doesn't it'.* (Interviewee S2).

Two respondents perceived culture purely in terms of good team working in primary care. The collection of individuals in the team that share the same culture is another way that can be used to understand the team climate. The introduction of working team practices that take account of 'different' cultures rather than always having to adopt a common 'generic' team culture is another possibility in certain team settings. This therefore does not mean that a uniform approach has to be adopted, rather differences can be seen often to add value and benefiting the relationships in the team. The important point is that the team culture(s) must not introduce mistrust but allow resolution, acceptance and positive working relationships:

> *'I think a lot of it is about personal characteristics, it's about relationships, it's about trust and so it's about valuing other people so a lot of it is about how other individuals behave towards one another. But it is also about being clear what you are there to do so shared purpose and value, a clear idea of the objectives that you are going to achieve. Those kind of issues make the difference to team working'.* (Interviewee S1).

> *'The particular member of staff has the right kind of attributes to make that type of work quite effective. It depends on personality'.* (Interviewee S2).

Personal qualities of individual team members was felt by respondents to be important in order that a balance was achieved that enabled individuals to bring their own

beliefs and attributes, whilst at the same time valuing other team member's perspectives. In essence, to develop a flexible, open and sharing culture. Individual team members bring their own personal identities and qualities to the multiprofessional team. Maintaining their own individual personality is important but they also need to become part of the wider structure. The issue of individual personal qualities and its position within group identity maintains a central position within the context of multiprofessional team working. In addition the individual member of the team brings with them their own networks.

Equally, individuals working within a multiprofessional team can seriously hinder the ability of that team to work and perform effectively together. The following respondent's view is that key motivational characteristics of individuals is also a driving force in delivering cultural change:

> *'It's generally not a planned coming together it's just a couple of people who have had a good idea and that some how through their own sheer motivation I think they have managed to cross boundary'.* (Interviewee S1).

The inhibition or motivational support within a team will shape the way in which individuals function within the team context. Schein (1997, p.114) has identified four specific personal factors that individuals bring to the team:

- *Identity*-their interpersonal role and their tasks in the open team must connect to their self-image and identity;
- *Control and influence;*
- *Needs and goals*-open team goals must include those of members;
- *Acceptance and intimacy*-members of the team want to be liked and are worried about being too close or too distant.

> *'I have an opportunity to really make considerable changes but I think it is changing the culture of a lot of people and I think that we can only do it in bite size chunks and I think that we can lead by example in certain areas'.*
> (Interviewee S10).

The need to bring to bear cultural changes in incremental or bite size chunks was emphasised. This supports the view of researchers such as Myerson and Martin (1987), Ferlie and Fitzgerald (2000) together with Peck, Towell and Gulliver (2001) who state that for a change to occur it requires an organisation wide shift in attitudes and beliefs, which may have been manipulated by management. Management and senior clinicians leading by example will facilitate this incremental change process in culture:

> *'The policy is broadly sensible, it's trying to do these things speedily in an environment, wider environment that's hostile and where professionals of all hues are feeling defensive, particularly doctors perhaps post Shipman, Alderhey and Bristol so that the reality of a no blame culture is very difficult to consolidate and times are hard I think. One of the things that would be nice to do as another part of the environment would be to work a few more good news stories into the media but we live in the real world'.* (Interviewee S8).

The dissemination of positive news stories as opposed to the all too frequent negative 'falling down' stories would provide a much needed fillip for NHS staff in general and a paradigm shift away from the existing 'blame culture'. The promotion of good practice and dissemination of these 'good news stories' in the cultural change of primary care services is paramount.

5.4 Flexible Team Working Practices

The move towards integrated working has political support and has an increased emphasis on centralizing the care of patients around the ideology of holistic care with the involvement of users and carers (both informal carers and the voluntary sector). This respondent highlights the need to introduce flexibility in roles in order to adjust appropriately to effective integrated working:

> *'Integrated working can be how well roles can be adjusted within a team, integrated working could be about how different teams work together on the*

patient pathway. Integrated working does not, in my view, have any form of automatic assumption. But it is about creating effective connections between a long part of the patient pathway and having flexibility in roles so that you can actually adjust according to local needs and circumstances'.
(Interviewee S11).

As stated by Tony Blair, Prime Minister, at the launch of the White Paper 'The New NHS: Modern, Dependable' (DoH, 1997) over the 'Third Way' of delivering the NHS. Mr Blair's introduction to that document suggests that the White Paper *'is a turning point for the NHS. It replaces the internal market with integrated care'* in relation to teams. The government's 'Partnership in Action' document (DoH, 1998b) further sought to highlight the need for collaboration and partnership models of working. This was given further policy support in 'The NHS Plan for England' (DoH, 2000a) whereupon the possibility of structural Integration of both NHS Trusts and Social Services Departments with pooling of budgets was reinforced:

'It is a genuine integration between the teams but within that you have to be watchful and mindful that you are not inappropriately using peoples skills and qualifications'. (Interviewee S7).

'For me it's about multiple disciplines working optimally together around for example care pathways serving particular needs of particular groups of patients to improve the quality of care they deliver'. (Interviewee S2).

The communication of how best to deliver integrated care between the different professionals in the primary care team has a different resonance for these two respondents. The dilemma is that of managing effectively this communication process to support 'optimal' working. According to Swage (2000, p. 96), Integrated Care Pathways, can be seen to determine locally agreed, multidisciplinary practice based on guidelines and evidence where available, for a specific patient/client group:

'I usually place integration on a scale of relationship. The top of which is fusion and unification and bottom of which is contact, dialogue and exchange. Integration comes at the point when you are moving beyond combinations of services to something which has a degree of unified organisation. So that's how I kind of intellectually perceive integration in terms of form. Integration I think implies simply a complimentary fusion of skills, backgrounds and contributions, a coalescence that is a coming together at a personal as well as a professional level so that the team functions as one'. (Interviewee S11).

This perceived scale of relationship, as suggested by the above respondent, is a helpful way of perceiving the process of integration, with the move along this scale towards 'something that has a degree of unified organisation' and the move towards different members of the group 'functioning as one'. Flexible teamworking relates to group or a team that work as one. There cannot be six different individuals all working for different organisations, each going back to their own area and then just coming together every so often, they will not function effectively. The skills and the expertise of those individuals or those groups of people need to be utilized to the maximum. To trust and understand each other's skills and competences is paramount.

The need to begin by focussing on the patient's journey through the care process is critical according to the view of respondents in this study:

'Team working practices need to be patient centred and not job centred'. (Interviewee S7).

'You have to take a step back and look at pathways and you look at doing a re-engineering job of the whole service and you have to start with the first step of that 100 mile journey that starts somewhere. You start in my view at looking at the patient's needs and how the best course for those patients can be achieved and then you start to look at how you deploy staff along that pathway. That is probably a bit fanciful but I think that is what you start doing'. (Interviewee S5).

A patient centred approach is what is of prime importance not the structures. The structures or roles of staff can be adjusted to support the patient not the other way round. This approach is also supported by the findings made by the Health Education Authority's Mutidisciplinary Team Workshop and Local Organising Team Programme (West and Pillinger, 1996). Key outcomes that were evaluated were particularly in the areas of communication, teamwork and team based skills learning. In 1987 the then Health Education Authority undertook a major national programme in order to promote health education on a national scale. The success of the programme led to the development and introduction of Local Organising Teams (LOTs), which were primarily concerned with the application of the programme in locality settings. The evaluation of the programme provided the following positive outcomes in relation to participants' perceptions of the benefit of the multidisciplinary team working in primary care:

- Sharing of knowledge and experience between teams;
- Improvement of team working skills;
- Improved multidisciplinary working.

It's all about bringing professionals together, bringing services together that work in a way that is most effective for the patient. This is a huge challenge for all professionals in healthcare, social care and partnership agencies. According to Humphris and Masterson (2000, p.186):

> *'Unless the right numbers of suitably trained and experienced staff are available when and where they are required patients' needs will not be met'.*

Workforce planning should play a critical part in ensuring that this is achieved. The following respondent's view is that there has and continues to be a gap in the success of this process:

> *'There's much more that could be done and much more that needs to be done as we move into an era when we are talking about skill mix and delegating what was once one persons role to other people, whether we are talking about*

doctors to nurses, nurses to care assistants, Consultants to GPs. New specialist roles of a fast changing system with new thoughts of job opportunities arising'. (Interviewee S7).

There has been a historical cycle of forecast planning reviews of the medical workforce on a ten -year cycle basis. The nursing and allied health professions have also been undertaking similar reviews. The problems have arisen in predicting the balance between the supply of labour set against the demand side. The fast changing NHS environment has brought with it service delivery pressures both in terms of recruitment and retention of staff and interviewees comments reflect this. For example:

'When it comes to workforces and the way in which our workforce is planned I think we could do it a lot better. I think that we are such a large organisation, that the people who have the overview of it all, don't really have much control on it and therefore, when one service or one directorate or one agency impacts on another, it really doesn't get considered properly and we find that there is a lot of duplication and replication of work and robbing Peter to pay Paul'. (Interviewee S5).

Flexible employment practices as well as flexible approaches to role development must become a cultural norm and not the exception to the rule. Organisational support for flexible employment is a key initiative that will improve retention and recruitment strategies for the primary care workforce across all professional areas. The makeup of the future professional workforce in health care according to Humphris and Masterson (2000) will be 50% female, this also relates to medicine as well as the other professional groupings. This will further dictate the need for a range of family-friendly employment processes including crèche, flexible hours and job share opportunities. The grading system is also subject to review under the 'Agenda for Change' legislation and aspires to modernise the existing Whitley and Medical and Dental salary arrangements. This respondent's comment highlights the difficulties experienced:

'I feel very angry because I am stuck with the grading and contracting system and an established salary so I can't go with the flow and so I have to wait for that decision to come from much higher up'. (Interviewee S7).

There have always been uniprofessional workforce planning exercises that have been largely diverse from reality. This process has inevitably stifled flexibility of roles and undermined any development in multiprofessional training and education. Respondents' comments reflect this:

'There is no forward planning, there is no projection of what the workforce is and what they are going to need in terms of family and social needs'. (Interviewee S9).

'It is frustrating since there appears to be no system in place to plan for the workforce required'. (Interviewee S6).

The traditional health care professional roles, as a result, have been maintained This mechanism has undermined the development of future health care worker roles even in the knowledge that GP shortages were on the horizon and simply training more of the 'same' may not necessarily be in the best interests of patient centred health care delivery. This was aptly summed up by the following respondent's comments:

'As for GPs there are areas where there are no GPs to practice and the Government's response is to say we will train more GPs. The medical school is suddenly training 200 a year and has been asked to bid for 240 but no funding has been made available to achieve this increased figure'. (Interviewee S11).

5.5 Leadership and Innovation

The role of leadership, champions and innovators was seen to be an important concept. The perceived view that GPs sometimes lack the management skills

necessary to lead the team effectively was reinforced in the following respondent's comment:

> *'The way that different health professionals, as it were, socialize gets a bit in the way of teamworking. It's almost a cliché to talk about the GP's shortcomings in this area and sometimes their lack of management skills and the extent to which they may, as a product to the way they are trained, lead teams rather inappropriately'.* (Interviewee S8).

The inference described by the following interviewee is that General Practitioners may consider teamwork as a mechanism for reinforcing their perceived position as team leader and controller of resources:

> *'The majority of family doctors still think that they are the team and that they are leading the team but hardly ever equal members of it. Certainly in the GMS contract the way the GPs are paid is an issue since they see themselves as devoting a lot of their personal resources and then they are controlling the flash leadership roles rather than working properly in the team'.*
> (Interviewee S3).

This view points out that other team members such as Health Visitors and District Nurses, enjoys less status and consider teamwork as a process of working in a subordinate role to the GP is also emergent in the data collected from the interviews. A 'prima interpares' first amongst equals philosophy seems not to be the case. The following comments are representative of numerous similar comments made by respondents in the interview stage of this study:

> *'The smaller practices tend to have much more discrete working and therefore the GP's tended to take much more of a lead and see themselves as doing everything really'.* (Interviewee S2).

The Independent Contractor status of GPs has had a key influence on the development of the character of primary care. The Doctor 'domination' issue is interesting to note.

As Independent Contractors and historical 'gatekeepers' for entry into the NHS since 1948 the GPs status has enabled them to take a 'top dog' persona which until recently has been fully supported by government and Department of Health Care policy and that GPs have jealously protected their independence. This is further highlighted in the following respondent's comment:

> *'We have to change organisations a bit better than we have. I think that my own view is that the PCTs are still too heavily doctor dominated'.*
> (Interviewee S3).

Recent changes in government policies (e.g. Nurse & Allied Health Professional Consultants, Nurse and other Health Professional Prescribing, Nurse Practitioners, NHS Direct) have encroached upon the power base of the GP by instilling a sense of imminent loss of the autonomy that has been present for the last 56 years:

> *'GPs and the people who are going to take the lead within the practices themselves, which might not necessarily be the GPs, they maybe a practice nurse. The leadership needs to be there, you need to have identified the need to support them, you need to develop them but good leaders actually their key task is to spot other leaders and develop them'.* (Interviewee S6).

The recognition that leaders once identified, require support and development opportunities was seen by this respondent as helpful. Also a key requirement of leadership was also to identify, support and develop other leaders. One of the real challenges from the health community is to identify and encourage and support the innovators because they are ones who take flack from professional colleagues early on. There are often champions within the practice or within the health community who are willing to put their heads above the parapet, and lead. The following respondent's view is that there is an organisational support requirement for leadership:

'Consistently giving the same messages about what we want to do. I think we have to put some resource into organisational development and in particular leadership and we have to devote more resources into leadership'.
(Interviewee S10).

Primary care maybe flat structurally speaking but it is important that teams are led and directed skilfully, and of course, leadership is also about clear objective setting, clear goal setting and imparting to other team members a clear vision of what they are doing and where they are going and at times of great organisation change that is sometimes very difficult to achieve. The view of leadership published by Selznick (1957) is an appropriate reminder of the educational process incumbent upon good leadership and that ultimately the leader is primarily an expert in the promotion and protection of values. Within the context of NHS primary care services leaders face the challenge and innovation to transform men/women from individual professions into willing and committed team players. The effective leader therefore needs to understand the meaning and become proficient in the techniques of education. The art of the effective leader is also the art of organisation building that embodies new and enduring values in members of the team and organisation. From the standpoint of the committed person, the organisation is changed from an expendable tool into a valued and prized source of personal satisfaction:

'Practice Management is a new discipline, relatively new, 20 years old, and has a lot to contribute and it is important that the managers in Primary Care are properly and professionally trained but in some ways I think that they have been overlooked'. (Interviewee S4).

Some concern was raised by the preceding interviewees comments, in relation to the need to deliver professional management training support to practice managers. This form of vocational learning should have an emphasis on practical competences and experience as outputs:

'I think that most of the people that work in Primary Care are less wedded and less precious about their position and that we have had a fairly long lead

in time to developing a multi-disciplinary approach. I can remember 20 years ago asking the question 'does this GP need to head up the primary care team.' It isn't new for us and I think over a period of time we've addressed this, I think we have still got a way to go but I think the building blocks are there'. (Interviewee S8).

The question of who leads in primary care teams really needs to focus upon an egalitarian approach with and between members of the team and the introduction and support of innovations in practice and role developments. The concept of continuous professional development that is in a multiprofessional context is the right way to go. There are huge benefits for shared learning and not necessarily just in a clinical perspective but also in terms of leadership, management and managers learning from each other. These are key elements in supporting the teams. Without shared responsibility or mutuality there will always be blame and guilt. This has been a recurrent theme from the evidence gained from the questionnaires and interviews. The need to have 'champions' or leaders for change is required, not least so that others can be supported in visualising how change can make improvements. This was appropriately summed up by the following interviewee's comments:

'I try to embrace in the concept of modernisation and doing things in different ways and moving forward and breaking down barriers. I think that people like me who seem to be fairly senior in an organisation need to lead by example and we need to demonstrate to people that we are prepared to do things in different ways and support the staff to do things in different ways and we do value them and to try and improve their working lives'. (Interviewee S9).

Leaders are critical in both the small day- to- day changes as well as the more adventurous step changes that will deliver new approaches to primary care service delivery.

The prevailing medical dominance model also appears to have undermined the need for the doctors to fully appreciate and understand the value and contribution of other

primary care practitioner roles in the context of the team and delivery of autonomous patient care. A view that other roles were simply there to free up doctors time, which had they (the Doctors) the desire could do that work but preferred to relinquish to another 'support' practitioner has become predominant. Inappropriate referrals by doctors to other professionals has led to ill feeling, frustration and a sense of being undervalued.

5.6 Modernisation and Policies

July 2000 saw the government's introduction of 'The NHS Plan' (DoH, 2000b). The plan contained ten core principles and a myriad of targets set out within the context of these principles. This plan sets out the government's vision for modernisation. A particular change related to the breaking down of historical professional role limitations. In structural terms, however, the roles of Primary Care Groups, and emerging Primary Care Trusts were not affected, but key performance targets were set. The following two interviewee comments are that the policies provide the foundation and opportunities for change:

> *'To scratch the surface the NHS plan has got lots and lots of targets which in themselves are quite threatening. But behind them there has been the opportunity around local modernisation plans to flag up where the risks are and particularly for us is the workforce development, given the fact of where we sit in relation to recruiting and retaining staff for that matter in the South East. There are all sorts of challenges that exist at the moment so if you take the documents at face value then you soon get lost within a morass of detail of the target but in fact its how you exploit that and how you get to reaching the targets that probably present a number of opportunities'.* (Interviewee S12).

> *'There is a very high expectation from these policies of a very different NHS and one which I don't think is necessarily 100% feasible but I think that what it does do is it lays down the foundations for change and I think with our own professional expertise and our own professional development we can use those*

documents to our advantage. But we have to take the opportunity to do that and you have to use them to our benefit'. (Interviewee S7).

This labour government's White Paper raised expectations and the foundations for change by seeking to deliver what has become to be known as the 'Third Way' (Giddens, 2002). Bond and Le Grand (in Dowling and Glendinning, 2003, p.21) suggests that this 'Third Way' rather than limiting policy thinking with outdated notions of ideological purity actually seeks to be guided by what actually works. The policies appear to undermine the traditional role historically held by the General Practitioner (GP) and coercion to deliver diversification and innovation has been set in progress. The role of the GP as 'Independent Contractor' is optimistically to be replaced largely by a 'Salaried Practitioner' model and a 'New GP contract' (GMS):

'I think they provide great possibilities, I think there are the overall policies of development and workforce confederations, focus on continuing professional development, more influence clearly from professional response to accreditation. The introduction of appraisal, there is the environment which people can't avoid any longer. The policy initiatives set the context for each end. Yes it is overlong and tedious to read but the general debate and principle are right. The professions are signing up to them and it creates the undercurrent, the unstoppable movements. You are on a river and you can't paddle back'. (Interviewee S2).

The preceding respondent describes a huge impetus provided by these policies in terms of primary care development. There is very little in the NHS policies, which consolidate the tradition of generalist personal care. Even where it's referred to, it's now become a common property, not the special relationship that was represented by the general practitioner as an intermediary between the state and the individual. It's almost as if there is a premium becoming attached to that. The policies will not sustain that model that we have known and they deliberately have been down graded in order to achieve diversification.

A broader perspective was taken by this respondent in stating that their belief in the fact that recent policies were delivering a staunch momentum for change:

> *'You have 'Making a Difference' document. I am not trying to be tribal in talking about the nursing aspect but it does raise up the opportunities that there are for new nursing roles. I would expand that, really it's about new clinical roles and new ways of working within that context and in terms of clinical governance I think it's probably one of the most critical policy statements. I think of underpinning everything in terms of what everybody does within health or within any approach of care delivery which does require us all to take some individual responsibilities as well as collective responsibility for the care that we give'.* (Interviewee S10).

