MIDDLESEX UNIVERSITY
SCHOOL OF HEALTH AND EDUCATION

Project Report:
An Evaluation of the Islington Community Education Provider Network Super Hub

A report commissioned by the Islington Community Education Provider Network and produced for the School of Health and Education Middlesex University by

Kevin Corbett
Anki Odelius
Michael Traynor
Sinead Mehigan

APRIL 2015
# Table of Contents

EXECUTIVE SUMMARY ........................................................................................................... 5

INTRODUCTION......................................................................................................................... 7

AIMS OF THE EVALUATION .................................................................................................... 9

BACKGROUND .......................................................................................................................... 10

  Literature review ..................................................................................................................... 10
  Seamless service and integrated care ..................................................................................... 10
  Community nurse recruitment ............................................................................................... 13
  The Local Integration Context ............................................................................................... 14
  Summary ................................................................................................................................ 16

EVALUATION DESIGN AND DATA COLLECTION ................................................................... 17

  Approach .................................................................................................................................. 17
  Approval and access .................................................................................................................. 17
  Data Analysis .......................................................................................................................... 19

FINDINGS .................................................................................................................................... 22

  Factors enabling transfer of nursing staff between sectors .................................................... 27
  Preceptorship and induction to support new RN’s moving into community roles .................. 32
  Primary/secondary care relations and developing supported patient journeys .................... 36
  Quality assuring the practice learning experience .................................................................. 42
  Approaches and recommendations for sustainable practice based learning for community nurses .......................................................................................................................... 45
  Approaches to locality-based multi-professional education .................................................... 47
  Student nurse placements and mentorship capacity in community settings ............................ 49

MAPPING OF WORKFORCE DEVELOPMENT AIMS, MECHANISMS AND OUTCOMES ........................................ 52

DISCUSSION .................................................................................................................................. 55

RECOMMENDATIONS ................................................................................................................. 58

LIMITATIONS ............................................................................................................................. 60

REFERENCES ............................................................................................................................... 61
Appendix 1. Survey Monkey Questionnaire.................................................................63
Appendix 2. Interview Topic Guides........................................................................65
Appendix 3. Changes needed to working life in order to deliver more integrated care . .........69
Appendix 4. Advice to practice area for improving care integration ..........................70
Appendix 5. Organisational advice to improve care integration ..............................71
Appendix 6. How an ‘integrated team approach’ helps learning ...............................72

LIST OF TABLES
Table 1. The work roles of the survey respondents...................................................20
Table 2. The work areas of the interviewees...............................................................21
Table 3. Working in an Integrated Care Organisation.................................................23
Table 4. Attributes of integrated working of benefit to patients.................................24
Table 5. Factors enabling the delivery of integrated care ............................................25
Table 6. Mechanisms enabling transfer of nursing staff between sectors...................31
Table 7. Mechanisms for preceptorship and induction to support new RN’s moving into community roles. .........................................................................................35
Table 8. Mechanisms operating in primary-secondary care relations and for developing supported patient journeys. ..................................................................................41
Table 9. Mechanisms relating to quality assuring the practice learning experience. .......44
Table 10. Sources of digital clinical information accessible from the workplace ..........45
Table 11. Mechanisms for sustaining practice based learning for community nurses.....46
Table 12. Reported mechanisms related to locality-based multi-professional education. ....48
Table 13. Mentor updates in Islington general practice. ...........................................50
Table 14. Reported mechanisms for student nurse placements and mentorship capacity....51
ACKNOWLEDGEMENTS

Kevin Corbett was project manager and undertook report writing, helped develop the methodology and undertook the analysis of survey data. Anki Odelius (University of Surrey) undertook in-depth interviews, interview data analysis and report writing. Michael Traynor and Sinead Mehigan both contributed to the study methodology, project management and proof reading. Nilam Mehta provided ongoing software expertise on Survey Monkey and contributed to the wording of the electronic survey. Martin Weller and Joady Mitchell (London South Bank University) facilitated access to students undertaking clinical placements within the Islington localities. Sule Kangulec gave advice and guidance in relation to local policy and personnel, along with the members of the CEPN Super Hub Task and Finish Group (NHS Islington CCG).
EXECUTIVE SUMMARY

This evaluation of the Islington CEPN Super Hub has found that staff thought Integrated Care:

a) has positive effects;

b) helps collaborative inter-professional working;

c) enables professionals to work with others across all care settings;

d) helps develop a flexible workforce who can work across primary, community and acute care.