The Department of Health document 'Making a Difference' (1999), specifically focused upon strengthening the nursing, midwifery and health visiting contribution to health and healthcare. According to the Secretary of State for Health at that time, Frank Dobson, the proposals set out within the document added up to a clear statement of the values it places on the contribution of nurses. The need to increase nursing numbers, strengthening education and training, developing modern career structures and working in new ways were just four of the key elements set out for action. The NHS agenda for change as outlined in the White Paper 'The New NHS: Modern, Dependable' (DoH, 1997b) sets out a grand plan of modernization. Two of the six key principles are:

- Getting the NHS to work in partnership, breaking down organizational barriers and forging stronger links with local authorities;

- Driving efficiency by a more rigorous approach to performance and by cutting bureaucracy.

There is a fundamental need for the funding for student places, to be grounded in a realistic funding allocation that matches the workforce planning requirements of the

provider organizations. This respondent describes the imbalance present in the desire to increase training places without the financial support to achieve this goal:

> *'Take Podiatry this year they told us there would be 30 students. Later on they told us they think it might be 34, but there is no money so they thought well we will pay you for 30 students but actually if you can take on 34 because of something we think might be needed in the future, but you cannot have any money to do it'.* (Interviewee S11).

The recognition that the health-care workforce is not based on a national market but operates within the context of distinct locally driven labour markets. This flexibility has to be factored into the planning stage between the Workforce Confederations and the providers (Primary Care Trusts). This respondent's comments are helpful in highlighting the situation:

> *'From an overall NHS I think it's not very good. From a PCT perspective I don't think it's very good either, I can turn around and say that I know from a workforce profile that I need 10 additional Health Visitors across the ...Kent tomorrow and I know that if I were to pay a premium in ... Kent or to be able to be more flexible about what I am asking my Health Visitors to do I would probably recruit them but I haven't got the money to do it or likely to get it'.* (Interviewee S12).

The 'Wanless Report' (HM Treasury, 2002) supports the notion of a rapid increase in primary care service capacity. This is also further supported by the increase in funding set out in the NHS Plan and modernization agenda of the NHS. Until this funding filters down the line to facilitate staffing establishment increases, that have been appropriately prioritized by the individual Trusts, this respondent's view will hold sway. The 'Primary Care Workforce Planning Framework' does make the commitment to now ensure that a 'Whole Systems' approach will be adopted to bring together service, capital/estate, and workforce planning across the whole range of primary care services in the following ways:

- Across both independent contractor practices and community services;

- Across professions, with a proper plan for use of all health care professionals and other staff;
- Across all types of primary care including local authority, voluntary sector, general dental services, community pharmacy, NHS Direct and walk-in centres;
- Includes the impact of changes in secondary and intermediate care settings.

There is evidence to suggest that interviewees believe that there is a lack of both workforce planning and financial resource . For example:

> *'I don't think that we plan far enough ahead, I don't think those plans get converted into anything that would make the number of college places look different or how we encourage people into the system'.* (Interviewee S3).

This shift towards an integrated and all embracing planning process is to be welcomed, albeit dependent upon financial resource streams being made available and prioritized effectively:

> *'Again we are dependent upon resources being available. We do our best to use what we have got, effectively remodelling job roles and skill mixing opportunities we do need to look to expand our workforce'.* (Interviewee S9).

Resource shortages have been a particular theme in the NHS since its inception in 1948 and a major driving force in the strategic thinking over ongoing service delivery. Work force shortages, the need to meet efficiency savings and at the same time deliver more clinically effective services have taken their toll. As a direct consequence, job remodelling and patient care pathways have risen to the top of the NHS agenda. Multiprofessional working with new roles and restructuring around practice delivery combined with multiprofessional learning is seen by many as a necessity not an option for the 21st century primary care services delivery:

> *'I can do a lot of forecasting but when the parameters are changed by new services that are coming in to plan like NHS direct a lot of the staff that I was*

assuming forecasting for have actually been recruited by a new arm of the organisation. Also staff are starting to leave and go and work for McDonalds or other places because they get paid more'. (Interviewee S2).

Retention of staff for this interviewee is seen as a particular hurdle by the preceding interviewee and will be influenced by workforce planning strategies and new service elements, such as NHS Direct, Primary Care Walk-In Centres. In addition 'Improving Working Lives' programmes, such as flexible working practices, will play an important role in the process. Equally, the financial remuneration for primary care staff needs to reflect the responsibilities, training and skills in order to retain and motivate the primary care workforce. The current 'Government Spending Round' increases in NHS funding needs to be reflected in addressing the gaps in terms of pay, inequalities in status together with training/education opportunities for all primary care practitioners, Failure to do so simply undermines the need to ensure equal partnerships and compromises the value of each individual member of the primary care team.

5.7 Organisational Structures and Processes

'I think there is a big gap between the rhetoric and aspirations of the NHS plan and understanding out there about what that means for their roles and willingness to embrace modernisation, and you see that particularly in general practice, the morale is generally low because willingness and enthusiasm for further structural change is very limited and that is a major obstacle plus issues like Clinical Governance funding is there but its not enough to free up time'. (Interviewee S6).

In describing the gap between the rhetoric and aspirations of the NHS Plan, it was highlighted by the preceding respondent, that structural inadequacies over practice alignment, together with the complexity of multi-faceted teams, present a barrier to innovation and responsive service delivery. It is the view of this respondent the top down rhetoric and the actual delivery at the front line do not match. The incessant structural changes in the NHS since 1979, together with cornerstone government

programmes such as 'Clinical Governance' has undermined morale. Lack of resources both in terms of finance and personnel time appears to have set up barriers to change.

A positive stance was held by this respondent in relation to the structural changes that had occurred over the instigation of new organisational models (PCGs and PCTs) for the delivery of local service delivery:

> *'I think that particularly with the development of PCG and PCT Trusts that there is a local focus and a local emphasis and therefore we will be meeting local demands and the health needs within that vicinity'.* (Interviewee S5).

One of the six key principles appertaining to the White Paper 'The New NHS-Modern, Dependable' (DoH, 1997b) was 'local responsibility' and one of the key organisational principles of the creation of PCGs and PCTs was devolution of power and responsibility to local level:

> *'I am captured by a programme running at the moment, pan London, sponsored by the Director of Primary Care, four programmes, Lambeth, Kentish Town, Dagenham and Bexley, I think, four sites, started in March, inter-professional learning to take forward different service programmes. By September, two of them have collapsed, why have they collapsed? All the staff have changed. Not only have the staff changed, the Director who was sponsoring this programme has now been moved. Occupational uncertainty and organisational role change when it is so fast, is the biggest obstacle to make. People don't know who they are'.* (Interviewee S12).

Occupational uncertainty due to Trust merger and de-mergers is seen as a key obstacle in inhibiting teamwork development by numerous comments made by respondents in this study.

The importance of managing organisational change was acknowledged by the following respondent in relation to professional group representation at the board level in order to be able to influence decision- making:

'There is a need to consider the organisational structure as well. That means bringing in other professions at board level into decision making. I'm sorry if I'm banging on a bit that's because I do see it as a doctors problem'. (Interviewee S9).

It is interesting to note that Doctors were perceived as a barrier to the decision making process at the board level. The introduction of other professions to appropriately influence both the operational and strategic decision making process was seen to be important:

'If you are talking about the way the NHS is going, you talk about Clinical networks, you talk about cancer networks, and I think that if you took a network approach to developing staff in Primary Care then you would have a bit more flexibility and supportive nature to it. Individual practices only do it if they can see benefit of it to themselves and that is true of anyone in the network. They want to know what's in it for them, so I think that if you describe it as a network then you could devise systems where there is mutual benefit in participating'. (Interviewee S1).

The establishment of the correct infrastructure to facilitate specific networks and services is seen by these respondents to be key to delivering the flexibility and support required in primary care. In order to achieve this goal it will need both strategic and operational managerial support and a long term planning approach:

'We could take the step of moving away from GP alignment within district nursing and health visiting. By that I mean that you could actually have a group of staff, lets say health visitors who focus on a geographical area rather than aligned to a general practice. You would then take away this ludicrous situation whereby you can have Health Visitor Joan Smith going to see family Y at 30 Rose Avenue and Pauline Jones going to see family Z at 31 Rose Avenue. You could actually say look Joan, you have this road which would then enable Joan to get a view of how the families themselves were networking

and what kind of opportunities there maybe for health promotion or development'. (Interviewee S6).

'If you actually have more patch working, by that I mean within a PCT perhaps five or six practices developing common services, and releasing time, and releasing skills, is a small practice 'the corner shop' as good as 'Tesco'? well the answer is the corner shop does give personal service and Tesco doesn't. It's different. So if you could keep corner shop personal care and Tesco services, you may be able to do it by patch working to enable and continue the important elements of primary care'. (Interviewee S3).

The existing GP alignment organisational model is critiqued and respondents' views appertaining to more effective utilisation of primary care staff manpower is stated. There has been an historical anomaly, whereby, flexible models of service delivery has not been possible. This has inevitably led to inappropriate access for patients and reduced possibilities for cross boundary working:

'The thing I would say that hinders it particularly is staff pressures, increased workload, changes in roles and responsibilities and organisational structures and it's caused fragmentation. Perhaps there is not as much effort put into teamwork because everyone is kind of looking after their own little patch ...the NHS under invests in professional development and continued learning and the only way to make it affordable is to accredit more learning together, at home as it were, in the home teams'. (Interviewee S7).

The magnitude of the changes experienced by NHS primary care professionals is severe and it is therefore not surprising that organisational structures are in a state of permanent flux in order to try and find the correct balance to deliver the political agenda that is in vogue at the current moment in time. Increased models of 'patch working' is one such structural change that seeks to allocate teams to geographical areas in pursuit of better links to the patient in the delivery of the specialist skills required. The structural changes and subsequent fragmentation of services together with increased expectation on performance has led to staff disillusionment. The

agenda of change is delivered by a millennium workforce that is already under staffed, and will require the responsiveness and flexibility that mirrors today's lifestyles. In addition the changes will need to be made in an environment in which the lifelong professions and practices upon which the NHS was founded, are being re-engineered. This agenda adds greatly to the pressure already felt by staff working within primary care.

5.8 Professional Boundary Changes and New Roles

> *'There is a lot of this relatively ill informed thought about skill substitution because actually you can only work in teams if you've got different roles. You have full backs, centre halves, you are all footballers. But only few of them score the goals and they are quite specialised at doing that'.* (Interviewee S6).

These comments are helpful in considering the fundamental issues over what the overall impact of skill substitution, would be both in terms of the cost-effectiveness and quality of service delivery in primary care. This has been highlighted as an area requiring further research in Chapter Six.

> *'If you think about workforce planning to be about putting the right people with the right skills in the right place at the right time and how you go about doing that, it still is focused around qualifications and lifelong learning. They have stereotypes attached to them. They are not aimed at new roles and they are not aimed at different ways of working so you have very traditional workforce planning coming along when for example the NHS is moving into care pathways and different models and contributions to that and one is very ridged workforce planning based upon 'how many people with x qualifications and various brass knobs on have they got' and how many people do you need to get the brass knob, and the other is much more fluid and creative and flexible. There are two different systems that don't necessarily help each other'.* (Interviewee S6).

The failure of the historic NHS workforce planning system can be seen in this context aptly expressed by the preceding interviewee. There is the danger that too rigid a focus on the old planning mechanism will hamper the flexible and innovative approach that is required to ensure posts are filled by the people with the right skills, delivering primary care services to the local community:

> *'Predictably, the consortia were really a transitional phase. The confederations do offer some advantage as long as they encompass medicine. They do offer a true framework for effective workforce planning and development and there are some good signs. I mean we ourselves are experiencing some of the positives in terms of people inviting us to take forward partnership working programmes between professions and skill substitution. It's terribly early days, it's always a challenge to know whether this can happen top down'.* (Interviewee S11).

The Workforce Consortia have now been replaced by Confederations. This was supported by government policy and in particular set out within the document entitled 'A Health Service of all the Talents: Developing the NHS Workforce' (DOH-2000c). The key messages that were central to this evolution were:

- Greater integration of workforce planning and development with service and financial planning;

- More flexible development of staff to maximize the use of their skills and abilities.

According to Payne (2000 p.132) identity and boundary are concerned with how people see their position in the network and where they see its boundary as being. These following respondents' views are that there is a requirement to *'burn our boundaries' and 'to train people to move across boundaries and pick up different tasks and responsibilities'* are recurring themes in this study. There is a need to consider the connection between one role and another and identify how these

boundaries can be blurred or broken down altogether, so that integrated and true inter-professional working becomes a reality:

> *'We do need to burn our boundaries, We need to be more flexible. We need to be more integrated. At the end of the day our patients don't care who they see or what organisation they work for as long as they get what they need in it's simplest and broadest terms. I think we need to be much more responsive to what the needs of our patients are and put ourselves in their position and look at the pathways of how those pathways go and look at the bureaucracy and look at how our own attitudes hinder that individuals progress. I think we need to be very broad- minded, very open to suggestions from everybody. We are going to need a lot of support and a lot of encouragement. There will be some people that will get left behind'.* (Interviewee S2).

> *'We need to be able to train people to move across boundaries to train more generically, people to pick up a range of different tasks and responsibilities and we need to free resources for things like the implementation of Clinical Governance and all the new revalidation and regulatory processes'.*
> (Interviewee S4).

The possibility of achieving the transition from the traditional tribal boundaries in primary care towards another division of labour will require considerable support in terms of organisational management backing, together with the design and implementation of innovative educational training resources. The following interviewee comments reflects this:

> *'The most important thing is developing a career structure and that means giving people opportunities to do different jobs within Primary Care'.*
> (Interviewee S7).

A key inference in the Department of Health's 'Making a Difference' (DoH, 1999), 'Meeting the Challenge ' (DoH, 2000d) and 'Knowledge and Skills Framework Review' (DoH, 2003) documents is the introduction of a modern career framework for NHS staff together with a modernised pay scale based upon skills and

competences. The aspiration is that new ways of working and role developments will accrue:

> *'The Professional Bodies will resist any changes that move away from the status quo'.* (Interviewee S11).

Changing practices and models of delivery of services will necessitate, first and foremost, involvement and consensus of front line staff, management and service users. As the preceding respondent indicates there is a particular concern over the commitment of Professional Bodies and Royal Colleges in delivering support and cooperation in this process. Protection of the specific body of knowledge would undermine the possibility of greater role flexibility and the likelihood of introducing new workers with the skills required for that new role. The view that these bodies/colleges will adopt a 'protectionist' and professionally defensive attitude, has been highlighted by the following interviewee:

> *'Well, I think it's hard to see how separate professional national institutions, The Royal Colleges, Health Visiting and Community Practitioners associations will deliver an integrated approach to professional development of primary care. It just will not happen'.* (Interviewee S12).

The NHS Executive's document 'Working Together' (DoH, 1998a) states that it aims to ensure a quality workforce in the right numbers, with the right skills and diversity. Respondents' views appertaining to flexible working, staffing increases and new role developments are reasonable and appear to be supported by political doctrine:

> *'Looking at deploying staff differently in that respect and looking at the interfaces and the relationships with other professionals within primary care, what is the work that needs to be done and what skills have we got and who is the best person to deliver it. I think that they are the kind of discussions that we have to have on debate and not be fearful of letting go and not be fearful of taking something on and having more of a flexible approach to working together'.* (Interviewee S5).

It is clear that whilst Government directives espouse the delivery of the right numbers of staff with the correct skills there is the annual efficiency rounds that reduces expenditure and therefore cuts the staffing numbers in the field. Additional pressures relate to the national work force shortages and poor staff retention rates. There was evidence, from numerous respondents in this study, to support the concept of introducing new roles in primary care:

> *'First and foremost you'd have to say just get the numbers up you know there is nothing remarkable about that but we are short of Doctors, nurses and we are short of others and allied professions, we are short of care workers and staff from social care and the government is committed to training more but clearly that on it's own is not enough. New roles are needed'.* (Interviewee S1).

The concept of needing to 'grow new animals' is a vital concept that has never been integrated into the planning stage at any time within the operation of the NHS. The existing gaps between planning, education and NHS Primary Care Trusts needs to be addressed or the rhetoric will never become reality:

> *'Once a year we sit down and we say how many of those do we need and how many of these do we need and do we want more of those. You have real problems because you deal with the demand side of the workforce plan but it doesn't give a notion about supply. I think what we don't do actually is the structuring and introduction of new practitioners particularly in a primary care setting. We may need another 10 more CPNs, but we don't think what is the need of the population. Does that need to be delivered by the CPN, how do we change development. We don't grow new animals to that, it tends to keep the status quo and we don't look for new animals'.* (Interviewee S4).

5.9 Quality and Accountability

> *'I think this is the nature of things that there is always a sort of gap between the aspiration centred on the ground and what happens in practice. Certainly, Clinical Governance, which is about tying up different aspects of the quality agenda whether it's evidence based practice, audit or CPD and so forth'.*
> (Interviewee S8).

The Clinical Governance framework has been introduced into the NHS to incrementally improve the quality of patient care. The individual 'autonomy' of clinicians is reduced and systems established to increase accountability for the quality of service delivery to patients. As suggested by both the preceding and following respondents, these tensions are multifaceted and evolving:

> *'The biggest move is in a sense, the least welcome to a health professional which is about the accountability. But if you manage accountability through a proper appraisal process whereby appraisal is seen to be formative and developmental, then I think the ambitions of the plan are there'.*
> (Interviewee S6)

The notion that individual health care practitioners are accountable carries the implication that individual practitioners will feel personally at risk and therefore the motivation is that the 'correct treatment' will be provided to their patients. This reinforces the requirement to deliver 'Evidence Based Practice' via 'Competency Based Frameworks and National Service Frameworks (NSFs) and is supported by recent NHS policies, the introduction of the 'National Institute of Clinical Excellence' (NICE) and the 'Commission for Health Improvement (CHI). The progressive shift towards staff appraisal and development review is further evidence that 'lifelong learning' as opposed to the historical 'trained for life' philosophy is central to the New NHS strategic direction. A positive stance, was taken by the following interviewee, over the NSFs and competency based frameworks, albeit with some reservations over the timescale of effectiveness:

'I think the NSF (National Service Framework) has been particularly influential and I think if you look at the mental health services in nursing there is actually a document entitled 'Competent Practitioner' which is saying in order to deliver the NSF this is what the staff need to have in terms of competencies. I think that that is very useful although probably in terms of it actually making a difference right this minute is probably minimal'.
(Interviewee S2).

Professional and personal accountability together with ethical decision-making is linked to professionalism. A point in case is the 'Hippocratic Oath' which, whilst no longer formally taken by the medical profession, still derives and delivers a sense of moral code of practice. National Service Frameworks and Clinical Governance mechanisms can be viewed as being contemporary 'Hippocratic Oaths' since acceptance of these modern day norms and set values indeed frames professional decision making, competency and accountability:

'It is naive in the length of time that it actually takes to implement some of this stuff outlined in the NHS Plan. Take an example of one third of General practitioners will be salaried by 2004. The BMA and almost certainly local medical committees may not support salaried GPs. As a consequence it is extremely difficult to deliver that target. So by that I mean that there are a number of targets in the plan that if they were resourced appropriately, and were given a long enough timescale over which to be implemented properly, could support the development of primary care services. I think that the reality of the situation is that we are expected to do too much within existing resources and there are too many targets to achieve in too short a timescale'.
(Interviewee S12).

Inappropriate targets and timescales were seen, by the preceding respondent, as unhelpful in the development of primary care services. The need to ground strategic planning within the context of achievable and sensible operational targets is highlighted.

Multiple targets and therefore multiple accountabilities for individual practitioners makes a strong case for greater 'professional autonomy', which can logically be seen to undermine the need for 'too many targets' since greater flexibility between the professional and patient is what is required. This clearly needs to be delivered within a framework of robust professional standards centred around the patient but not centred around political doctrine, targets and organisational priorities. The Clinical Governance agenda could be seen in the long term to be too overly prescriptive and has the potential to be a 'straight jacket' for flexible and innovative practice development. Innovators require a high degree of individual autonomy, which could be put at risk by over targeting and doctrinal restrictions.

5.10 Shared Learning

> *'There is plenty of research that suggests that poorly designed inappropriately timed shared learning opportunities can consolidate prejudice and bias. Equally shared learning opportunities which are adhered to an integrated service appropriately timed in the educational curriculum for pre and post registration points in peoples development can be effective'.* (Interviewee S7).

Shared learning opportunities have key benefits not least by affording the opportunity to understand other professionals' roles and areas of expertise thereby fostering a sense of 'mutuality' but also facilitating improved opportunities for inter professional and organizational communication. The idea that nurses, allied health professionals, social workers and medical staff could share a common curriculum prior to specialization is a very attractive idea for the development of Health & Social Care Services of the future. These opportunities could be fostered at both undergraduate and postgraduate level. Respondents felt that appropriately timed shared learning opportunities, that are focused upon clear tangible objectives, are effective. In essence integrated learning that has relevance. Simply leaving 'Shared Learning' developments to Universities will fail. A partnership process engaging the NHS Primary Care Trust, Professional Bodies and Work Force Confederations will be an absolute requirement to ensure attainment of the multiprofessional agenda:

'What is quite obvious is that shared learning can never be the end in itself. Just to pursue the process outcome never works so it's got to be shared learning geared into a task or a tangible objective'. (Interviewee S6).

'The concern I and many of my colleagues have is over whether support for interprofessional learning will be sanctioned by our professional body and indeed the medical Royal Colleges'. (Interviewee S4).

The government's document 'Working Together-Learning Together' (DoH, 2001) fully supports the notion of shared and lifelong learning, however, difficulties arise in relation to the educational criteria and philosophies of the Professional Bodies and Royal Colleges, which currently are not commensurate with learning in a shared and collaborative fashion. Professionals are presently and retrospectively trained to work independently and autonomously. The argument that proposes that Workforce Confederations will collaborate to deliver appropriate shared learning 'programmes' would not function solely on a 'national' footing. The need to ensure that 'locally' implemented programmes are established would work since there are many local variations and nuances in recruitment, retention and skills shortfalls that cannot simply be used as a template for a national proposal. The delivery and timing of these shared learning programmes will also need to be influenced by local needs and service delivery pressures. The government has outlined in 'Working Together-Learning Together' (DoH, 2001) that it currently invests £2.5 billion in NHS education and training per annum. The strategy framework outlined in the document is particularly interested in ensuring that the funding is used effectively. There is a 'mis-match' with the front line perception of the existing investment into shared learning, the actual funding spent and indeed whether that funding is being effectively utilized or sufficient to deliver its purpose.

'We're trying within the PCT to develop a multidisciplinary approach to learning and education. At the moment that's had some success and I think that there is more that we certainly need to do, for instance each practice has a Clinical Governance lead who may not be the doctors traditionally, but other members of the teams are picking that work up'. (Interviewee S5).

A 'partnership' model of delivering shared learning must engender the evolution of team orientated skills based training and have a direct support to the strengthening of multiprofessional team working. The Clinical Governance lead in the Primary Care Trust needs to be aware and receive training and support in how best to implement multidisciplinary training in order to avoid the pitfalls that could potentially jeopardize its introduction. The UK Centre for the Advancement of Inter Professional Education (CAIPE) undertook a survey of their members in 1992 and as a result two key principles were formulated to assist in highlighting specific benchmarks in implementing inter-professional educational learning opportunities:

1. The best way to learn about working together is by doing it. Didactic teaching has a very limited place. Most emphasis should be on group discussion of cases or situations and on group involvement in a shared project with a shared purpose related to patient care;

2. Teachers themselves need interdisciplinary training so that they can act as role models. But they, too, need the understanding and support of administrators and managers so that they can devote the necessary time and get funding. CAIPE (cited in Soothill et al. 1995, p.159).

A lack of Personal Development Planning through a structured appraisal process will inevitably lead to poor staff retention. Self-development needs to be encouraged. Individuals need to be supported in gaining experiences, skills and competences to be more autonomous in developing their own career progression. The following interviewee's views are helpful in reflecting the balance that needs to be struck between individual and team support and development:

> *'Our emphasis has to be not only in developing the individual skills but also supporting the team base skills'. (Interviewee S10).*

There has to be a balance between the needs of the individual, other team members and the organization:

'I don't believe that we necessarily think that we are terribly good at is giving people support in finding a career path. I think that we allow people to sort of make roads for themselves, and we are not very good at succession planning people through the system. We lose people as they go off onto tangents'. (Interviewee S8).

The most effective way to achieve this outcome will be via the appraisal route with specific training and developments plans being agreed with individual members of the team. By identifying good and poor performers, the appraisal system assessment will facilitate the organization to support the individuals in the process of succession planning. Resources can be targeted on those individuals and team members who will respond most positively to the development process. A fair and equal balance needs to be achieved at all times:

'There is no quick fix to that and there has to be a long- term commitment to multiprofessional education and Clinical Supervision within the team. You have got to find the time again to value it'. (Interviewee S7).

As evidenced by the preceding respondent's comments, changing the culture to support staff development and training is critical. Clinical Supervision according to Platt-Koch (1986) describes it as an expansion of the practitioner's knowledge base, assisting in the development of the professional autonomy and the growth of autonomy and self esteem of the individual practitioner:

'We still have difficulties in staff development because we have limited resources and finding the time to actually access it. That is still a problem that gets in the way of how effective it can be'. (Interviewee S10).

There has been a historical allocation funding process across medical, nursing and other health professionals (NMET, SIFT, MADEL). These anomalies, as expressed by the preceding interviewee's comments, have led to inequalities across the range of staff groups being able to access funding for training and development and have perpetuated historical distinctions in professional education and development. The

Department of Health's document entitled 'Funding Learning and Development for the Healthcare Workforce' (DoH, 2002) has considered how best the NHS should now use its £3 billion annual funding for learning and personal development in order to support the development of staff, and to deliver the necessary skills to support patient centred services and public health strategies. The proposal has stated that the funding should be reorganized on an interdisciplinary basis, ending the present rigid demarcations in the support given to the various professional disciplines.

A single integrated budget designed to support learning across all the professions with the abolishment of the three historical 'pots' of funding that have been seen to be lacking equitable allocation. This closer integration of funding for CPD is hoped to give credibility and support to the development of all staffing groups in the NHS.

The Workforce Development Confederations will play a 'gatekeeper' role in the allocation of funding and monitoring and evaluation of expenditure. The financial benefits accrued by working in partnership include:

- Reduction in transaction costs;
- Economies of scale;
- Pooling of specific budgets which were previously ringfenced as uniprofessional monies;
- Reduction in commissioning and bureaucratic costs.

All these benefits will bolster the possibility to target effective shared learning opportunities at both the under graduate and post graduate NHS primary care workforce and thereby increasing the overall capacity to deliver patient centred services. Existing problems in providing equitable learning resources were highlighted by the following interviewee:

> *'When I look at the PCT, in it's wider context, I do see that there are tremendous opportunities for some staff, nursing is always the example quoted and the medical profession it's fairly similar. Then when I look at the other professions, physiotherapy, and occupational therapy and the other health professions then when you get to non- clinical staff, appalling education and training. We have seen an example recently... where staff were being urged to*

do some audit and research and none of them had computing skills or access to computers to do simple tasks. I think that even if there is an infrastructure then the resources aren't there in an equitable fashion'. (Interviewee S5).

The delivery of a supportive learning culture in the Universities is a vital component in the partnership required to ensure that the post-graduate courses reflect the CPD needs of NHS primary care staff. The following respondent's comments are helpful in considering this concept:

'I think that there are problems, which you have in all professions and that's about making sure that universities deliver courses that reflect our needs'. (Interviewee S4).

Therefore this supportive learning culture has to be influenced by the culture of the work place. It is true to say that it is the individual that engages in the learning process, however, this process can either be encouraged or impeded by either or both the work place or university cultural stance towards lifelong learning:

'In a way that is about lifelong learning, continuing professional development and other opportunities I suppose'. (Interviewee S2).

An effective two- way dialogue between the Primary Care Trust and University to ensure that staff training and delivery accurately reflects the requirements of individuals' development needs will be critical in this process:

'Whilst most people, can't necessarily get to an expensive conference every year, my feeling is that in-house, there is a lot of development education going on and not a lot of it is linked to peoples' appraisals'. (Interviewee S10).

The need to ensure that all staff have regular personal development appraisal is reflected in this respondent's comments. There are numerous benefits to both the individual and the organization for this process to become firmly established in the culture of the work place:

'The existing training I think is very good to a limited degree in the uni-professional lines and there is not nearly enough multi-disciplinary staff training, we are just scratching the surface as far as that goes'.
(Interviewee S7).

Uniprofessional training can be seen to reinforce the stereotyping of other professions and the ways in which those professions work. The consequence could be that this reinforcement continues to promulgate these perceptions of one profession over another in terms of status and power. Any potential constraints to multiprofessional education will be due in part to the possible fear and anxiety that could come through loss of professional identity and engenders a tribal blinkered perspective:

'In developing individuals, you need a much wider grouping to do that picking up of individuals from different parts of Kent, even wider just to get a cross section of ideas. So *that learning tends to be very much along uniprofessional lines which is a hindrance'.* (Interviewee S10).

Hindrances to 'collaborative learning', derives often from a fundamental need for individuals to protect their professional identities. To assist in breaking down these behaviours it will be necessary to examine the organisational role and existing culture of how these role insecurities and anxieties are supported. Open communication at both the undergraduate and post- graduate stages to support the process of collaboration, will again be of critical importance in effectively managing the process:

'Technically the non health professional staff which I call the practice managers, training is hit and miss'. (Interviewee S1).

Practice Manager training, support and development was seen by the preceding respondent to be poor and lacked co-ordination. As a key member of the primary care team there is a clear requirement for multi-professional training to be encapsulated within their development plans. Although these individuals are often multi talented their main focus has historically been, as employees of the GPs, on the practice business. As a result, one of their key responsibilities has been to implement the

policies of their GPs. With the new structural changes, with the introduction of Primary Care Trusts, their role has moved towards ensuring that the needs of the local community are met. This change of emphasis in their role and responsibility has added impetus for the need to ensure that they possess a full understanding of the scope and competences of all members of the primary care team, not just GPs and community and practice nurses. Their professional role has widened over the last few years and needs to be underpinned by effective training and shared learning opportunities in the same way as any clinical team member:

> *'It seems to me illogical that if you are training to be a family doctor and want to work as a family doctor in the broadest sense that you should spend 2 years on hospital specialism on the way there. However, I understand the service need. I don't think that the nurses have got their act together at all. The RCN have difficulty in recognising the term 'Nurse Practitioner' and what it needs for ongoing support. I don't believe the professional organisations are doing very well supporting their members in developing their skills. New and innovative roles in primary care are urgently needed'.* (Interviewee S8).

The role of the Royal Colleges and Professional Bodies comes under criticism, by the comments made by the preceding interviewee, for not setting appropriate professional training syllabuses and for not providing appropriate leadership for their professional members. The ongoing support for new roles, such as Nurse Practitioner, was also seen to be hampered by a lack of understanding and development support by a Professional Body:

> *'The planners, the manpower planners, sorry human resource planners get it wrong. They are almost bound to get it wrong and it never seems that we go far enough back to influence a curriculum'.* (Interviewee S9).

The comments made by the above interviewee, perceived curriculum planning as appearing to be 'one step' behind and not able to keep pace with practice development needs. The existing workforce planning processes are perceived to be divorced from reality by this respondent. The planning process is not flexible enough to take account

of changing environmental factors and curriculum and syllabus changes required. The duplication, replication and 'robbing Peter to pay Paul' philosophy has actually played an integral part in compounding the existing primary care labour market crisis that is currently being experienced:

> *'We have very limited community development and public health training and we have almost non-existent preparation for what is now the largest financial responsibility, which are the commissioning runs. Even listing those makes you realise the challenge there is in terms of working together and personal development because of the scale of those responsibilities. In terms of managing organisations and the relationships that go with that, not much training is provided'.* (Interviewee S6).

A lack of training and development together with public health training, according to the preceding respondent, has left shortfalls in skills and competences for undertaking specific responsibilities. This presents both an organization and personal risk for those members of the team expected to fulfil these obligations. The current modernization of the NHS will result in different skill mix models of care to be required and delivered. Good risk management, according to Mohanna and Chambers (2001, p. 65) will require:

- Anticipation of changes in skill-mix and arranging education and training or recruitment of new staff prior to any changes coming into force;

- Development of practice protocols that specify the maximum responsibility allowed for particular grades of staff; lines of accountability and how that will be managed and monitored.

The following interviewee's view is that focussed educational need to ensure that the correct skill mix is trained and established to deliver the primary care services required:

'Certainly with the work I have done at universities in the post registration review I think that actually education is becoming more focused. It is always the balance between what you need as an individual for your development as opposed to what we actually need for the service. I think the NHS Modernisation and Clinical Governance framework has actually said to people come on we cannot keep spending money willy nilly. What we need to do is have education activities that are focused around, making sure that people have the right skills to deliver these documents'. (Interviewee S11).

The implementation of new regulations around Personal Medical Services (PMS) has enabled a new wave of GP opportunities to practice. This is in stark contrast to the historical 'Independent Contractor Status' of General Practice. A 'pick and mix' arrangement can also now be offered that delivers grater flexibility within this professional group. This is exemplified in the following respondent's comments:

'A few years ago in General Practice there was only one thing, you became a GP principle or you didn't and there was very little else. But now there are a whole range of options from salaried partners to PMS pilots, principle posts, community trust posts, so there is much more of a opportunity for a portfolio career. The other primary care professions have a limited or non-existent attitude, over supporting their members in developing their careers'. (Interviewee S8).

The Department of Health's 'Working Together-Learning Together' document (DoH, 2001) fully supports the notion of focused educational activities within health care and places learning and development at the centre of delivering the NHS plan:

'You have nurses, practice nurses, district nurses, health visitors, so there are bits of a nursing family that don't necessarily have the same view or understanding of what they need to be trained with. We haven't those competencies and I think that is a big issue in terms of training because you don't know what people need to deal with at different levels and how you demonstrate that. I think that with Doctors in Primary Care they still train on

their own and that they go and do their vocational training and it is not tied to anybody else's training at all'. (Interviewee S7).

Ultimately, the need to understand and respect other professional roles will be supported by shared and collaborative learning opportunities. Isolationism in the culture of the delivery of training on a uniprofessional basis will maintain the existing 'status quo' within the context of the team and multiprofessional practice will not thrive or develop.

5.11 Tribalism

'...all those issues, those tribal issues' (Interviewee S9).

The need to work across organizational boundaries places particular emphasis on the issues around 'tribalism'or 'professional territorialism' which acts as a key barrier to effective team working. It is evident from the interview responses that professional 'isolationism' is prevalent within the primary care team setting. Professional identity does have particular benefits for the individual. As suggested by Evetts (1999) the professional identity accrued can become an integral part of an individual's identity, which is developed and protected by the profession.

Unfortunately, professional demarcation disputes and conflict can and does undermine effective team working within primary care health services. The concept of 'Professional Adulthood', as described by Laidler (1991), reaffirms the requirement that different professionals need to feel sufficiently confident in their roles and professional identities in order to learn 'to work with your enemy'. This position is appropriately reflected in the following two interviewee comments:

'I tend to think that it is possible to even start to think about teamworking in terms of working with your enemy, and longstanding demarcation disputes, often arising out of insecurities of one sort or another can obviously get in the way'. (Interviewee S5).

'If you have somebody who knows that teamworking is good, and they know how to lead a team or to put a team together then it will happen. However if you have just a group of people trying to work together then I think, you just have people working in isolation and they only talk to each other over a cup of coffee. You see this in community clinics all the time'. (Interviewee S2).

Professional territorialism or tribalism is integral to the way in which primary care services have developed. Without clear guidance and support for individuals and teams the additional requirement to work across both professional and organisational boundaries will exacerbate potential problems of tribalism. Professional territorial concerns relate to feelings of a diminishment of role security. The development of collaborating practice between health and social care professionals may have the ironic 'knock on effect' that individual professions will attempt to build in what I would term a 'uniprofessional remarkability' to ensure the maintenance of their autonomous status and 'professional ring-fencing'. Examples of this can be already be found developing in areas such as Podiatric Surgery. The end result of these potential strategic developments will be towards an increase in ' intra-professional speciality demarcations'. Breaking down 'inter-professional barriers' may well lead to the hasty erection of ' intra-professional barricades'.

5.12 Summary and Overview of Themes

The interview data has provided valuable evidence in seeking to achieve primary care stakeholders' perceptions of the:

- existing culture and change processes required for the delivery of effective multiprofessional education and teamwork;
- the vision for the future workforce and staff development which delivers effective teamwork for patient care.

The analysis and interpretation of these eleven themes enables firm conclusions and recommendations to be made, which are considered in detail in Chapter Six.

5.12.1 Relative Importance of the Themes Identified

During the analysis stage of the study coding was utilised **(see Section: 3.14)**. In total 88 sub-theme codes were allocated and eventually enabled the development of the eleven overarching themes that has been discussed in this chapter **(see Appendices: Eight and Nine)**. Quotes specific to each of the eleven semi-structured interview questions were collected and analysed **(Appendix Ten).**

The following overview **(see Table 4)** of the recurring thematic 'threads' is provided in the hope that it will be helpful in setting out the relative importance of each theme identified.
Also, additional critical reflection has been added **(see Section: 3.17)** in order seek to ascertain which themes may have been 'designed in' by the questions posed and which themes have directly 'emerged' as a result of the study.

The eleven themes have been ranked in line with the greatest number of 'sub-theme codes' allocated to them. In doing so, it simply highlights the frequency of thematic data that was produced across all three data sets provided by the respondents that took part in the study.

Table 4. Frequency of Thematic Data

Ranking	Theme	Number of sub codes (Appendix Eight)
1	• Cultural Dissonance	19
2	• Modernisation and Policies • Professional Boundary Changes and New Roles • Shared Learning	10
3	• Organisational Structures and Processes	9
4	• Flexible Team Working Practices	8

5	• Collaboration and Mutual Understanding of Role	5
6	• Quality and Accountability	4
7	• Communication and Shared Language • Tribalism	3
8	• Leadership and Innovation	2

CHAPTER SIX-CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

The purpose of this chapter is twofold. Firstly, to draw together all the key aspects of the research and deliver overall conclusions that are fully supported by the evidence presented in the study. Secondly, to set out recommendations together with future research recommendations in the field of study.

6.1.1 Conclusions

The objectives of this research were as follows:

- To establish 'key stakeholders' perceptions of the existing culture and change processes required for the delivery of effective multiprofessional education and teamwork in NHS primary care services. (Linked to research questions one and two).

- To gain 'key stakeholders' vision for the future workforce and staff development to ensure effective teamworking for the delivery of patient care. (Linked to research question three).

These objectives have been met by setting out to investigate three key Research Questions. Each Research Question will be considered and evidence from the study used to deliver specific conclusions.

As stated in the context of **Section: 1.7** of Chapter One, NHS structural changes were particularly active in primary care services at and around the time at which this research study was undertaken, this will have an influence any generalisations that may be made in relation to the conclusions drawn **(see Section: 3.17)**.

6.1.1 How important is multiprofessional teamwork in Primary Care Trusts for the effective delivery of services?

The current model of uniprofessional service provision is operated by the key principle that professionals from the same discipline form into departments and each department is essentially professionally led thereby this can be seen to undermine the need for effective multiprofessional team- work. Evidence gleaned from this study clearly supports the concept of teamwork developments in primary care **(see Sections: 4.2.1-4.5.4 and 5.1-5.11)**. Individuals in the team will need to have duplicity in terms of identity with both their professional discipline and the team. The need to ensure that the team goals and objectives are clearly understood and effectively communicated is a major factor in ensuring that any perceived loss of professional status or identity is enhanced by the understanding that individuals have a key role in delivering the overall team objectives and goals.
The following five key features of teamworking have been emphasised and drawn from the results spanning chapters five and six, namely:

- Shared knowledge and understanding of each others professional roles and responsibilities;
- Mutual responsibility and team objectives and goals that are collectively shared and understood by all members of the primary care team;
- Establish common ground between primary care team members and avoid duplication;
- Complimentary skills and competences that supports high quality delivery of patient care;
- Communication opportunities between multi-professional staff.