A range of specific mechanisms and outcomes are identified for workforce development and planning.

There is a variety of narrative evidence of staff engagement and of staff motivations which are useful for the development of integrated care.

A tripartite workforce development and planning approach is suggested.

The evidence from this evaluation further suggests that CEPN members should:

1. Consider prioritising within their own provider organisation specific workforce development mechanisms and outcomes mapped by this evaluation.

2. Discuss the feasibility of adopting a workforce development and planning model with a tripartite focus which:

   a) ensures students, preceptees and mentees understand integrated working;

   b) offers new recruits blended roles so that new opportunities can be created which precipitate integrated working;

   c) offers existing professional and support staff a range of incentives to undertake rotational and/or blended roles.

3. Undertake a feasibility exercise on the potential utility of making new posts more flexible through the developing rotational and/or blended roles.

4. Support the creation of blended or rotational roles through learning and development and by the creation of local incentives.

5. Develop more robust support for the learning and development of existing staff roles based on the consideration of personal choice and role preferences.

6. Develop prospective job advertisements, job role descriptors and job interview schedules which explicitly include employee preparedness to undertake work across the range of provider sites and/or within/across Care Pathways.
7. Higher Education Institutions, providers and commissioners should collaborate in order to provide students with the experience of integrated Care Pathways using inter-organisational and inter-sectoral placements which further develops student appreciation of the value of primary and community care including general practice.

8. Organise tailored multi-professional education on the terminology and the nature of existing Care Pathways.

9. Locally tailor existing learning and development to include diverse content and narratives from multi-disciplinary practice.

10. Higher Education Institutions, care providers and commissioners should collaborate in order to create interventions which effectively:

   a) Dispel myths which may mislead students that they need to work within the acute sector;

   b) Demonstrate how specialist nurses link different sectors and sites within Care Pathways to optimise patient outcomes
INTRODUCTION

Health Education England (HEE) fund the Community Education Provider Networks (CEPNs) to focus local care on joint learning for service improvement.

This model aims to align health and social care service providers, community groups and education providers, in order to focus on developing ‘learning communities’ defined as: “different parts of the health and social care workforce, patients and the public systematically improving services by learning with and from each other” (HEE, 2015).

HEE set the following objectives for CEPNs:

- Facilitate integrated care through provision of educational projects and programmes across the whole workforce, both clinical and non-clinical, to help improve productivity, patient experience, and the quality of care.
- Act as a catalyst for the adoption of best practice through the creation of learning communities across healthcare including social service and community groups.
- Create new innovative educational models to support local workforce transformation and enable service redesign through educational redesign along pathways.
- Engage patients and the public in the training and education of the healthcare workforce.

A range of workforce development initiatives, called ‘Super Hubs’, have been developed for promoting access to general practice, locality-based integration of care services, health visiting training and the integration of emergency responders.

In 2014, the Islington Super Hub was initially defined as a workstream of the Islington CEPN to aid the learning and development of community nursing and new apprenticeships:

Super hub for community nursing. This involves plans to increase library access for all nursing staff and to update and improve the quality of clinical supervision and mentoring opportunities. It will also explore how apprenticeships can be used to develop new career pathways across health and care. This will be particularly important in support of the work of the local Islington Employment Commission that reported in 2014 (NHS England, 2014).

Both the Super Hub and the CEPN are hosted by Islington Clinical Commissioning Group (CCG)\(^1\), a clinically led NHS membership organisation of general practices.