The primary care team is a complex structure of individual professions, commitments and aspirations both inside and outside the team framework. Work undertaken by MacIntosh and McCormack (2001, p.3) suggested that the management of the team and tackling difficult situations that encompasses the requirements of the individual, primary care team plus the professional group to which they belong is *'time consuming and non trivial'*. These sentiments have been borne out by the findings of this study.

The potential size of the primary care team, whilst not forming part of the research scope of this study, may present a key dilemma and warrants further research in the field **(see Section 6.3)**. Research undertaken by Poulton (1995, p. 10-11) has suggested that the optimum size is best set as between 8-12 members. This is a reasonable range for the majority of team sizes encountered within primary care settings and facilitates a patient centred approach for service delivery.

Good team working also requires individuals to learn to communicate effectively **(see Sections: 4.2., 5.6., 5.7 and 5.3)** and also to resolve conflicts when they arise. Evidence gained from this study also exemplifies the need for ensuring that a shared purpose with clear goals is necessary to facilitate the unified commitment of the team **(see Sections: 4.2., 5.1., 5.3., 5.10 and 5.11)** and will be helpful in the overall team management process. Primary Care team members possess cultural and professional differences and therefore 'trust' needs to be established between individual team members. The establishment of an understanding of the values, norms and expectations for the professionals making the team is also seen to be of critical importance. Team members, for example General Practitioners, who have held dominant team positions historically, can be seen by the evidence collected **(see Sections: 4.4.2. and 5.3)** in this study to have a clear vested interest in potentially not wishing to change the basis of the team dynamics. A path through these 'vested interest' obstacles needs to be made, since inter professional collaboration and appropriate team power sharing is an essential pre-requisite in the strategy for the modernised NHS supported by recent policy legislation. Power sharing in primary team settings has been evidenced in this study **(see Sections: 5.1., 5.4.,5.5 and 5.6)** as playing a critical part of the new move towards true team collaboration. Group decisions will not always be possible or indeed appropriate in all situations, however, it is a desirable outcome in the planning of services and patient care plans. It will also facilitate trust in agreeing new roles and responsibilities.

Professional role understanding, respect and more efficient communication have also all been highlighted as important **(see Sections: 4.1.8.,4.2.,5.1 and 5.2)** to enable these partnerships and collaborations to be supported. Professional members of the team need not only to fully understand the fundamental principles of their own profession but also to foster a commitment and willingness to work in partnership and

on an equal basis with other professional colleagues. This can be termed as having achieved a sense of 'mutuality'. Mutuality and the need to break down and blur professional barriers is also supported in the evidence of this study **(see Section: 5.1)**. The need and desire to both acknowledge and respect professional differences in order to work with and through any areas of conflict has also been highlighted **(see Section: 5.11)**. There is also broad support to the view that learning together will be helpful in preventing negative attributes and stereotypes of each of the professional groups **(see Sections: 4.1.,4.1.8.,4.2 and 5.10)**.

It is therefore the contention of this study that multiprofessional teamworking in Primary Care Trusts is most important for the effective delivery of services. It is necessary for the different professional groups that operate in primary care to develop a more collaborative, team-based approach to their work with the promotion of professional adulthood for all the professions. The promotion of professional adulthood can be brought about by staff becoming confident of their professional identity and core expertise. The deferment of individual professional autonomy, and discontinuation of the historic tribal attitudes towards perceived status and values inherent within specific professional groups will also be a requirement.

6.1.2 What changes in organisational culture and processes are required to promote multiprofessional education in Primary Care Trusts?

It is clear from the results in **Sections: 4.1.8, 4.2 and 5.3** that the move towards a 'common or shared culture' would be a fundamental requirement for the successful delivery of multi-professional education. Key 'champions' of cultural change **(see Section: 5.5)** will need to both facilitate and provide ongoing support in the process and will be critical to its success (Freeth –2001, p.38) and *' the impact of local enthusiasts should not be underestimated'*.

Overall consensus of respondents in the study **(see Sections: 4.1.8.,4.2., 5.1.,5.2.,5.4.,5.7.,5.8 and 5.10)** leads to the concept that whilst existing professional training biases a uniprofessional focus, there is a clear need to 'blur' and break down the professional barriers in order to achieve 'mutuality' in respect to training

processes involving multi-professional education. The data collected in this study evidences the conclusion that at present the system reflects practice **(see Sections: 5.4., 5.8 and 5.10)** but is failing to make the connections across disciplines or externally to educational institutes. However, the opportunities, in the current political environment, are there to reshape the educational organisations so as to reflect models of integrated primary care practice within the framework of innovation in role developments and interprofessional teamworking **(see Section: 5.6)**.

The introduction of an organisation wide learning culture is of critical importance to support this direction of culture change. The 'lifelong learning' process was also considered to be of particular benefit to support this paradigm shift **(Section: 5.10)**. A central theme that has emerged from the study is around 'cultural dissonance' between professional groups **(see Section 3.17, in relation to the questions formulated in this research study and their potential influence on themes that have emerged)**. A resolution to this obstacle will be via the inclusion of lifelong learning delivery of multi-professional education work plans in the person specifications of existing and new posts within NHS primary care services **(see Section: 5.8)**.

Historically, the culture of uniprofessional training has been developed and supported by a variety of funding arrangements and professional allowances such as the Post Graduate Educational Allowances (PGEA) for medical staff and Nursing requirements such as Post Registration Educational Portfolio (PREP) .It has been said that this approach has served to perpetuate uniprofessional paradigms, professional development and concepts of professionalism (Starey, 2003). The modernisation agenda for the NHS will seek to ensure to reallocate these resources to enable access by all professional groups hence reducing the perceived divisiveness of the historical allocation arrangements within primary care settings **(see Sections: 4.2., 5.3., 5.6 and 5.10)**.

External drivers for multi-professional collaboration have been set through Department of Health policy documentation such as 'Working Together-Learning Together'. There will be a requirement for health and medical professional groups to lay aside their historical barriers to collaboration. The evidence from this study

supports the position that this milestone can be achieved via the multiprofessional training programmes and enhanced opportunities for interprofessional working **(see Sections: 4.2., 5.1., 5.3., 5.4., 5.6 and 5.10)**. Pilot Inter-Professional Learning programmes such as Southampton University's 'New Generation Project' will hopefully support the modernisation at the pre-registration level for medical, nursing and other health professional students.

There is also a need, shown through this study, that training and development in areas other than clinical CPD, needs to be included in the individual development plans of primary care professionals. Areas such as information management & technology, management, communication, budgetry control and finance, personnel management and change management also needs to be factored into plans and delivery processes. **(see Sections: 4.1.8., 4.2 and 5.10)**.

The need to 'stretch' professional boundaries will require a flexible approach by the individual staff, professional bodies, Royal colleges and Primary Care Trusts. In addition the development of 'interprofessional trust' will support changes. Evidence in the study **(see Sections: 4.3.1., 5.4., 5.6 and 5.8)** support the view that flexibility in roles and understanding each others roles is valued to a high degree by the respondents involved in this study as opposed to the maintenance of the 'status quo' . Barriers to change in the context of inter-professional education relates to the 'pace of change'. Rapid change without perceived benefit by staff and staff groups concerned will be viewed with scepticism, and will be detrimental to ongoing collaboration and evolution of effective teamwork. Failures in collaboration and teamwork can also be linked to inappropriate or lack of communication **(see Sections: 4.2., 5.1., 5.2 and 5.3)**. Teamworking involves interactions and failures in delivering appropriate dialogue between team members and other stakeholders may be seen to prevent the Primary Care Trust, with a restrictive culture, from tackling problems related to open communication.

The challenge is for all the professional groups to engage in the cultural changes required to deliver effective multi-professional education. This is to be set alongside the challenges for educational organisations to set the appropriate groundwork for this collaboration by the development of appropriate educational interventions.

As stated by Nolan et al (1998, p 34) there are '*specific obstacles to collaboration*' which is supported by evidence of this study. In particular, individual practitioners lack of knowledge of other professionals and the stereotyping of other health workers **(see Sections: 4.2.,5.3 and 5.10)**. This poor understanding leads to lack of confidence in undertaking more focus upon collaborative educational opportunities. The change in NHS primary care culture required to deliver, for example, the clinical governance agenda effectively is considerable **(see Section: 5.9)**. There is a need to establish the correct culture for shared beliefs, commitment and values to achieving quality. This issue has a bearing on the 'status quo' perceived gatekeepers in primary care, namely, the GPs. If it transpires that there is resistance to the introduction of Clinical Governance then the cultural changes required will be hampered **(see Sections: 5.1., 5.4.,5.5 and 5.9)**.

Diverse professional cultures and indeed issues related to professional ethics seek to explain situations in entirely different ways and based upon their own cultural frame of reference **(see Sections: 5.1 and 5.3)**. This goes a long way to explaining how differences of interpretation between professional cultures can and does lead to varying approaches to patient treatment and allocation of priorities. This is also true of professional terminology and language. Communication between professional groups can be framed around jargon peculiar to that discipline **(see Section: 5.2)**. Agreement as to when this form of language is appropriate and inappropriate between members of the multi-disciplinary team is seen to be a helpful step forward in building rapport in the delivery of inter professional education and in terms of good practice in team work. There are six criteria that have been developed generically, from the evidence gained from both the questionnaires and interview stages in this study, that are required to ensure the effective delivery of multi-professional education in primary care settings:

- Political support for multi-professional education;
- Integration of individual learning in the context of professional training and organisational learning;
- Champions for change by individuals with creative leadership skills and competences;

- Culture shift towards the philosophy of life long learning by delivering quality training and educational initiatives;
- Mutuality of the willingness to understand and respect the skills and competences of other professional groups;
- Environmental workplace support, which provides encouragement for individuals, team and organisational learning.

There also needs to be a fundamental review of the current undergraduate education systems as to how new health professionals are 'socialized' into their roles and what efforts are to be used in preparing graduates in an environment that requires inter professional collaboration and partnership. This will require a process of delivering 'team awareness' **(see Sections: 5.1., 5.8., 5.10 and 5.11)**.

Evidence from this study strongly supports the notion that the understanding of the fundamental aspects of teamworking should be gained within the context of basic undergraduate education **(Section: 5.10)**. This will support the process of preventing entrenched attitudes and behaviours inherent in their own professional disciplines socialization **(see Sections: 4.2.,5.1., 5.2 and 5.8)**.

The overarching culture in primary care has to move away from being professionally dominated and hierarchical, towards a professionally supportive and integrated team service, that is driven by the local needs of the community that it serves with the patient firmly established at the centre not the disease. Until this occurs the traditional 'medical dominance' approach will hold sway **(see Sections: 4.2.,5.1.,5.3 and 5.11)**.

At the time of writing the conclusions for this research, it is clear that inter - professional based education and training have so far failed to deliver an acknowledged interprofessional agenda, within the context of this study. For this to happen, the delivery of joint in service practice based training, acquisition of skills of collaborative working and gaining greater understanding of each discipline's skills, roles and responsibilities will be critical starting points to delivering the cultural and change processes required. In order for multiprofessional education to be effective the training intervention needs to have clear relevance to the professionals receiving

training and to a level that provides the right degree of understanding **(see Sections: 4.1.8.,4.2 and 5.10)**.

There are indeed often specific structural barriers to the planning and delivery of multi-professional learning **(see Section: 5.7)**. These difficulties are certainly not insurmountable but include the following areas:

- Resource and funding arrangements;
- Location of the educational facility;
- Duration of programme;
- Complexity of subject;
- Professional language and 'jargon' avoidance;
- Curriculum and assessment processes;
- Royal Colleges and Professional Body Accreditation procedures.

A positive view was related to the benefits of achieving a greater understanding of the various 'professional languages and jargon' used and thereby enhances communication and team working. Leaviss (2000) has argued that 'interprofessional education' should commence early on and prior to those stereotypical or tribal viewpoints being allowed to shape inter-professional collaboration. This view has been further enhanced by research undertaken by Horsburgh et al (2001) whereby it was shown, in their study of first year medical, nursing and pharmacy students, that there are benefits to be accrued through interprofessional education and learning in the front line delivery of inter-professional patient care (see Sections: 4.2.,5.1., 5.3., 5.4.,5.8., 5.10 and 5.11).However, the stance taken by Leaviss and Horsburgh fails to consider the importance of the stereotyping of professions that occur early in life and the associated 'baggage' that can arise as a consequence (Freeth and Reeves, 2004, p49).

This study has focussed upon the views of professional graduates and has considered postgraduate education integration and convergence. There has been broad support for the development of postgraduate education in the context of the primary healthcare team. This was linked to the need to blur and breakdown professional boundaries and

to introduce extended professional roles **(see Sections: 5.3., 5.6., 5.8 and 5.10)**. Of particular importance was the view that inter-professional education in the workplace is necessary to improve effective team- work since role clarification will be enhanced. Finch (2000) supports this view and suggests the introduction of shared learning opportunities from an early stage in the clinical settings. The majority of respondents in this study have stated that they value the opportunity to meet and train alongside colleagues from other professional groups and disciplines **(see Sections: 4.1.8, 4.2., 5.1.,5.4 and 5.10)**.

Barriers to achieving these aims, whilst not immovable, do present challenges. The overarching NHS and higher education agendas will need to continue to fit strategically. This will require operational anomalies such as logistics of timetabling, course appropriateness and multiprofessional group sizes to be suitably ratified and successfully implemented.

However, the positive benefits of multi-professional education are to be commended it is also true that different professionals groups often will need to undertake uniprofessional specific training that would not be appropriate to provide on a multi-professional basis **(see Sections: 4.2 and 5.10)**. Development and implementation of education integration within primary care would represent a major paradigm shift away from the existing culture of uniprofessional training and will create the absolute need for strengthening collaboration and partnership across all professional disciplines based within primary care **(see Sections: 5.1 and 5.10)**.

If inter-professional education is to become truly integrated it will be important for the educators to fully understand the conflicting agendas of the team members and other stakeholders and the barriers to assist in overcoming professional tribalism **(see Sections: 5.3 and 5.11)**. The Royal Colleges and Professional Bodies need to provide leadership to enable to integration of primary care professions. This does not mean the loss of specialist skills but requires the primary health care professions to work collaboratively and in a flexible way to transcend the barriers rather than taking up positions behind them. New and innovative roles will develop as a result that otherwise would have been resisted due to historic vested interests **(see Sections: 4.3.1.,5.1.,5.3.,5.4.,5.6.,5.8).**

It is therefore the contention of this thesis that the development of a more collaborative team-based approach to service delivery in primary care will require an extensive change in culture.

6.1.3 What changes in workforce and staff development are required to promote multiprofessional teamwork in Primary Care Trusts?

Evidence from this study also supports the view that a closer collaboration needs to be developed and the Workforce Development Confederations are to be key partners in higher and further education **(see Sections: 5.6 and 5.8)**. In terms of primary care workforce planning, historically, this has been carried out on a purely uni-professional basis and limited planning was undertaken. The historical anomalies in NHS workforce planning for primary care has presented many difficulties in ensuring that the demand and supply of appropriately qualified and experienced staff are in place to deliver the service requirements of patients. The growing crisis of recruitment and retention in all the primary care health professions is apparent. According to Leese & Young (1999) this crisis is most acute amongst general practitioners. Recent government policy guidance, set out in the latest White Paper and the NHS Plan, has stated that the key activity in local primary care workforce planning will be the interaction between Primary Care Trusts (PCTs) and the Workforce Development Confederations (WDCs). This paradigm shift towards a new focus of workforce development planning will hopefully ensure that PCTs are the prime- planning base and will play an essential link in setting the work force planning agenda.

The solutions, according to this study, are to be found in workforce and staff development that considers new role developments and new career professions spanning and overlapping all the existing primary care professional areas **(see Sections: 5.4.,5.6.,57.,5.8 and 5.10).** This new way of the 'Flexible Primary Care Workforce' will not only require substitution of existing roles but also innovative models of undergraduate and postgraduate training and development programmes to keep pace with the service delivery aspirations of a millennium patient caseload who seek to be better informed than at any time before. This 'Professional repositioning

and displacement' will facilitate the introduction of what could be described as the introduction of a new breed of 'Primary Care Practitioner (PCP)' for the millennium workforce, that will replace the existing 'General Practitioner' model that has been in place since the inception of the NHS **(see Sections: 4.3.1.,5.4.,5.6 and 5.8)**. This new member of the team will have a substantial background in any one of the Nursing or Allied Health Professions and will have successfully completed post-graduate extended role training through accredited modular units **(see Section: 5.10)**. This practitioner will have the confidence and training to work effectively across the traditional professional boundaries and knowledge to refer to other specialist practitioners, both within the primary care setting and secondary care service areas. The modular nature of the training will enable the 'PCP' to undertake flexible approaches to their career progression. For example the 'PCP' may have a nursing or physiotherapy background specialising in a specific field and continue to undertake a part –time commitment to that specialism, whilst undertaking a generalist part time role as a 'Primary Care Practitioner'. The focus upon enhanced communication and information management and technology (IM &T) multiprofessional and interprofessional training will facilitate the philosophy of patient-centred care and introduction of initiatives such as the 'expert patient' programmes that have already been piloted nationally in primary care settings. In addition the enhanced IM &T training and knowledge will support further primary care initiatives, such as telemedicine and use of the internet for R&D and patient information programmes. Up to the present time telemedicine initiatives have largely been within the domain of secondary and tertiary diagnostic services and internet access for primary care has in the main be non existent.

The undergraduate training will be gained for new practitioners in line with Common Learning initiatives currently being piloted nationally. These postgraduate training programmes need to ensure that the following parameters are fully supported and achieved. The key stakeholders in this process will be Primary Care Trusts, Workforce Development Confederations, Royal Colleges, Professional Bodies, Strategic Health Authorities and Patient User Groups and Forums. This study has evidenced the requirement for the following criteria to be met by all the stakeholders involved:

- Receptive to new role developments with potential for innovations in funding **(see Sections: 5.4., 5.6., 5.8., 5.10)**;
- Implementation of accredited multiprofessional training programmes for all primary care professional disciplines **(see Sections: 4.1.3.,4.1.8.,4.1.9.,4.2.1.,4.3.3.,5.10)**;
- Workforce planning to be firmly established within the context of local level agreements set out in PCTs' Health Improvement Programmes/Local Delivery Plans **(see Sections: 5.4., 5.6., 5.8., 5.10)**;
- Workforce plans to span role developments that will support the substitution of historically secondary care activities, for example: Day Case Ambulatory Foot Surgery **(see Sections: 5.4., 5.6., 5.7., 5.8., 5.10)**;
- Workforce Confederations to support introduction of new role developments, skill mix and skills escalator developments **(see Sections: 5.4., 5.6.,5.7.,5.8., 5.10)**.

Evidence from this study supports the key aim that effective multi-professional education will be achieved by the implementation of 'Staff Development Appraisal' which provides key opportunities to explore each professions perception of each other skills and competences and potential for new role development **(see Sections: 5.6.,5.8 and 5.10)**. Political and organisational support and nurturing will be required over the long term to ensure success. The benefits for the implementation of 'Staff Development Appraisal' can be summarised to include the following eight key aspects from the evidence gained in this study:

- Facilitates the identification of individual training and development needs and thereby increasing the appropriateness of the educational/training intervention **(see Sections: 4.1.8.,4.1.9.,5.6.,5.10)**;
- Supports staff career progression and role satisfaction **(see Sections: 5.6., 5.10)**;
- Reduces the risks of duplication of training and other educational programmes **(see Sections: 5.6., 5.10)**;
- Promotes the delivery of quality education and training programmes **(see Sections: 5.6., 5.10)**;

- Supports flexible modes of education and training programme delivery **(see Sections: 5.6., 5.10)**;
- Enhances staff recruitment, retention and succession planning processes **(see Sections: 5.6., 5.10)**;
- Standards of care to patients is subject to ongoing improvements in service delivery based on appropriate care pathways embedded in evidence based practice **(see Sections: 5.4., 5.9)**.

Staff Development Appraisal can also be linked with performance review enabling mutual benefits for employee and employer to be accrued and realised. A strategic, but operationally supportive, view needs to be undertaken on the potential solutions to succession planning and the development of posts. To simply wait for staff to 'move on' in order to free up funding is neither, logical or supportive of innovations in service delivery.

Learning and development are both central to the government's vision of patient centred care in the NHS and can be seen as critical in delivering the NHS Plan **(see Sections: 5.6 and 5.7)**. The recent NHS Lifelong Learning Framework document 'Working Together-Learning Together' (DOH-November 2001) sets out a vision for delivering this agenda.

Evidence gained from respondents from both the questionnaire and interview components of this study supports the following key statements and can be seen to support the vision outlined in the Lifelong Learning framework agenda.

- NHS Primary Care staff are entitled to work in an environment which fully equips them with the skills to perform their current roles to the best of their ability, developing their roles to the best of their ability, developing their career potential and working individually and in teams in as creative and fulfilling way as possible;
- Whenever practical, learning should be shared by different staff groups and professions;

- Access to education, training and development should be as open and flexible as possible.

The continual updating and extending knowledge and skills will be essential to the continual professional development (CPD) framework of primary care staff. There needs to be constant evolution in this process in order to take account and keep pace of the developments in health care **(see Sections: 4.1.8.,4.2., 5.6.,5.9 and 5.10)**. This is for personal development and to ensure protection of the public. All stakeholders in this environment must work more effectively together and promote consistency in quality and standards of service delivery. The key to achieving this will be through a rigorous approach to appraisal and personal development planning for all members of the primary care team. Until this is actioned the fundamental 'building blocks' to implement lifelong learning will not be in place. The main vision for primary care services, supported by the recent legislation, is to provide all patents in primary care settings with fast and convenient access to high quality care delivered by appropriately skilled staff.

Evidence from this study also supports the conclusion that the focus of attention needs to be with the patient's journey through the primary care health process and when alternatives to current staff roles, professional or organisational boundaries can be found then innovation needs to be pursued towards implementation **(see Sections: 5.4.,5.6.,5.8 and 5.9).** The need to modernise the traditional role, whereby the GP has acted as the 'gatekeeper' to secondary care, is now to move to making more effective use of all other members of the primary health care team. The way in which primary care is being delivered is changing. Rethinking the way in which care is delivered supports the need to redesign roles and to blur the demarcation between existing roles and job functions. The extended Primary Care Practitioner, Allied Health Professional and Nursing Consultants and Primary Care Prescribing for other members of the team are examples of this already implemented.

National policy does indeed support the ongoing development and introduction of educational integration and convergence of primary care professions (for example: The NHS Plan, The Health Services of all the Talents, Learning Together-Working Together). It is evident from this study that there is a commitment from respondents

to seek to work together more closely in pursuance of multi-professional workforce and staff developments **(see Sections: 4.1.8.,4.2.,5.1.,5.3.,5.4.,5.8.,5.9 and 5.10)**. This major paradigm shift has been resisted historically by the Royal Colleges and Professional Bodies. Evidence cited in this study strongly supports the establishment of a Royal College with a vested interest in supporting all the Primary Care professions **(see Sections: 5.1.,5.3 and 5.8)**. The establishment of a 'Royal College of Primary Care' would indeed be most opportune in the following areas in order to:

- Support collaborative and partnership models of primary care service delivery;
- Support the introduction of new roles that previously were considered to be only to be delivered from within the Royal Colleges and Professional Bodies;
- Support the introduction of multi-professional educational training programmes;
- Combat the uniprofessional interests that are inherent within existing Royal Colleges and Professional Bodies;
- Support standard setting and evaluation of Research & Development programmes to influence Evidence Based Practice and Clinical Governance strategies.

Multi-professional education interventions and convergence of primary care professions is a central aspect of contemporary health care and would be greatly supported if the following three keys factors were to be delivered:

- Establishment of a Royal College of Primary Care to ensure the formalisation and ongoing development of key role developments together with Research & Development and Clinical Governance;
- Shared vision in the benefits of training and education across multi-professional disciplines;
- Political support to facilitate change grounded in clear policy and legislative guidance.

It is therefore the contention of this thesis that new models of workforce planning, training and development will need to involve a paradigm shift in the culture of professional education, training and development and indeed in the conventional ideas

relating to professional career pathways. Traditional uniprofessional models of education, training and development greatly control and constrict the way in which professionals adjust to the innovations of change.

6.2 Recommendations for future practice

There is clear evidence drawn from this study to support the introduction of a more effective multiprofessional training framework and interprofessional working practices for the future delivery of primary care services **(see Section: 3.17).** This will be a requirement at both undergraduate and post- graduate level. The ongoing development of inter-professional/multiprofessional training is likely to be delivered more and more within the primary care practice environment since work based learning is a key policy statement by the existing government.

This lends itself favourably to the introduction of a new breed of 'Primary Care Practitioner (PCP)' that has been evidenced as a requirement in this study **(see Sections: 4.3.1.,5.4.,5.6 and 5.8)**. This new post will be integral to the delivery of a flexible multi-skilled primary care workforce and can only be successfully implemented if there is support from existing Royal Colleges and Professional Bodies. This 'PCP' will provide substitution and enhancement for the existing 'GP' role that has been the mainstay and gatekeeper for primary care. This new practitioner will be provided with modular training accreditation to enable them to undertake a 'full initial assessment' of patients' health needs. This has only ever been the historical domain of the GP. The background of the 'PCP' could span any of the existing medical, nursing and allied health professional groups and will have a thorough understanding of the skills and competences of these professions.

The evidence from this study **(see Sections: 5.1., 5.3 and 5.8)** would suggest that something like a Royal College of Primary Care would be a useful development in order to promote and support teamwork and multiprofessional education in primary care. The establishment of a 'Royal College of Primary Care' will have an overarching strategic lead, both in terms of education and service delivery to all patients receiving services in the primary care setting. This will provide the political and legitimate support to deliver the changes required which would otherwise be

subject to barriers related to historical professional inflexibilities. There needs to be effective collaboration, joint planning and consensus between the Royal Colleges, Professional Bodies and General Medical Council in moving positively forward with the Primary Care- led NHS. Royal colleges have historically undertaken a protectionist attitude towards their vested interest groups. A collaborative and open evidenced based philosophy needs to be the new culture in order that barriers are dismantled and the patient rather than the 'professional group' is placed centre stage. Existing Allied Health Professional bodies will also need to be 'superseded' by an umbrella ' New Allied Professional Body' which incorporates all the individual bodies thereby facilitating the emergence of new professional roles that have to date been prevented by professional 'blocking'. This new body can be set up along the lines of the introduction of the Health Professions Council and helps to refocus the agenda away from the traditional self-regulation philosophy, towards a more open and accountable framework, with standards set and monitored from the patients' holistic health care requirements.

I propose that should a Royal College of Primary Care be established, the current Royal Colleges should remain **(see Diagram: Two)**. The Royal College of Primary Care will function on behalf of all professional groups practicing within primary care settings (16 professions highlighted in this study) and will include Allied Health Professions as well as Medicine and Nursing. There would not be a requirement to introduce duplication with the implementation of a Royal College of Allied Health Professionals. The 'umbrella' Allied Health Professional (AHP) Body will replace the thirteen individual AHP Professional Bodies. The prime function, as now, would be to:

- Safeguard professional standards;
- Ensure that education and training are appropriate to safeguard professional standards and competences;
- To provide accreditation for the education and training of health care professionals;
- Provide union representation for its member.

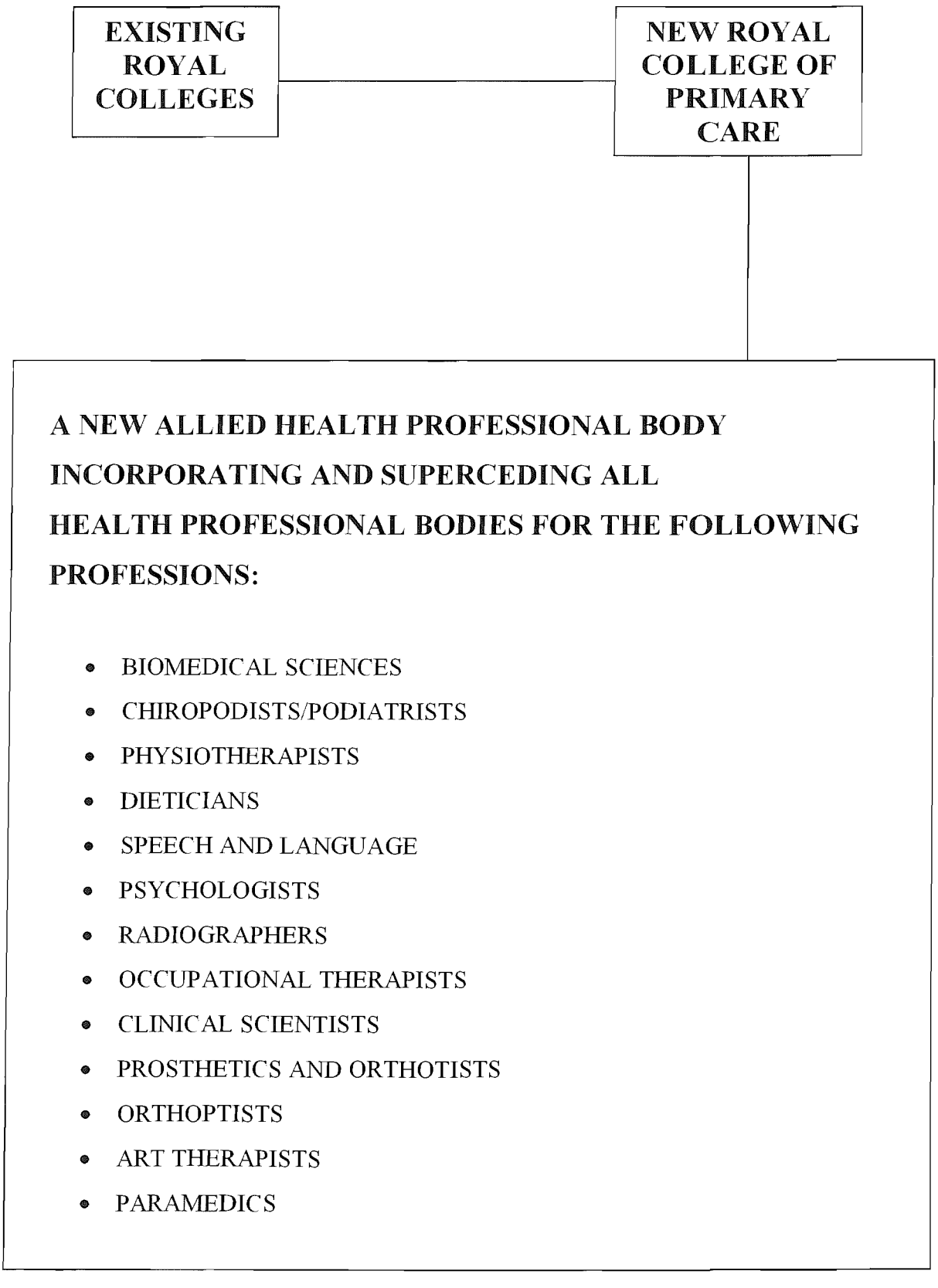
The establishment in 2004 of a new statutory regulatory body, the Health Professions Council (HPC), does not provide a union affiliation to its registrants and functions to supersede the role previously held by the Council for Professions Supplementary to Medicine (CPSM). A key function of the HPC is to provide greater integration and co-ordination with and through the individual Professional Bodies. Professional Bodies, since the implementation of the HPC, in 2004 are accountable to the HPC for ensuring processes are in place to support best practice in protecting the interests of the public (DoH, 2001b).

The proposal made in this study to introduce an umbrella 'Allied Health Profession' Body, to replace the thirteen individual Professional Bodies, will assist in delivering the 'greater integration and co-ordination' required by the Health Professions Council (HPC) in guaranteeing professional standards and competences. The 'joined up' training and education planning that would result from the removal of 'Professional Body' tribalism would b helpful in delivering interprofessional training and development opportunities.

These proposed changes would not be unproblematic and would require existing 'Professional Body' common sense to prevail. Unfortunately, 'vested interests' and 'protectionist' attitudes abound. There will be a requirement for government legislative processes to make statutory changes to the status quo.

Diagram: Two

Proposed Royal College of Primary Care and New Allied Health Professional Body.



The implementation of a more widespread utilisation of 'integrated care pathways' across all primary care services will have particular benefits to patients for the following three key reasons:

- Access to services and delivery will be streamlined and based upon user involvement satisfaction;
- Improved use of evidenced based programmes of care delivered across the whole primary care team;

Enhanced communication, collaboration and understanding for patient, carer and health professional.

The findings of this research study supports the recommendation that the future of primary care education needs to reflect the breadth of skills and competences that is required to deliver the modern service and characteristics of that care. This new approach will require that all primary care professionals are committed to take on the changing and widening roles and responsibilities that innovation will bring. Paramount to these changes will be involvement in more interdisiplinary and multiprofessional working, a positive engagement with the new 'disciplines' and a more eclectic approach to the personal continuing development process. There will inevitably be greater opportunity for some professional staff to undertake a lead within the widening agenda, for example Lead Nurses in the context of the new GMS contract, but this will also lead to widening opportunities for all the members of the primary care team to fully participate in leading the direction of primary care away from the existing 'medical dominance model that has held sway since 1948. This not only requires professional education to recognise the shared concerns involved in basic professional practice, but also the requirement to blur the boundaries around professional roles as careers develop and a more responsive and appropriate model of primary care evolves.

The implementation of the proposed 'Primary Care Practitioner' will be less reliant on structural changes, that has predominated the NHS, and more upon having the appropriate training and competences to provide excellence in delivering patient centred care in the context of a specialist team setting. The role that education will play in this 'brave new world' will be of the greatest significance, particularly as the partnership between the existing professional bodies and the proposed new 'Royal College of Primary Care' in curriculum development and achieving a modular approach to post graduate accreditation in the work place setting.

As evidenced in **Sections: 5.1 and 5.10**, syllabus redesign, along the lines of the pilot common learning sites, will facilitate change in the culture of existing interprofessional rivalry together with the appropriateness of educational content that has greater relevance to primary care service delivery. Clearly there will still be the potential to accrue 'tribal barrier conflicts' around professions that emerge, however, the interprofessional conflicts should be sufficiently negated through greater understanding of each others roles and responsibilities together with greater opportunities for staff to change career direction if they so desire. This flexibility of approach will also enable staff to review their career direction at a later stage than historically has been possible. This would also support the recruitment and retention priorities since there will be more combinations of circumstances to introduce primary care generalists than currently could be achieved with the existing 'medical school ' training model. This argument is made specifically in relation to the 'age time bomb' projections over the shortfall of recruiting GPs to practice and the current model for training GPs. The innovation would also achieve flexibilities for delivering a wider range of 'specialist' services, that are currently the domain of secondary and hospital based service provision. These 'domains' have been fiercely guarded and protected against change. A good example relates to the introduction of day case ambulatory foot surgery carried out by primary care trust staff. Podiatrists who have received specific post graduate training to undertake a range of foot surgical procedures effectively have often been blocked from using theatre accommodation in acute hospital settings by some orthopaedic surgeons who have maintained that they have the only autonomy to undertake this type of surgical intervention. This stance has been based not upon a patient centred philosophy of care rather than a vested interest

over an individual professional group's perceived professional status. These changes also support the concept that referrals requiring specialist consideration in primary care could become the 'norm' rather than the exception. This is further supported by the current improvements in the building of 'fit for purpose' primary care resource centres that have all the modern diagnostic and day case surgical facilities. Supervision and continuous professional development will be required to redeem these innovations in primary care delivery. This will necessitate an enhanced relationship between education and training establishments and will demand exciting and challenging cultural changes in the prevailing training and education provision.

As Senge (1999) suggests the 'lifelong learning' opportunities are great within the primary care environments. The delivery of CPD is to be coordinated across a interprofessional front if the professions are to support the opportunities that are available. The need to deliver this development through an intelligible process as opposed to an ad- hoc and fragmented approach cannot be overemphasized. The individual portfolio mechanism adopted by nursing and allied health professions is a helpful tool but still lacks the cohesion required. Houle (1980) sets out a key principle that:

> *'professions need organized educational opportunities in order to prepare for key career transitions'* (Houle 1980).

The integration and reinforcement of delivering multi-professional training in order to change practice will augment the quality of the learning experience and at the same time assist in breaking down professional barriers and tribal protectionist behaviours that have been culturally established within primary care. The need to support primary care staff in undertaking and establishing a culture of research and development will also reinforce the evidence based delivery of care culture demanded for excellence in patient-centred service provision. Primary care professional innovations in service provision must be delivered appropriately by the educational establishments. This will require an innovative and flexible approach also to be adopted by the educational establishments and a sea-change move away from historic models of education. The control currently exercised by the professional bodies needs to be flexed towards a proactive engagement over the need to participate in multiprofessional accreditation programmes in CPD and new innovations in practice. Resources will also play a

critical role in implementing these changes. Organisational and cultural changes is costly, particularly in the in the short term, when transitional costs will be incurred and the momentum needs to be maintained. In the longer term, it is probably true to state that savings will occur as professional boundaries become blurred and innovation becomes the new cultural norm. If these changes cannot be enacted both in the transformation to the existing culture and historic role delivery then the much espoused primary care led NHS will be on the wrong road.

6.3 Recommendations for future research:

6.3.1 It would be helpful to examine existing NHS Primary Care Organisational structures and to assess to what degree these structures provide sufficient space and flexibility to facilitate organisational adaptation for cultural change in relation to the delivery to effective multi-professional teamwork and training.

6.3.2 To investigate in detail the key 'change agents' that will be required in NHS primary care services to provide a more supportive environment for multi-professional staff and deliver a more supportive environment for patients and students who will be the health professionals of tomorrow.

6.3.3 This was a relatively small study and although able to be generalised it cannot be regarded as representative of the wider NHS picture. Further work could be undertaken over a much wider regional or county -wide framework.

6.3.4 The study only focussed upon professional staff views. It would be helpful and indeed desirable to necessitate a study of patients' views.

6.3.5 The medical model adopted by most health service professionals heavily relies upon treatment decisions made directly by the GP or health professional. Traditionally this involves little patient involvement. A study undertaking a detailed analysis of Training Schools models of delivery will enlighten the case and should lead to useful recommendations to support transition and

change towards a more patient focussed model of undergraduate and postgraduate education.

6.3.6 The impact of patient empowerment in helping to form and structure services is also part of recent NHS policy guidance. A similar study could be undertaken in evaluating the success or otherwise in this aspiration.

6.3.7 The challenges inherent in implementing institutional change that leads towards a more collaborative model of education and learning needs to be explored in more detail than current research provides.

6.3.8 This study along with others make the statement that the benefits of multi-professional education and teamwork delivers a better more holistic and seamless service for patients and users. This claim requires further research and evaluation.

6.3.9 The structural differences between NHS Primary Care Organisations will present different and often conflicting organisational and professional agendas, which will effect the delivery of effective communication. A study focussing upon these specific areas would be helpful in ascertaining complexities to deliver a national framework of inter-professional teamwork and education.

6.3.10 The perceived scarcity of resources *(financial and professional staffing)* across the health and social care economies may present particular pressures effecting the interprofessional and interorganisational barriers to change. These issues would require further consideration and investigation.

6.3.11 To review the structures and workforce models in primary care across an international context.

6.3.12 The study of 'structuration' that was mentioned in section 4.3.1 of this research, would provide an excellent process tool whereby further studies

of the structural changes in relation to primary care have or could be delivered.

6.3.13 The process of 'unlearning' in order to deliver constructive changes in the context of the Primary Care led NHS.

6.3.14 To examine specific variations in individual professions accessing Multiprofessional Education training opportunities.

6.3.15 To investigate optimal team size elements of the primary care team in effective service delivery and communication processes.

6.4 Final concluding remarks

The evidence presented in this thesis and the conclusions and recommendations drawn needs to be viewed in the context of the rapid organisational and professional change that has occurred since the birth of the NHS in 1948.