\(^1\) Islington CCG Mission Statement: “As practices we are committed to working together as a Clinical Commissioning Group to ensure our communities receive the best evidence based care possible within the available resources. We will strive to ensure that patients’ views are heard and that their journey through our local health system is seamless through integration and partnership working” (http://www.islingtonccg.nhs.uk/about-us/vision.htm)
(Pollock and Price, 2013, p.12). NHS Islington CCG is composed of 36 general practices in the London Borough of Islington (NHS Islington Clinical Commissioning Group, 2015, clause 1.2.3).
AIMS OF THE EVALUATION

This evaluation aims to collect data from Islington-based provider organisations in order to identify evidence of the context, mechanisms and outcomes associated with following areas of the Super Hub’s workforce development activity:

1. The enabling factors for the transfer of nursing staff between sectors.

2. The current preceptorship and induction (formal/informal) programmes which support newly registered nurses moving into community roles on registration.

3. The current relations between primary/secondary care in order to both strengthen relationships between sectors and the core training needed for hospital-based nurses to support patient journeys.

4. The practice learning experience of a representative sample of community nurses such as specialist practitioners (district nurses/health visitors); non-specialist practitioners; and health care assistants in order to ensure community nurses in training have an excellent practice learning experience.

5. The current approaches used or recommended to build sustainable approaches to practice based learning for enhanced community nursing learning/development.

6. The current approaches to multi-professional education across all [Islington] localities which contribute to establishing robust community focussed multi-professional collaborative educational approaches across Islington for the benefit of patients and population health.

7. The number/type of student nurse placements in community settings in order to help increase mentorship capacity in community settings.

The above are the aims of the Islington CEPN Super Hub which represent a prospective programme of learning and development for nursing and associated support staff which is emerging across the borough.

In addition, this evaluation will address contextual issues surrounding apprenticeship support roles.

---

2 This workstream seems to have expanded given the original definition cited in NHS England (2014).
BACKGROUND

Literature review
A rapid thematic literature and policy review was undertaken at the proposal stage and towards the end of the evaluation. The aim of the rapid review was to inform the original proposal and to identify the characteristics of workforce development, workforce planning and learning and development within integrated care organisations (ICOs) as well as identify the measures taken by ICOs to achieve the latter. The rationale for repeating the review during the evaluation was to include any recently published work of relevance. This rapid review aimed to discover developments in the research and health policy literature for the ICO experience with workforce development, workforce planning and learning and development; both any positive and negative experiences from the perspectives of the ICOs and their staff. These themes were reviewed using two accessible bibliographic databases, CINAHL and MEDLINE. The latter were searched, along with any local sources of ‘grey’ literature. Key words enabled the literature search in order to synthesise findings of utility to the above themes. Key words used included various combinations of the following: ‘workforce development’, ‘workforce planning’, ‘learning and development’ and ‘integrated care organisation’. This section reviews and summarises key findings from the review.

Seamless service and integrated care
Integration of services and ‘seamlessness’ across primary and secondary healthcare, as well as health and social care, have been elusive goals within the UK NHS since at least the 1990s. National policy at times has appeared to hinder such coordination rather than enable it. The Department of Health and Social Security was split into two parts in 1988 in order to differentiate the budgets of the two and the planning and coordination roles of area and regional health authorities abolished in 1982 and 1996-2002 respectively.

Since 1991 when the ‘purchaser-provider split’ was implemented, the first NHS Trusts (few were combined acute and community care trusts) and new purchasing powers were introduced for certain General Practitioners (GPs), the pace of NHS reorganisation has increased, making the effect of any single change difficult to evaluate. From the mid-1990s policy has also had the aim of rebalancing the service

3 “Literature that has not been formally published in sources such as books or journal articles.” National institute of Health and Care Excellence (https://www.nice.org.uk/Glossary).
toward primary and community care\textsuperscript{4} away from secondary care and successive governments have introduced a series of different arrangements for the commissioning of services, such as GP fundholding, Family Health Service Authorities, local health authorities, primary care groups then trusts, and more recently clinical commissioning groups overseen by the NHS Commissioning Board established in October 2012.