The central role handed to Primary Care Trusts, as a result of the government's modernisation agenda, makes the requirement to continue to implement positive developments in the delivery of NHS primary care services a critical process. The prime value of this research study is in the acquisition of a greater understanding of the teamworking and educational processes of NHS primary care services. Thus by seeking to make a contribution to gaining better sense of these core processes it is hoped that the future care provided to patients will be of the highest standard possible.

Glossary

Listed below is a description of the terms used within the context of this research thesis.

Agenda for Change (AfC)- The new NHS pay system. The system will combine national standards with local flexibility for employers. It is based on the principle of equal pay for equal work and will reward staff who develop into new roles. A limited number of pay bands will be used and jobs will be matched to these using evaluation. An NHS staff council will take over the work of the 11 Whitley Councils and the remit of the pay review bodies will be modified. Due for national implementation in September 2005. (Wellard's NHS Handbook, 2003/2004).

Allied Health Professionals (AHPs)- represents over 120,000 members of 13 professions: art therapists, clinical scientists, dieticians, biomedical scientists, occupational therapists, orthoptists, paramedics, physiotherapists, podiatrists, prosthetists and orthotists, psychologists, radiographers,and speech and language therapists. (Wellard's NHS Handbook, 2003/2004).

Appraisal- is a systematic process that will focus not just on performance, but also upon what the staff member has learned, how they have developed and how their learning and development can best proceed and be nurtured in the forthcoming period (Hawkins and Shohet,2002, pp.176).

Audit-Clinical/Medical- use the same cycle of activity, focussing on the delivery of care. Most types start with observing current practice, and comparing this with information on what was the expected or desired outcome. The next stage is to take action to address the difference between the observed and expected standards of practice. This in turn is evaluated and the process starts again until the desired standards are met or exceeded. Then the standards are revised upwards in a continual upward spiral of improvement (Ranade, 1997, pp.145).

British Medical Association (BMA)- the trade union of medical practitioners.

Clinical Freedom- relates to clinical decisions regarding the who, when and how of treatment is left in professional hands and the Royal Commission on the NHS in 1979 (Report. London: HMSO) stated that:

> *'It is important to note that the existence of clinical freedom substantially reduces the ability of the central authority to determine objectives and priorities and to control individual facets of expenditure'.*

Clinical Governance (CG)- The Department of Health (A first class service,1998,London) defines clinical governance as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical Supervision- according to Bishop (1998, pp8) is the designated interaction between two or more practitioners, within a safe/supported environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patent services.

Commission for Healthcare Audit and Inspection (CHAI)- A new independent inspectorate for healthcare established in April 2004 in England bringing together: The functions of CHI, the NHS value for money studies of the Audit Commission, the private healthcare role of the National Care Standards Commission and the Mental Health Act Commission. CHAI will work closely with the Commission of Social Care Inspection, creating a system in which the management, provision and quality of both health and social care can be examined (Wellard's NHS Handbook, 2003/2004)

Commission for Health Improvement (CHI)- A statutory body established by the 1999 Health Act, CHI evaluates and refines local systems designed to safeguard clinical quality. Operating at arms length from the Department of Health. Its aims are to reduce variations in clinical quality across the country and rapidly eliminate malpractice (Wellard's NHS Handbook, 2003/2004).

Common Learning- in the context of this thesis it is the mechanism through which students/health care professionals facilitate learning and their ability to:

- Respect, understand and support the roles of other professionals involved in health and social care delivery;
- Make an effective contribution as an equal member of an interprofessional team;
- Learn from others in an interprofessional team;
- Collaborate with other professionals in practice;
- Understand stereotyping and professional prejudices and the impact of these on interprofessional working;
- Practice in a patient centred manner.

(Adapted from The New Generation Project, Common Learning Handbook, March 2003).

Continuing Professional Development (CPD)- In the context of this thesis CPD is defined as:

'...the systematic maintenance, improvement and broadening of knowledge and skill, and the development of personal qualities necessary for the executive of professional, managerial and technical duties through the professional's working life'.

(Walsh and Woodward, 1989, pp.129).

Continuing Professional Education (CPE)- In the context of this thesis CPE can be considered as possessing a more specific focus upon formally or accredited courses and targeted educational events as compared to CPD (Eraut, 1994).

> *'These work based opportunities for professional development are also dependent on a set of attitudes and beliefs about learning. These attitudes span both the individual, team and organisational level'.*
> (Pringle, 2000, pp.81.)

Council for Professions Supplementary to Medicine (CPSM)- In April 2002, the regulatory body entitled the CPSM was replaced by the Health Professions Council (Wellard's NHS Handbook, 2003/2004).

Day Case Ambulatory Foot Surgery- This term applies primarily to routine foot surgery, normally carried out by a Podiatric Surgeon, on a day case basis. The surgical procedure is carried out using local anaesthesia, which does not require the patient to be admitted to a hospital bed either pre or post surgery.

Department of Health (DOH)- Formed in 1988 when the Department of Health and Social Security was split into the Department of Health and Department of Social Security (Harrison and Dixon, 2000, King's Fund). supports the Secretary of State and health ministers in carrying out their functions. It is responsible at a national level For the NHS, public health and social care. The Department is led by its permanent secretary, who is also NHS chief executive (Wellard's NHS Handbook, 2003/2004).

Evidence Based Practice (EBP)- Reflects the emphasis now placed upon evidence based practice and guidelines as a mechanism of rationing and the wider movement to strengthen the scientific basis of medicine, challenging clinical freedom in the pursuit of continuous improvements in efficiency and quality. (Coulter and Ham, The Global Challenge of Healthcare Rationing, 2000, Open University Press, Buckingham.).

Foundation Trusts- Free standing independent public interest organisations modelled on co-operatives and mutual organisations. NHS Trusts will remain part of the NHS and will treat NHS patients according to NHS principles and standards. In 2003, 29 shadow Foundation Trusts were to be established (fully operational from April 2004). At present only NHS Trusts that have a three star rating (highest rating) are able to apply. (Wellard's NHS Handbook, 2003/2004)

Gatekeeper- The ethos established by the implementation of the NHS in 1948 served to institutionalise the referral system and the gatekeeper role of the GP. Gatekeeping served as an effective way of controlling patient demand and ensuring the protection of specialist services. The 'gatekeeper system' established the separation of primary

and secondary care, with a referral letter and discharge note being the currency of transfer between the sectors. (Starey, The Challenge of Primary Care, pp.5).

Generalist- In the context of this thesis this terms refers to a general practitioner (GP).

General Medical Services (GMS)- are services provided by the four independent contractor services-general practice, community pharmacy, optical services and dentistry. All four professional areas have historically been funded through general taxation via the GMS budget. This has supported the independent elements of the primary care sector and independent contractors have drawn their income from the budget once all their other expenses have been met, for example, cost of premises, staff employment, management costs and professional expenses such as equipment and subscriptions.
(Starey, The Challenge of Primary Care, 2003,pp.29).

General Practitioner (GP)- Historically, for many of the UK population the general practitioner (family doctor) is often the first and continuing patient contact with the NHS and initial decisions are made about each problem presented. In the UK, unlike other countries, patients do not normally have direct access to a hospital consultant but they are referred by their GP.
(Wellard's NHS Handbook, 2003/2004).

General Practitioner Fundholding (GPFH)- Practices that chose to accept a budget for all or part of their practice and to manage the budget for hospital and community health services themselves. Introduced by the NHS and Community Care Act 1990, they were effectively abolished in 1997, but this was not made official until 1999 (Harrison and Dixon, 2000, King's Fund)

Health Improvement Programme (HimP)/ Health Improvement and Modernisation Plan (HIMP)-NHS: modern, dependable (1997). This programme was the local action programme to improve health and health care. Led by the then Health Authorities in England, HimPs were used to seek to identify the health needs of local people and provide strategic plans of action to meet those needs. With he

introduction of the NHS modernisation agenda has now transformed the term and acronym to include the all embracing term 'Modernisation'.

Health Professions Council (HPC)- The new regulatory council replaced the CPSM in April 2002 and its thirteen boards as part of the government's modernisation agenda and wider strategy to modernise the whole of the NHS to help deliver better health and faster, fairer care. (Modernising Regulation-The New Health Professions Council, August 2000, NHS Executive).

Health Promotion Clinics- Refer to the General Practice clinics introduced during the GP Fundholding period. Financial enhancements were paid to GPs and practice staff for undertaking clinics that focused upon 'Health of the Nation' target reductions and targeted clinics to improve the health and well being of their practice caseload. For example, blood pressure monitoring clinics to reduce risks associated with stokes, coronary heart disease or counselling services.

Her Majesty's Stationery Office (HMSO)/The Stationery Office- Government and Department of Health publications, London.

Hippocratic Oath- Founded on the teachings of Hippocrates (c.460-377 BC). Hippocratic doctors, according to Porter (2003), whilst making no pretence to miracles cures, did pledge to above all do no harm (primum non nocere). Ethical concerns about medical conduct were addressed in the oath.

Independent Contractor- Refers to the following four professional healthcare groups, namely: General practitioners, dentists, community pharmacists and optical services. Independent contractors work within the in the primary care sector are not constrained, due to their historic lack of accountability, for the allocation and transfer of resources, as compared to all other primary care practitioners in primary care (Starey, 2003, pp.137).

Individual Personal Development (IPD)- See Appraisal.

Integrated Care- Changes to acute and primary care services can be seen in terms of a wider political trend towards seeking to the integration of care provision in the NHS. Clinical teams are seen in the context of working in increasingly 'integrated networks' of care.

Integrated Care Pathway (ICP)- determines locally agreed, multidisciplinary practice based on guidelines and evidence where available, for a specific patient/client group. It forms all or part of the clinical record, documents the care given and facilitates the evaluation of outcomes for continuous quality improvement (National Care Pathways Association, cited in Middleton and Roberts, 2000, pp.4).

Interprofessional Education (IPE)- The definition provided by CAIPE (1997) is the definition used in the context of this thesis:

> *'Occasions when two or more professions learn together with the object of cultivating collaborative practice'.*

Joint Evaluation Team (JET)- Composed of lead members of the UK Centre for the Advancement of Interprofessional Education (CAIPE). JET have been actively involved in undertaking critical review of evaluations of interprofessional education.

Knowledge and Skills Framework (KSF)- defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development of all staff, and lies at the heart of the career and pay progression strand of Agenda for Change (Introduction to the Knowledge and Skill Framework, October 2004, Department of Health).

Local Delivery Plans (LDPs)- are three-year programmes to improve the health status and healthcare of a local population. They have to reflect national priorities and are drawn up by Primary Care Trusts (Wellard's NHS Handbook, 2003/2004).

Lifelong Learning- as defined by the Department of Health (1998a) is:

'A process of continuing development for all individuals and teams which meets the needs of patients and delivers the healthcare outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential'

Local Organising Teams (LOTs)- relates to the Teambuilding work undertaken by the Health Education Authority by West and Pillinger in 1996. The focus of the work was upon evaluating team building methods in primary care settings.

Market / Internal Market – As part of the initiative to foster greater competition in the early 1990s, the then conservative government introduced an internal market in the NHS through the introduction of the 'NHS and Community Care Act (1990). GP fundholding practices were enabled to purchase community and hospital services for the benefit of their patients. The introduction of the purchaser/provider internal market was established (Ham, 1992).

Medical and Dental Education Levy (MADEL)- An historic element of the funding allocation for learning and development for the medical and dental element of the NHS workforce (A Health Service of all the Talents, DOH, April, 2000).

Medical Model- refers to the individualistic, functional fitness, curative approach which, according to Ham (1992), is the most influential in western societies. A model in which doctors have a central role and hospitals play a major part. The medical model emphasises specific, explicit causes of ill health and searches for specific cures for these illnesses.

'Acceptance of the medical model is important, first in justifying the pre-eminent position of the medical profession in health matters, and second, in helping to explain the pattern of investment in health services' (Ham, 1992, pp. 225).

Multiprofessional Education (MPE)- The definition provided by CAIPE is the definition used in the context of this thesis:

' Occasions when two or more professions learn side by side for whatever reason'.

Multiprofessional Teamworking /Interproferssional Teamworking-

As with multiprofessional and interprofessional education there is a need to make the distinction between people who come together and perhaps agree to exchange information and collaborate to a degree, as opposed to a team whose members decide to share vision and overcome boundaries in order to work collectively in pursuit of the common goal.

According to Martin and Rogers (2004), in the early stages of 'interprofessional teamwork'it would be more appropriate to apply the term 'multiprofessional teamworking'so as to describe the degree of interaction.
The Interprofessional team is:

> *'a unique form of team which involves significant collaboration and the breaking down of boundaries, although these teams can be formed within the same department or organisation'.* (Martin and Rogers, 2004, pp.161).

For the context of this research the terms are used interchangeably in order to seek to provide clarity over the defensive, tribal behaviours of professions in preserving their protective boundaries and also in the context where professionals consent to blur or work across their professional boundaries.

National Health Service (NHS)- The NHS was established by the National Health Service Act of 1946 and commenced in 1948. Under the act, the Secretary of State for Health is responsible for the provision of health services in England. Parliament holds the Secretary of State to account for the functioning of the NHS and the use of resources. The original aims of the NHS as set out in the 1946 Act were:

> *'To continue the promotion in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of*

the people of these countries and in the prevention, diagnosis and treatment of illness'.

National Health Service Direct (NHS Direct)- provides people with prompt and comprehensive access to health information and advice. Launched in March 1998, nurses and other professionals advise callers, suggest the best courses of action and are also able to pass calls directly to the emergency services. The service covers the whole of England and Wales, with lines open 24 hours a day, 365 days a year. Some half a million calls per month are taken across the 22 NHS sites in England (Wellard's NHS Handbook, 2003/2004).

National Health Service Modernisation Agency (NHS Modernisation Agency)- works closely with Strategic Health Authorities in order to ensure that every NHS trust participates in the wide-ranging programme of improvement.
To seek to deliver consistently high standards across the NHS, the programme is being targeted at two star and particularly one and zero star NHS organisations and involves:

- Clear assessment of need;
- Tailored support;
- Leadership development;
- Targeted resources.

(Wellard's NHS Handbook, 2003/2004)

National Health Service Plan (NHS Plan)- was published in July 2000 and represents a blueprint for the radical reform of the NHS over a ten year period. The plan sets out how extra funding, announced in the comprehensive spending reviews, is to be allocated and spent (Wellard's NHS Handbook, 2003/2004).

National Health Service Trust (NHS Trust)- NHS trusts are self-governing organisations with responsibilities for the services they control and they are expected to work in partnership with primary care trusts and other agencies. NHS trusts receive the major part of their income from service agreements negotiated with primary care

trusts for the provision of healthcare. There are around 270 NHS trusts in England responsible for managing the provision of hospitals (acute), mental health and ambulance services (Wellard's NHS Handbook, 2003/2004).

National Institute of Clinical Excellence (NICE)- was formed in April 1999. It is a special health authority that produces formal advice for NHS clinicians and managers in England and Wales on the clinical and cost effectiveness of new and existing technologies-including medicines, diagnostic tests and surgical procedures. It also advises on best practice in the use of these treatments (Wellard's NHS Handbook, 2003/2004).

National Service Framework (NSF)- are evidenced based programmes spelling out the standards the health service must meet in major case areas and disease groups. As well as setting explicit standards and principles for services, they specify the type of services that should be available in primary care settings, local hospitals and specialist centres (Wellard's NHS Handbook, 2003/2004).

National Workforce Development Board (NWDB)- set out in the context of the NHS workforce planning document 'A Health Service of all the talents: Developing the NHS workforce', DOH, April 2000. The board would be chaired by the NHS Chief Executive and be responsible for setting the strategic direction for the NHS workforce development issues.

Non-Medical Education and Training (NMET)- An historic element of the funding allocation for learning and development for the non medical workforce in the NHS. The NMET levy did not cover all the postgraduate training for all non- medical professions (A Health Service of all the Talents: Developing the NHS workforce, DOH, April 2000).

Nurse Practitioners- Their role, according to Reveley, Walsh and Crumbie, 2001) has been the subject of considerable British research. Despite this research there is still no consensus on how best to define the nurse practitioner role in the UK.

'It would be surprising to find the role neatly defined with all loose ends tied up. It is an exciting area in which to work and gives us a great deal of freedom. Uncertainty is sometimes the price to pay for opportunity'.
(Reveley, Walsh and Crumbie, 2001, pp.29)

In this research the term is used in the context of a practitioner who is trained with the skills to assess and manage patients with a wide range of health problems. The practitioner's skills will include medical diagnosis and the pro-activity to work across the usual/historical ' professional boundaries.

Personal Medical Services / Pilots (PMS)- The NHS (Primary Care) Act 1997 allowed members of the NHS 'family' (ie: an NHS Trust, an NHS employee, a qualifying body and suitably experienced medical practitioners capable of providing general medical services to submit proposals to provide services under a pilot scheme and contract with the commissioning authority (Health Authority at the time of the Act) to do so. Personal Medical Services are exactly the same type of services that are currently known as General Medical Services.

Post -Graduate Educational Allowances (PGEA)- Funding allocated to General Practitioners if they have attended 25 days of accredited postgraduate education spread reasonably over the five years preceding the claim. In addition, during that time attended at least two accredited courses in each of these three subject areas:

- Health promotion and illness prevention;
- Disease management;
- Service management.

(Ellis and Chisholme, 1997, pp 147)

Post-Registration Educational and Practice (PREP)- The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) issued a revised PREP (Continuing Professional Development) standard in 1999, and it consisted of three requirements:

- a requirement to undertake at least 5 days (35 hours) of learning activity relevant to the nurse, midwife or health visitor's work during the three years prior to renewal of registration;
- maintenance of a personal professional profile (PPP) of learning activity;
- compliance with any request for auditing of the practitioner's profile by the UKCC.

The compliance with the PREP (CPD) is necessary in order for continued registration with the Nursing and Midwifery Council (NMC).
(Quinn, 2000, pp.5)

Primary Care/ Primary Health Care Team (PHCT)- In the context of this thesis it is the population's initial contact with health services, and provides a broad multidisciplinary approach. In the UK, primary care has been centralised within the arena of general practice. A full range of professional groups make up the primary care team component. According to Wellard's NHS Handbook (2003/2004) over 90% of all episodes of illness are managed wholly in general practice/primary care.

Primary Care Groups (PCGs)- Introduced in the government's 1997 White Paper 'The New NHS: modern, dependable', PCGs were local groups of GPs and practice teams that consisted of groups of general practices serving on average 100,000 people. Formed in 1999 to replace GP fundholding. Superceded to the implementation of Primary Care Trusts. (Wellard's NHS Handbook, 2003/2004).

Primary Care Investment Plan (PCIP)- These were planning mechanisms utilised by PCGs for investing in the General Medical Services infrastructure, which covered practice staff and premises. They also considered the development of any GP practice-based service, together with a review of the primary care workfoce. These plans can be seen as the initial process whereby PCGs began to consider how best to

address inequalities within their geographical area, whilst reflecting national and local strategies at the time. Now superceded by the implementation of Local Delivery Plans (LDPs) within the context of Primary Care Trusts.

Primary Care Led NHS- relates to where priorities for health care are agreed, and who takes part in the process. It signifies the convergence in the primary care setting of the NHS clinical referral powers and financial controls. (Meads, 1996,pp.12).

Primary Care Trust (PCT)-It is a free -standing NHS body and was introduced to replace PCGs. There are just over 300 primary care trusts in England are charged with improving the health of local people, developing primary and community health services and commissioning hospital services. They provide a means of involving GPs and other primary care and community health staff in the planning and commissioning of services. PCTs secure the full range of services for their resident populations, and have the responsibility for the management, development and integration of all primary care services (Wellard's NHS Handbook, 2003/2004).

Primary Care Walk In Centres- Provide high quality, quick and convenient treatment to help relieve pressure on GPs and hospital emergency departments. They are a complementary service, playing a major role in helping patients make better use of the NHS. The centres offer free consultations, available without an appointment, and provide treatment for minor injuries and illnesses, general health information, self-treatment advice, information about out-of-hours GP/dental services and local pharmacy services. There are 42 centres operating in England covering around 11 million people (Wellard's NHS Handbook, 2003/2004).

Professional Body- The primary functions of a professional body are to safeguard professional standards and to ensure that education and training are appropriate to that purpose (Wellard's NHS Handbook, 2003/2004).

Purchaser /Provider- relates to the introduction of the internal market after the implementation of the 1990 NHS and Community Care Act. The introduction of the

concept of involvement of front line-line professionals in the business of commissioning and accountability for clinical behaviour enshrined within the GP fundholding context (Smith, 2001, pp.3).

Royal Colleges (RC)- are professional bodies introduced to promote the interests of their members. For example, according to Starey,

> *'the Royal College of General Practitioners was established so that family medicine, with its own skills and knowledge base, would have its own academic body, curriculum, research and college to promote it'.*
> (Starey, 2003, pp. 8).

Secondary Care- In the context of this thesis these are medical and surgical treatment and care mainly provided in acute service settings such as hospitals.

Service Increment for Teaching (SIFT)- The historic funding stream for undergraduate medical education support (A Health Service of all the Talents, DOH, April 2000).

Single Assessment Process/ Tool (SAP)- for older people was introduced in the National Service Framework for Older People in 2002 (DOH). The purpose of the SAP is to ensure that older people receive appropriate, effective timely responses to their health and social care needs, and that professional resources are used effectively. In pursuit of these aims, SAP should ensure that:

- Individuals are placed at the heart of the assessment and care planning, and these processes are timely and in proportion to individuals' needs;
- Professionals are willing, able and confident to use their judgement;
- Care plans or statements of service delivery are routinely produced and service users receive a copy;
- Professionals contribute to assessments in the most effective way, and care co-ordinators are agreed in individual cases when necessary;
- Information is collected, stored and shared as effectively as possible and subject to consent;

- Professionals and agencies do not duplicate each other's assessments.

(Department of Health web site www.doh.gov.uk/policy/health and Social Care Topics. Introduction to the single assessment process guidance)

Skills Escalator- describes a career as a succession of stages, each with its own pay band and learning requirements. Staff are assisted to renew and extend skills and knowledge through lifelong learning, enabling them to move up the escalator. Meanwhile roles and workload are passed down the escalator, giving greater job satisfaction and generating efficiencies. The skills escalator is also about attracting a wider range of people to work within the NHS by offering a greater variety of step-on and step-off points (Wellard's NHS Handbook, 2003/2004).

Skill Mix- in the context of this thesis relates to the goal to achieve a mix of professional staff in primary care to provide high quality, cost effective care that meets both the needs of the patients receiving the care together with the standards and aims of the primary care trust organisation. According to Jones and McDonnell:

> *' Determination of skills and he mix of skills to meet patients' needs cannot be separated from individual, group, organisation, economic and environmental factors. The NHS, with its numerous reorganisations, has introduced new structures, roles and objectives and in doing so has paid little attention to some important factors affecting skill mix such as motivation, satisfaction, role clarity, job design and human resource management'.*
> (Jones and McDonnell, 1993, pp.44)

Specialist- In the context of this thesis the term refers to a healthcare/medical/surgical practitioner other than a GP.

Strategic Health Authority (SHA)- There are 28 strategic health authorities in England each serving a population of 1.5 million on average. They have the responsibility for overseeing the development of the NHS and social care. SHAs broker solutions to local problems and hold local services to account through the performance management of NHS trusts and primary care trusts.

Succession Planning- in the context of this research is linked to staff appraisal and individual staff development. By identifying good and poor performers, the appraisal assessment can enable the organisation to focus succession planning and resources on the individuals who are most likely to respond positively and effectively for the benefits of patient care delivery and organisational development. The need to undertake and apply the succession planning process consistently, within the 'equal opportunities' framework, is critical.

Tertiary Care- in the context of this thesis these are supra specialist services which would be provided within hospital/teaching hospital settings on a regional basis. For example, neurosurgery, plastic surgery, specialist cancer treatments. Referral would normally be from secondary care Consultant locations as opposed to GP referral.

The Bristol Inquiry- In July 2001 the report of the inquiry into young people receiving complex heart surgery in Bristol who died or were damaged was published. The team conducting the inquiry was led by Professor Sir Ian Kennedy. A central message of the Kennedy report was the need for a change in culture in the NHS so that patients are able to be active partners in their care (Wellard's NHS Handbook, 2003/2004).

The Third Way- In the context of this thesis it refers to an underpinning of New Labour's 'modernisation' of the NHS, a pragmatic paradigm that involves the best of traditional, hierarchical, state based welfare and more recent market approaches to social policy and building upon these.

> *'In paving the way for the new NHS the government is committed to building on what has worked but discarding what has failed. There will be no return to the old centralised command and control systems of the 1970s...But nor will there be a return to the divisive internal market system of the 1990s...instead there will be a 'Third Way' of running the NHS- a system based on partnership and driven by performance'.*
>
> (Secretary of State for Health, 1997, The New NHS: Modern, Dependable, London, The Stationery Office)

As stated by Giddens (2002) it is a framework of thinking and policy making that seeks to adapt social democracy to a world which has changed fundamentally over the past two or three decades. It is a third way in the sense that it is an attempt to transcend both the old style social democracy and neoliberalism.

The United Kingdom Centre for the Advancement of Interprofessional Education (CAIPE)- is a charitable organisation that has for many years been promoting interprofessional education for health, social care and the related professions.

Wanless Review- Commissioned by the New Labour government. The recommendations were that there should be regular and rigorous independent audit of all healthcare spending. The Chancellor of the Exchequer asked Derek Wanless and his team to make a further inquiry into NHS funding in 2004, which was subsequently reflected in increases in national insurance payments (Wellard's NHS Handbook, 2003/2004).

Whitley/Whitley Councils- A machinery of negotiation in the NHS, for dealing with the professional associations or trade unions that represented the NHS workers. Negotiations embodying conditions and terms of work and pay awards. (Klein,The Politics of the National Health Service, 1983, pp.43). These councils are now obsolete, due to the introduction of the Agenda for Change 'Pay Banding' and 'Knowledge and Skills Framework' for all NHS staff which has been introduced in 2005.

Workforce Development Confederations (WDCs)- In April 2001, 28 workforce development confederations were created and replaced the educational consortia and local medical advisory group functions. WDCs take the lead on developing integrated workforce planning for healthcare communities. They have the overall responsibility for developing the existing and future workforce of the NHS at a sub-regional level (Wellard's NHS Handbook, 2003/2004).

Workforce Planning (WP)- Workforce planning is the process which allows an organisation to maintain and develop their workforce asset.

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APPENDICES ONE-TEN

APPENDIX ONE

38 Abbey Gardens
Canterbury
Kent
CT2 7EU

PRIVATE AND CONFIDENTIAL

Dear

Re: Multiprofessional Education and Teamworking in Primary Care

I would like to thank you for taking the time and trouble to participate in the interview stage of my research study.

Please find attached a copy of your interview transcript for your validation.

Once you have had the opportunity to read the transcript I would be grateful if you could complete the validation slip below and return to me in the 'stamped addressed envelope' provided together with annotated comments on the transcript if you wish to correct or amend the transcript document.

As agreed at our recent meeting, all information will be treated in the strictest confidence and at no time will your name or identifying characteristics be linked to any specific excerpt or comments within my thesis documentation.

With kindest regards,

Yours sincerely,

Neil W J Brown *MBA., BA., BSc.*

Enc: Validation Acceptance Slip
Stamped addressed envelope

Strictly Private and Confidential

INTERVIEW TRANSCRIPT VALIDATION SLIP

I have received and read the attached transcript and can validate that it is a true and accurate account of the interview undertaken.

Name.....Signed.....Date.....

APPENDIX TWO

Example of Anonymised Interview Transcript-S3

N.B. Can I first of all thank you for participating in this research interview and for consenting to the interview being transcribed. As agreed the interview will be anonymised and be subject to the confidentiality and ethical agreements we have made. I will also forward to you a copy of the full transcript for you to confirm its accuracy or otherwise.
Please bear in mind that there are no right or wrong answers, the purpose is simply to explore your ideas.

Firstly, in your view how effective in general terms, do you existing Primary Care teamworking across professional and organisational boundaries?

Interviewee:

I think modest at best, the majority of family doctors still think that they are the team and that they are leading the team but hardly ever are equal members of it. Certainly in the GMS contract the way the GPs are paid is an issue since they see themselves as devoting a lot of their personal resources and then they are controlling the flash leadership roles rather than working properly in the team.

N.B In your opinion, what key factors or attributes lead to good teamworking?

Interviewee:

In a sense you have to take some of the negative attributes and try to get rid of these negative attributes. One that I feel needs attention is to address the equality in the team issue. I would go for a long run strategic answer that if we had a common Bachelor of Medicine degree so that everybody had a couple of years together in the first instance, for example, medics, pharmacists, professions allied to medicine, you know it wouldn't be purely medicine but it would be about professional lives. Then I think that that is a long runner. The short term is very difficult. So I think that we have to do many things. I think that we have to continue to address the cultural dissidence. In 5 years we could have 5/6s of the same professionals working who are already graduated and already in employment, consistently giving the same messages about what we want to do. I think we have to put some resource into organisational development and in particular leadership and we have to devote more into leadership for non- doctors, because I think a key problem is the professional inequality issues. I think we have to change organisations a bit better than we have. I think that my own view is that the PCTs are still too heavily doctor dominated.

N.B. In your view do you consider that shared learning opportunities encourage or hinder effective teamwork and professional development?

Interviewee:

One of the things that I would wish to see happen is to stop accrediting teaching in general practice but accredit learning so that much more of the learning needs to be at home as it were as teams. So I think that shared professional learning is working together and learning together, and another is if you like, multi-cultural which is separate. I think that the most important one is the working together and learning together but unless we change the structures around it we won't do anything. Unless we change the funding streams and other things we won't see anything done. The other thing is that I think that the NHS under invests in professional development and continued learning and the only way to make it affordable it to accredit more learning together at home as it were in the home primary care teams.

N.B. What is your understanding of the term 'integrated working'?

Interviewee:

Integrated working to me is around flexibility, transparency and openness of boundaries, reduction of duplication and smoother pathways for the patients
So take an example, if you were to have greater integration between District Nursing and Practice Nursing, you may have a particular Practice Nurse that is supporting a particular group of patients throughout their pathway of care, whether they attend the clinic or are housebound. Integration, reflects effective team working and understanding each others roles so as to negate duplication in service delivery.

N.B. What is you understanding of the term 'culture' in relation to the NHS environment?

Interviewee:

I think it's the attributes and nuances around the way things are done together with the structures and processes, protocols and procedures. I think that the culture of a team will be around how people work together, how committed they are to the teams identity. It's the glue or lack of glue that determines the type of culture that you are working with.

N. B. What ways, if any, do you consider that the existing NHS Primary Care culture supports or hinders the delivery of effective teamworking?

Interviewee:

If you are taking the NHS from a macro level the culture hinders it and by that I mean things like the Royal Colleges and Professional Bodies and professional boundary alignments, such that the UKCC may have a particular definition of professionalism and appropriate protocols to be working to. Conversely the British Dietetic Association covers a different viewpoint so that if you have a District Nurse looking

to give dietetic advice in order to facilitate integration, then you have this sort of Royal College and Professional Body conflict so you do not actually facilitate any integration actually happening. At a micro level the culture of the NHS is actually open to integration. If you can get teams working together around a particular agenda and have individual clinicians open to the skills that other people are able to bring to the table then it can work very well. The culture should, in theory, give people the tools that they may need to grow and fit well within the team.

N.B. How effective do you consider the existing training and education processes for Primary Care staff in terms of career and professional development?

Interviewee:

A few years ago in General Practice there was only one thing, you became a GP principle or you didn't and there was very little else. But now there are a whole range of options from salaried partners to PMS pilots, principle posts, community trust posts so there is much more of a opportunity for a portfolio career. The other primary care professions have a limited or non-existent attitude, in my opinion, over supporting their members in developing their careers. The portfolio of career development is no where near as good for the other professions, which is a shame and a major lost opportunity.

N.B. How satisfactory and effective do you consider the existing NHS workforce planning process to be?

Interviewee:

Not very good at getting it right, but that might be because it's not possible to get it right and it is quite interesting to compare the outputs with other European countries that we have always relied on importing medical staff so you could argue in a perverse way that the planning process is adequate in as much as we don't actually over invest in Doctors since we always import Doctors.

I think the plans are too far divorced from reality. The period of time from A to B is too long, we determine that we need additional medics in the system tomorrow and there seems to be very little understanding that there is actually a seven year process and then you cannot guarantee that what you put in the system is going to come out the sausage factory at the end and give you what you want. I don't think that we plan far enough ahead, I don't think that those plans get converted into anything that would make the number of college places look different or how we encourage people into the system.

N.B. Within the context of Primary Care services, what improvements, if any, could be made in the way staff are deployed to ensure maximum benefits to patient care delivery?

Interviewee:

I think the unit of general practice is quite an efficient unit as a sort of local answer to patient needs, I think that if you actually have more patch working, by that I mean within a PCT perhaps 5 or 6 practices developing common services, and releasing time, and releasing skills, is a small practice 'the corner shop' as good as Tesco, well the answer is the corner shop does give personal service and Tesco doesn't. It's different. So if you could keep corner shop personal care and Tesco services, you may be able to do it by patch working to enable and continue the important elements of primary care which are around continuity, risk management, good access, conducting people through the trajectory of care elsewhere in the NHS and receiving them back. Those are the big elements and I think you could actually improve deployment. You could still have the practice as the unit but contributing skills in a wider area and develop new roles and ultimately new posts.

N.B There has been an abundance of recent NHS policies, and strategic guidance relating to NHS modernisation for example, the NHS plan, Clinical Governance. In what way if any do you consider professional development in Primary Care is supported by these policies and guidelines?

Interviewee:

I think the NHS plan does support professional development by saying that all staff should receive proper development and appraisal, which is a novelty still in the service and long overdue. I think that in a sense a personal appraisal is a basic unit of planning. You can aggregate personal plans to give a skills audit and to give the learning needs in the organisation. You can also determine how it can begin to provide care as well.
The resource allocation issue is still not clear, for example, how much more new money will be directed into the primary care services and how much substitution of services, currently located in the secondary care services will be vired across to support the delivery at the front line. The rhetoric appears to suggest this will happen from a policy perspective. But in reality this is yet to be ascertained.

N.B. Are there any other comments you wish to make?
Interviewee:

There is a gap in our ability to spread best practice. It is partly because the NHS is a big place. It is partly that there are resources around but they are unevenly distributed. If you are working in an environment in the NHS you have got to consider who you are and what your skills are and then you have got to consider the environment you are working within, which may have been pretty badly invested in the past.

APPENDIX THREE

SEMI-STRUCTURED INTERVIEW SCHEDULE

Can I first of all thank you for participating in this research interview and for consenting to the interview being transcribed. As agreed the interview will be anonymised and be subject to the confidentiality and ethical agreements we have made. I will also forward to you a copy of the full transcript for you to confirm its accuracy or otherwise.
Please bear in mind that there are no right or wrong answers, the purpose is simply to explore your ideas.

1. In your view how effective, in general terms, do you consider existing primary care team working across professional and organisational boundaries?

2. In your opinion what key factors or attributes lead to good team working?

3. In your view, do you consider that shared learning opportunities encourage or hinder effective team work and professional development?

4. What is your understanding of the term 'integrated working'?

5. What is your understanding of the term culture in relation to the NHS environment?

6. What ways, if any, do you consider the existing primary care culture supports or hinders the delivery of effective team working?

7. How effective do you consider the existing training and education processes for primary care staff in terms of career and professional development?

8. How satisfactory and effective do you consider the existing NHS workforce planning process to be?

9. Within the context of primary care services, what improvements, if any, could be made in the ways staff are deployed to ensure maximum benefits to patient care delivery?

10. There has been an abundance of recent NHS policies and strategic guidance to the NHS modernisation (for example: The NHS Plan, Clinical Governance). In what ways, if any, do you consider professional development in primary care is supported by these policies and guidelines?

11. Are there any other comments you would wish to make?

APPENDIX FOUR

PRIVATE AND CONFIDENTIAL

Dear

Re: Multiprofessional Education and Teamworking in Primary Care

I am undertaking research towards my part-time doctoral studies with the University of Southampton.

My research will seek to address the following key research questions:

1. How important is multiprofessioal teamwork in Primary Care Trusts for the effective delivery of services?

2. What changes in organisational culture and processes are required to promote multiprofessional education in Primary Care Trusts?

3. What changes in workforce and staff development are required to promote multiprofessional teamwork in Primary Care Trusts?

I would wish to interview you in order to gain your insight in relation to the above mentioned research questions. It is anticipated that interviews will be scheduled for July to October 2001 and each interview will last approximately one hour.

Please could you complete the attached slip and return to me in the 'stamped addressed envelope' provided. All the information will be maintained in the strictest confidence.

With kindest regards,

Yours sincerely,

Neil W J Brown *MBA., BA., BSc.*

Enc: Acceptance Slip
Stamped addressed envelope

ACCEPTANCE FORM

Confidential

Name and Address of Addressee

I will/will not be able to participate in this research project.

(Please delete as appropriate)

If you are able to participate in this research study I would be grateful if you could indicate below the most convenient date(s) and time(s) in July to October 2001 for the interview to be scheduled (approximately one hour).

.....
.....
.....
.....
.....
.....
.....

Kind regards,

Yours sincerely,

Neil Brown

Interview Consent Form and Ethical Principles

To be read by the interviewee at the beginning of the interview.

My name is Neil Brown and I am currently undertaking research towards my part-time doctoral studies with the University of Southampton. The details of my research have been set out in the cover letter sent to you recently.

Thank you for your willingness to participate in this research project. Your participation is very much appreciated. Before we start the interview, I would like to reassure you that as a participant in this project you have several very definite rights.

First, your participation in this interview is entirely voluntary. You are free to refuse to answer any question at any time and you are free to withdraw from the interview at any time.

This interview will be kept strictly confidential and will be undertaken within the context of the following core principles:

- Interviewees will be fully informed of the nature of the research.
- Interviewees will be able to terminate the interview at any stage.
- To discontinue the tape recording at any stage of the interview.
- To have your comments and any information safeguarded.
- To have the right to anonymity.
- To have your views objectively reflected.
- To receive a full transcript of the interview and make comment/ agree accuracy over the validation of the interview transcript

Excerpts of this interview may be made part of the final research thesis but under no circumstances will your name or identifying characteristics be linked to any specific excerpt or transcript section included in the thesis.

With your consent I will, however, acknowledge your name and designation as being one of the interviewees who has participated in this research study.

I would be grateful if you would sign this form to show that you have read and understood its contents and have consented to participate in this research study based on the ethical agreements made between us.

.....Sign .....Date.

.....Print Name.

(Adapted from McCracken, 1988. and Fogg, 1988)

PRIVATE AND CONFIDENTIAL

Dear Colleague,

Re: Multiprofessional Education and Teamworking in Primary Care

I am undertaking research towards my part-time doctoral studies with the University of Southampton.

As part of this process I would be most grateful if you could complete the attached questionnaire and return it to me in the stamped addressed envelope provided.

Please be reassured that your feedback and comments will be maintained in the strictest confidence and will remain anonymous.

My research will seek to address the following key research questions:

1. How important is multiprofessioal teamwork in Primary Care Trusts for the effective delivery of services?

2. What changes in organisational culture and processes are required to promote multiprofessional education in Primary Care Trusts?

3. What changes in workforce and staff development are required to promote multiprofessional teamwork in Primary Care Trusts?

With many thanks for your assistance in this matter.

With kindest regards,

Yours sincerely,

Neil W J Brown *MBA., BA., BSc.*

Enc: Stamped addressed envelope

MULTIPROFESSIONAL EDUCATION AND TEAM WORKING IN PRIMARY CARE

QUESTIONNAIRE

Notes:

For the Purposes of this research-:

Multiprofessional Education can be defined as any event (course, seminar, study day, training session) at which members of two or more professions are present together.

For each of the sections please tick the most appropriate answer to the question or where appropriate provide comments in the space allocated.