Howarth et al (2006) undertook a systematic review to identify the education needs of the primary care workforce to promote integrated health and social care. They identified essential thematic elements needed for integrated care which included effective communication between professional groups within teams and an emphasis on role awareness. In addition, education about partnership working and gaining practice development and leadership skills through professional and personal development were also essential attributes. They concluded that education which embeds these essential attributes for integrated working is needed to advance inter-professional working. This was seen as involving the reinforcement of partnerships between higher education institutions and care organizations so as to ensure that the workforce is educated to manage continuous change in service delivery.

Commissioning Boards, as well as other commissioning bodies, were given duties to promote better integrated care in the Health and Social Care Act (2012). Lord Darzi’s NHS Next Stage Review (Department of Health, 2008) introduced the concept of integrated care organisations (ICOs)\textsuperscript{5}, various models of which were piloted across England. Some 16 initiatives were involved in this pilot called the ‘Pioneers Programme’ (NHS England, 2013) and each identified the main area or client group that would form the focus for integration\textsuperscript{6}. Islington CCG is listed on the NHS England website as a member of that programme:

Islington

Islington Clinical Commissioning Group and Islington Council are working together to ensure local patients benefit from better health outcomes. They are working with people to develop individual care plans, looking at their goals and wishes around care and incorporating this into how they receive care. They have already established an integrated care organisation at Whittington Health better aligning acute and community provision.

\textsuperscript{4} Many policy documents use the term ‘primary care’ to refer specifically to General Practice while ‘community care’ is often used to include community nursing and other services.

\textsuperscript{5} The Review sets out an intention to ‘provide more integrated services for patients by piloting new integrated care organisations (ICOs) bringing together health and social care professionals from a range of organisations – community services, hospitals, local authorities and others, depending on local needs. The aim of these ICOs will be to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices)’. (Page 56)

\textsuperscript{6} Other NHS sites in England not involved in the pilot also explored developing integration in healthcare or across health and social care (Lewis et al 2010)
Patients will benefit from having a single point of contact rather than dealing with different contacts, providing different services. Patients will feel better supported and listened to. (NHS England, 2013)

The 2014 Integrated Care Pioneer Programme Annual Report (NHS England, 2014) lists the Pioneer developments for Islington CCG as including: i) improving care pathways; ii) the CEPN; iii) integrated IT; iv) better understanding of patient journeys; v) integrated community ageing team; vi) integrated liaison and assessment team (mental health); vii) locality navigators; and viii) a proactive model of ambulatory care. One major strategy to help achieve this is the integration of care.

In 2014, the ‘enablers’ for these developments were cited as:

i) Three local IT solutions:
   a. Integrated digital care record
   b. Integration engine that will enable IT interoperability
   c. Person-held record

ii) Public and patient participation with a focus on overcoming barriers to access,

iii) Co-production of care plans, and feedback informing commissioning.

iv) Launch of Community Education Provider Network in April.


In 2012, the pilots were evaluated (RAND Europe and Ernst & Young 2012). It was shown that whilst staff perceived that ICOs improved care this was not supported by the evidence. Surveys of staff involved in those pilots revealed a sense of improved team working and better communication within and across their organizations. Many staff described their jobs as involving more responsibility, greater breadth and depth and having become more interesting. However, while staff identified a need for further training for their new roles, less than 30 per cent felt that they had increased support for training and some were critical of the lack of formal training. Staff training is therefore an important issue for the success of integration strategies.

---

7 The term “interoperability” is found within many NHS Islington CCG documents available in the public domain (e.g. see NHS Islington CCG Person Held Record and Interoperability Business Case 2014). It implies IT systems which can be accessed from different organisations and by different providers i.e. integrated systems. The NHS England (2014) publication also states that Islington CCG were “now at the point of commissioning this facility” i.e. commissioning the “integration engine” (NHS England 2014, p.49-50). For a brief report on plans for this scheme which allows all doctors and nurses to access and update patient records including patient self-access for controlling their own data, see The Commissioning Review (2014).
Ignatowicz et al (2014) evaluated the development of integrated care in North West London. It was reported that leaders and managers need to be aware of the impact of professional engagement, understand its value and drivers, and promote change in ways that appeal to care professionals, in order to advance the integrated care agenda.

A review of the NHS under the coalition government by The King's Fund (Ham et al, 2015) has recently showed that integrated care emerged as an explicit policy priority under the coalition reforms involving several new initiatives. First, statutory health and wellbeing boards were created to aid integration and collaboration yet their impact has varied. Second, the Integration Transformation Fund (renamed the Better Care Fund) was created with a pooled budget to increase integration between health and social care by reducing avoidable emergency admissions, facilitating data sharing, penalising delayed transfers of care and promoting seven day working, although its full impact will not be known until 2015/16 (Ham et al, 2015). Although Ham et al (2015) note the establishment of Health Education England as a ‘special health authority’, for the provision of national leadership in the training of the clinical workforce and to ensure adequate staff supply, they did not comment on its performance to date in relation to ICO workforce planning and workforce development.

**Community nurse recruitment**

Workforce planning in nursing is notoriously underdeveloped with a number of reports pointing to inadequate planning and strong variations in training numbers in response to short term economic influences. Reduction in numbers is often followed by recruitment drives for overseas-qualified nurses (Buchan et al, 2013). Recruiting to community roles has proved particularly difficult and highly problematic in the context of sustained policy emphasis on this sector of healthcare. For example, a target set for health visitor recruitment in 2011 has yet to be met, despite incentives (Department of Health, 2011, Whittaker et al 2013). Partly because of this difficulty and partly as a response to financial pressures, the community based nursing workforces of many NHS trusts feature a skill-mix light on district nurses and heavy on staff nurses without specialist practitioner qualifications and unqualified support roles (RCN, 2012).
The Local Integration Context

Community Education Provider Networks and ‘Super Hubs’

Many NHS organisations in London face the dual but interlinked challenges of attracting and retaining a suitable nursing workforce particularly in the community setting and equipping new and existing staff to work in roles characterised by integration and multidisciplinary working. To this end, the LETBs have a number of objectives which are aimed at facilitating education in community settings, recruitment to these settings and the development of a care workforce prepared (in both senses) to ‘rotate’ between hospital and community roles (HE NCEL, 2014, p8). There is a clear synergy to be had in how these imperatives are responded to as reflected in the above aims of the Islington CEPN Super Hub.

Whittington Health: an Integrated Care Organisation

Whittington Health was established on 1st April 2011 from the integration of The Whittington Hospital NHS Trust with the community health services of Islington and Haringey Primary Care Trusts and Islington Social Services. It comprised 4,237 staff (hospital 2,640, community 1597) and a budget of £273m (hospital £181m, community £92m), Whittington Health operates the 384 bed Whittington Hospital and 16 health centres across these boroughs.

In a strategic document concerning integrated care by the then Whittington Chief Executive (Koh 2011), the following imperatives were set out:

- Redefine the business around populations
- Organise high volume generic community services that are essential to the delivery of primary care around GP practices
- Integrate with social care
- Collaborate with other local healthcare providers
- Measure results to determine value
- Transform information sharing with GPs and patients
- Innovate to create new funding models and currencies (Koh, 2011, p 4)

To facilitate integration, the Whittington Health’s services were restructured in September 2011 into three broad areas:
Acute medicine and integrated care: this cares for adult patients in five pathways: urgent care, long term conditions, rehabilitation, prison healthcare and disease prevention and health promotion. The division is integrated with Islington adult social care and operates Whittington Health Integrated Care Strategy out of the hospital, health centres, GP surgeries and council buildings, as well as provides care in patients’ homes.