Section 1:

1. In the last twelve months how much continuing professional education have you undertaken as a course participant? (Please include all courses attended but not reading or private study).

- ☐ Less than one day
- ☐ One full day
- ☐ More than one full day
- ☐ Up to five days
- ☐ More than five days

2. In the last twelve months have you attended as a participant any course, training or study session at which members of more than one health care profession were present?

- ☐ No (go to section 1b)
- ☐ Yes (go to Section 2)

Section 1b:

For those who did not attend any Multiprofessional Education or Training Event in the last twelve months.

3. Were any opportunities for Multiprofessional Education available to you?

- ☐ No (please answer question 5)
- ☐ Yes (please answer question 4)

4. If yes: what prevented you from attending?

- ❑ Cost
- ❑ Distance
- ❑ Timing (inconvenient day/time of day)
- ❑ Too busy at work
- ❑ Home/Family commitments
- ❑ Not interested in content of course
- ❑ Not interested in meeting other professions
- ❑ Senior Manager or Colleague could not support your application
- ❑ Other, please give reason:

5. If no: if an opportunity for Multiprofessional learning had been available how interested would you have been in attending?

- ❑ Definitely not interested
- ❑ Not really interested
- ❑ Uncertain
- ❑ Moderately interested
- ❑ Extremely interested

Please go to Section 3

Section 2:

For those who have attended any Multiprofessional Education or Training Event in the last twelve months.

6. Please state the title of the course(s) or give a brief description of the nature of the event:

7. Where was the course(s) held?

8. How far did you travel to attend this course? (If you have attended more than one course,please state the furthest distance travelled).

- ❑ 0/4 miles
- ❑ 5/9 miles
- ❑ 10/14 miles
- ❑ 15/19 miles
- ❑ 20 miles or more (please specify miles)

9. How does this compare with the distance you normally travel to work?

- ❑ Not as far
- ❑ About the same
- ❑ Slightly further
- ❑ Considerably further

10. How long did the course last?

- ❑ Half a day or less
- ❑ One full day
- ❑ Several half days (please state how many)
- ❑ Several full days (please state how many)

11. Who organised or ran it?

- ❑ Not known
- ❑ University or College
- ❑ Professional Body
- ❑ Your employer or employing authority
- ❑ Other, please specify if known

12. Who paid for you to attend?
(If applicable, please specify how the 'costs' were apportioned between course fees, travel time and time -off for attendance:

- ❑ You
- ❑ Your employer
- ❑ Other, please give details

13. If you paid any part of the cost yourself please indicate how much

- ❑ £15 or less
- ❑ £16-£30
- ❑ £31-£45
- ❑ £45 or more (please state how much)

14. Did it lead to or contribute towards a recognised qualification?

- ❑ No
- ❑ Yes (please specify)

15. Which Professions, besides your own, were present on the course that you were attending?

16. Did you actively engage with the other professionals in group work or other activity?

- ❑ No
- ❑ Yes

17. Would you go on such a course again or participate in a follow up?

- ❑ Definitely not
- ❑ Probably not
- ❑ Uncertain
- ❑ Yes, possibly
- ❑ Yes, definitely

Section 3:

Attitudes and Needs

Notes:

For the purpose of this questionnaire-:

Culture can be defined as 'the customary or traditional ways of thinking or doing things which are shared to a greater or lesser extent by all members of the organisation and which new members must learn and at least partially accept in order to be accepted into the service' (Lynn Mekk 1988).

Do you agree or disagree with the following statements?

(Mark the response which most closely reflects your own feelings)

18. The existing culture within your organisation supports the best mechanism for delivering Multidisciplinary Primary Care Services.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly agree

Please add comments below if required:

19. Learning with members of my own profession is more worthwhile than learning in a Multiprofessional Group.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly disagree

20. There should be more opportunities for Multiprofessional learning than there are at present.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly disagree

21. I consider that shared learning opportunities encourage effective health care delivery.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly disagree

22. At present there is a good understanding of each others Professional role and function within Primary Care.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly disagree

23. Multi-Professional Training and Development would assist in providing a greater understanding of the roles and functions of Primary Care Professionals.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly disagree

24. The existing NHS Workforce Planning Process is effective in delivering the right skill mix within Primary Care.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly disagree

25. The existing Primary Care team working across professional and organisational boundaries is effective.

- ❑ Strongly agree
- ❑ Agree
- ❑ Uncertain
- ❑ Disagree
- ❑ Strongly disagree

26. What advantages, in your opinion ,are there in learning with other professions besides your own?

27. What disadvantages, in your opinion, are there in learning in a Multiprofessional group?

28. Please identify the professions that you most benefit from meeting in a Multi-Professional group?

29. Which of any of the following professional issues would you be interested in learning about in a Multiprofessional group setting?

- ❑ Clinical skills
- ❑ Counselling/Communication skills
- ❑ Ethics
- ❑ Information Technology
- ❑ Management skills
- ❑ NHS policy issues
- ❑ Personal/Professional development
- ❑ Research methods and issues
- ❑ None
- ❑ Other, please specify

30. How far would you be prepared to travel to attend a Multiprofessional course?

- ❑ Up to 5 miles (single journey)
- ❑ Up to 10 miles
- ❑ Up to 25 miles
- ❑ Up to 50 miles
- ❑ More than 50 miles (please specify miles)
- ❑ Would not be prepared to attend

31. Have you at any time assisted in the teaching of a Multiprofessional course?

- ❑ No
- ❑ Yes

32. Do you have any further comments you would like to make about Multi-Professional Education/Developments or about any Multiprofessional course that you have attended?

Section 4:

Personal Details

I would be grateful if you could provide the following personal details to assist in the analysis of the data.

33. Please indicate your age group

- ❑ 20-29 years
- ❑ 30-39 years
- ❑ 40-49 years
- ❑ 50-59 years
- ❑ 60 or over

34. What is your gender?

- ❑ Male
- ❑ Female

35. What is your profession?

- ❑ Chiropodist/Podiatrist/Podiatric Surgeon
- ❑ Clinical Psychologist
- ❑ Dentist/Dental Surgeon
- ❑ Dietician
- ❑ General Practitioner
- ❑ Health Visitor
- ❑ Nurse, Community (Mental Health or Learning Disability)
- ❑ Nurse, District
- ❑ Nurse, Practice
- ❑ Nurse, School
- ❑ Occupational Therapist
- ❑ Pharmacist
- ❑ Physiotherapist
- ❑ Practice Manager
- ❑ Social Worker
- ❑ Speech Thearapist
- ❑ Other (Please Specify)

36. What is your position or grade?

37. Where is your work based? (eg. Community Health Centre, Hospital Setting).

38. Do you work full-time or part-time?

- ❑ Full Time
- ❑ Part Time

39. How many years have you been qualified? (In the Professional group indicated).

40. Have you worked continuously since qualifying? (In the Professional group indicated).

- ❑ Yes
- ❑ No

41. If you have taken a career break for any reason, how recently have you returned?

Thank you very much for your help in completing this questionnaire, please note that this information will be kept in the strictest confidence.

Please Return (in the envelope provided) to:

Neil W J Brown

APPENDIX EIGHT

THEMATIC CODES and SUB CODING

Collaboration and a Mutual Understanding of Roles- CM

Collaboration	CM-CL
Role Understanding	CM-RU
Integration of Teams	CM-IT
Mutuality	CM-MT
Working Together in Teams	CM-WT

Communication & Shared Language- CS

Communication	CS-CM
Role Understanding	CS-RU
Shared Language	CS-SL

Cultural Dissonance- CD

Avoidance of Blame Culture/Risk Management	CD-BC
Changing the Culture	CD-CC
Cultural Flux	CD-CF
Cultural Leap	CD-CL
Culture of the Independent Practitioner	CD-IP
Culture of Team Working	CD-TW
Dinosaur Culture	CD-DC
Distinct Identities	CD-DI
Influenced by Values and Beliefs	CD-VB
Leadership	CD-LS
Macro and Micro Level Cultures	CD-MM
News Stories	CD-NS
Organisational Norms	CD-ON
Personal Qualities	CD-PQ
Reflection of Values and Attitudes	CD-RVA
Reinforcing Behaviour	CD-RB
Secret Culture	CD-SC
Sub Culture	CD-SBC
Successful and Unsuccessful Cultures	CD-SUC

Flexible Team Working Practices- FT

Avoidance of duplication	FT-AD
Bringing professionals and services together	FT-BPS
Duplication, Replication & Robbing Peter to Pay Paul	FT-DR
Effective Connections and Flexibility of Roles	FT-CF
Personal Qualities	FT-PQ
Scale of Relationship and Complimentary Functions	FT-SRF
Size Matters	FT-SM
Working as One	FT-WO

Leadership and Innovation- LI

Change Management	LI-CM
Management Training	LI-MT
Multidisciplinary Approach- Who Leads?	LI-MAL
Multiprofessional CPD-Team Support	LI-MDS
Power and Leadership	LI-PL
Shared Management	LI-SM
Support Innovators	LI-SI

Modernisation and Policies- MP

Funding for Student Places	MP-FS
Inappropriate Targets & Time Scales	MP-IT
Leadership	MP-LD
Flexible Employment Practices	MP-FEP
Forward Planning	MP-FP
Patient Centred	MP-PC
Recruitment and Retention of Staff	MP-RR
Resources	MP-RS
Training Inadequacies to be addressed	MP-TI
Workforce Confederations	MP-WC

Organisational Structures and Processes- SP

Career Support-Succession Planning	SP-CSS
Equal Opportunities	SP-EO
Fragmentation	SP-FG
Lifelong Learning & Continuous Professional Development	SP-LLC
Limited Resources	SP-LR
New Organisational Models for Local Service Delivery	SP-OML
Occupational Uncertainty	SP-OU
Poor Planning Process	SP-PP
Professional Career Opportunities and Support	SP-PCO

Professional Boundary Changes and New Roles- BR

Complexity	BR-CP
Flexibility and Transparency	BR-FT
Growing New Animals	BR-NA
Making a Difference	BR-MD
Meeting the Challenge	BR-MC
Momentum for Change	BR-MOC
Optimal Working of Multidisciplinary Teams	BR-OWM
Skill Substitution	BR-SS
Tradition of Generalist Practitioner Undermined	BR-GPU
Workforce Development Opportunities	BR-WDO

Quality and Accountability- QA

Accountability & Appraisal	QA-AA
Clinical Governance	QA-CG
Competency Based Frameworks	QA-CBF
Individual Development Reviews	QA-IDR

Shared Learning- SL

Curriculum Influences	SL-CI
Design of Learning Opportunities	SL-DLO
Focused Educational Activities	SL-FEA
Horses for Courses-The Tools for the Job	SL-HFC
Investment in Professional Development and Learning	SL-IDL
Multidisciplinary Approach	SL-MDA
Multiprofessional Training/ Uniprofessional Training	SL-MUT
Practice Support Based Learning	SL-PBL
Shared Learning	SL-SI
Supporting Team Based Skills	SL-TBS

Tribalism- TR

Hierarchical and Uniprofessional	TR-HU
Isolationism	TR-IS
Tribalism	TR-TR

APPENDIX NINE

QSR N5 Full version, revision 5.0.
Licensee: NBrown.

PROJECT: project, EdD Thesis-Initial Code Search (ch-change processes)

++
+++ Text search for 'change'

+++ Searching document: EdD Anonymised Transcript-S3.
professional inequality issues. I think we have to CHANGE organisations a 49
but unless we CHANGE the structures around it we won't do anything. 64
Unless we CHANGE the funding streams and other things we won't see 65
+++ 3 text units out of 260. = 1.2%

++
+++ Results of text search for 'change':
++ Total number of text units found = 3
++ Finds in 1 documents out of 1 online documents. = 100%.
++ The online documents with finds have a total of 260 text units.
so text units found in these documents = 1.2%.
++ The selected online documents have a total of 260 text units.
so text units found in these documents = 1.2%.
++

PROJECT: project, EdD Thesis-Initial Code Search (cu- cultural issues)

++
+++ Text search for 'culture'

+++ Searching document: EdD Anonymised Transcript-S3
think that the CULTURE of a team will be around how people work together. 86
glue that determines the type of CULTURE that you are working with. 88
Care CULTURE supports or hinders the delivery of effective teamworking? 90
If you are taking the NHS from a macro level the CULTURE hinders it and 92
the CULTURE of the NHS is actually open to integration. If you can get 101
table then it can work very well. The CULTURE should, in theory, give 104
+++ 6 text units out of 260. = 2.3%

++
+++ Results of text search for 'culture':
++ Total number of text units found = 6
++ Finds in 1 documents out of 1 online documents. = 100%.
++ The online documents with finds have a total of 260 text units.
so text units found in these documents = 2.3%.
++ The selected online documents have a total of 260 text units.
so text units found in these documents = 2.3%.
++

PROJECT: project,EdD Thesis-Initial Code Search (sd-staff development)

++
+++ Text search for 'development'

+++ Searching document: EdD Anonymised Transcript-S3
DEVELOPMENT and in particular leadership and we have to devote more into 47
encourage or hinder effective teamwork and professional DEVELOPMENT? 56
invests in professional DEVELOPMENT and continued learning and the only 67
DEVELOPMENT? 108
DEVELOPMENT is no where near as good for the other professions, which is 117
DEVELOPMENT in Primary Care is supported by these policies and guidelines? 163
I think the NHS plan does support professional DEVELOPMENT by saying that 165
all staff should receive proper DEVELOPMENT and appraisal, which is a 166
+++ 8 text units out of 260. = 3.1%

++
+++ Results of text search for 'development':
++ Total number of text units found = 8
++ Finds in 1 documents out of 1 online documents. = 100%.
++ The online documents with finds have a total of 260 text units.
so text units found in these documents = 3.1%.
++ The selected online documents have a total of 260 text units.

++
+++ Text search for 'planning'

+++ Searching document: EdD Anonymised Transcript-S3
workforce PLANNING process to be? 120
PLANNING process is adequate in as much as we don't actually over invest 126
personal appraisal is a basic unit of PLANNING. You can aggregate 168
+++ 3 text units out of 260, = 1.2%

++
+++ Results of text search for 'planning':
++ Total number of text units found = 3
++ Finds in 1 documents out of 1 online documents, = 100%.
++ The online documents with finds have a total of 260 text units,
so text units found in these documents = 1.2%.
++ The selected online documents have a total of 260 text units,
so text units found in these documents = 1.2%.
++

PROJECT: project, EdD Thesis- Initial Code Search
(elt-education/learning/training)

++
+++ Text search for 'learning'

+++ Searching document: EdD Anonymised Transcript-S3
N.B.In your view do you consider that shared LEARNING opportunities 55
teaching in general practice but accredit LEARNING so that much more of 59
the LEARNING needs to be at home as it were as teams. So I think that 60
shared professional LEARNING is working together and learning together, 61
that the most important one is the working together and LEARNING together 63
invests in professional development and continued LEARNING and the only 67
way to make it affordable it to accredit more LEARNING together at home 68
personal plans to give a skills audit and to give the LEARNING needs in 169
+++ 8 text units out of 260, = 3.1%

++
+++ Results of text search for 'learning':
++ Total number of text units found = 8
++ Finds in 1 documents out of 1 online documents, = 100%.
++ The online documents with finds have a total of 260 text units,
so text units found in these documents = 3.1%.
++ The selected online documents have a total of 260 text units,
so text units found in these documents = 3.1%.
++

PROJECT: project, EdD Thesis-Initial Code Search (tw- teams/teamworking)

++
+++ Text search for 'teams'

+++ Searching document: EdD Anonymised Transcript-S3
the learning needs to be at home as it were as TEAMS. So I think that 60
as it were in the home primary care TEAMS. 69
how committed they are to the TEAMS identity. It's the glue or lack of 87
TEAMS working together around a particular agenda and have individual 102
+++ 4 text units out of 260, = 1.5%

++
+++ Results of text search for 'teams':
++ Total number of text units found = 4
++ Finds in 1 documents out of 1 online documents, = 100%.
++ The online documents with finds have a total of 260 text units,
so text units found in these documents = 1.5%.
++ The selected online documents have a total of 260 text units,
so text units found in these documents = 1.5%.
++

+++ Text search for 'care'

+++ Searching document: EdD Anonymised Transcript-S3
Primary CARE teamworking across professional and organisational 22
as it were in the home primary CARE teams. 69
pathway of CARE, whether they attend the clinic or are housebound. 78
CARE culture supports or hinders the delivery of effective teamworking? 90
processes for Primary CARE staff in terms of career and professional 107
opportunity for a portfolio career. The other primary CARE professions 114
N.B. Within the context of Primary CARE services, what improvements, if 142
benefits to patient CARE delivery? 144
different. So if you could keep corner shop personal CARE and Tesco 152
continue the important elements of primary CARE which are around 154
trajectory of CARE elsewhere in the NHS and receiving them back. Those 156
development in Primary CARE is supported by these policies and guidelines? 163
CARE as well. 171
more new money will be directed into the primary CARE services and how 173
much substitution of services, currently located in the secondary CARE 174
+++ 15 text units out of 260. = 5.8%

+++ Results of text search for 'care':
++ Total number of text units found = 15
++ Finds in 1 documents out of 1 online documents. = 100%.
++ The online documents with finds have a total of 260 text units.
so text units found in these documents = 5.8%.
++ The selected online documents have a total of 260 text units.
so text units found in these documents = 5.8%.

APPENDIX TEN

Interview questions and emerging themes specific to each question:

1 **In your view, how effective, in general terms do you consider existing Primary Care team working across the professional and organisational boundaries?**

- Collaboration and Mutual Understanding of Roles;
- Communication and Shared Language;
- Leadership and Innovation;
- Organisational Structure and Processes;
- Tribalism.

2 **In your opinion what key factors or attributes lead to good and effective team working?**

- Collaboration and Mutual Understanding of Roles;
- Communication and Shared Language;
- Cultural Dissonance (Address);
- Flexible Team Working Practices;
- Leadership and Innovation;
- Shared Learning;
- Tribalism (Avoidance).

3 **Do you consider that shared learning opportunities encourage or hinder effective teamwork and professional development?**

- Collaboration and Mutual Understanding of Roles;
- Communication and Shared Language;
- Flexible Team Working Practices;
- Professional Boundary Changes and New Roles.

4 **What is your understanding of the term 'integrated working'?**

- Collaboration and Mutual Understanding of Roles;
- Communication and Shared Language;
- Flexible Team Working Practices;
- Organisational Structures and Processes;
- Professional Boundary Changes and New Roles;
- Shared Learning.

5 **What is your understanding of the term 'culture' in relation to the NHS environment?**

- Blame Culture;
- Dinosaur Culture;
- Hierarchical and Uni-professional;
- Reflecting Values, Attitudes, Beliefs, Norms and Behaviour;
- Sub Culture and Secret Culture.

6 **In what ways, if any, do you consider that the existing Primary Care culture supports or hinders the delivery of effective teamwork?**

- Cultural Flux;
- Huge Cultural Leap;
- Macro and Micro Levels;
- The Culture of the Independent Practitioner (GP).

7 **How effective do you consider the existing training and education processes for the Primary Care staff in terms of career and professional developments?**

- Cultural Dissonance;
- Shared Learning.

8 **How satisfactory and effective do you consider the existing NHS workforce planning process to be?**

- Flexible and Team Working Practices;
- Modernisation Policies;
- Organisational Structure and Processes;
- Professional Boundary Changes and New Roles.

9 **Within the context of Primary Care services, what improvements, if any, could be made in the way staff are deployed to ensure maximum benefits to patient care delivery?**

- Flexible Team Working Practices;
- Organisational Structure and Processes;
- Professional Boundary Changes and New Roles.

10 **There has been an abundance of recent NHS policies and strategic guidance relating to the NHS organisation, for example, the NHS plan, Clinical Governance, in what ways, if any, do you consider professional development in Primary Care is supported by these policies and guidelines?**

- Leadership and Innovation;
- Modernisation Policies;
- Organisational Structure and Processes;
- Quality and Accountability;
- Shared Learning
-

11 **Are there any other comments that you wish to make?**

- Cultural Dissonance;
- Leadership and Innovation;
- Quality and Accountability;

  Shared Learning.