Women, children and families: this provides women’s health services, sexual health services, children’s services and includes population based disease prevention programmes. The division is integrated with Islington children’s social services and operates out of the hospital, health centres, children’s centres, GP surgeries and schools.

Surgery, diagnostics and cancer: this provides all surgery, investigations (including imaging and laboratory tests), intensive care and community dentistry. It coordinates cancer care across the trust.

Koh (2011) also set out a number of workforce changes that integration would enable. Among them was a new emphasis on teaching by collaborating with local universities to develop integrated care education and training programmes for undergraduates and postgraduates.

Islington experiences of integrated care & the Integrated Care Ageing Team 2015

Healthwatch Islington was commissioned by Islington CCG to undertake interviews with residents, relatives, carers and staff in local care homes (Healthwatch Islington 2015). The aim was to identify user experiences of the Integrated Care Ageing Team (ICAT) service and how residents (and where appropriate relatives/carers) had been involved in their treatment, and in conversations about their end of life care. It was reported that integration was working. Service users and relatives generally reported that the service had known who they were and that the service user’s story had not needed to be repeated. Nursing home staff also noted that the ICAT service had enabled them to provide a better service to the users (Healthwatch Islington 2015).

Islington Integrated Workforce Assessment Modelling (IWAM) 2015

Islington Integrated Workforce Assessment Modelling (IWAM) was commissioned by Islington CCG from Skills for Health in order to gather information on the health community for use with informing and preparing the future integrated workforce (Skills for Health 2015). There was agreement that re-designing current roles, not developing new ones, was the most effective way of enabling integrated working to progress. A paucity of ‘new roles’ were identified as not being consistently developed such as: i) the navigator role in Age UK, ii) assistant practitioners; iii)
advanced/specialist practitioners; and iv) apprenticeships. Further development of these roles was the preferred way forward. There was enthusiasm for joint learning in recognition that it provides opportunities for improving understanding of other roles and developing relationships. Several new ways of working were identified:

Multidisciplinary teams and interdisciplinary team working which reportedly were not ‘common’ practice so requiring further support and development.

Pathway working with several exemplars e.g. ‘outreach’, ‘in reach’ and or ‘following the person’ pathway approach which were also reportedly in need of further development.

Summary

i) Although integrated health and social care have long been goals of health and social care policy, the particular characteristics of workforce development, planning and learning and development within the newly emerging ICOs have not been robustly researched and the measures taken by ICOs to achieve the latter are not well known nor well understood within the literature.

ii) The ‘grey’ literature however does show some outputs related to such developments. The research-based literature suggests some essential attributes that are associated with the development of integrated care which include effective communication between professional groups within teams, role awareness, education about partnership working as well as practice development and leadership skills gained through professional/personal development.

iii) Research suggests that in order to drive forward the development of integrated care, leaders and managers need to be aware of the impact of professional engagement, understand its value and drivers, and promote change in ways that appeal to care professionals.

iv) Locally, re-designing current roles is viewed as the most effective way of enabling integrated working together with development of existing roles such as assistant practitioners, advanced/specialist practitioners and apprenticeship schemes. New ways of team working were locally identified as multidisciplinary and interdisciplinary together with different forms of pathway working.
EVALUATION DESIGN AND DATA COLLECTION

Approach

Our evaluation approach is similar to that of Pawson and Tilley called ‘realistic evaluation’ (Pawson and Tilley 1997). This approach assumes that material causal relationships emerge around new initiatives such as the CEPN and the Super Hub. It also assumes that local participants have special relevance for the successful implementation and evaluation of such initiatives. According to Pawson and Tilley (1997) this particular approach enables a particular focus on the real world links between context, mechanism and outcome.

The context for the Islington CEPN Super Hub includes those locally emerging conditions of relevance to the above aims of workforce learning and development. The mechanisms at play in the Super Hub include the local means by which those aims can be evidenced from within the existing human, fiscal and stakeholder resources, thereby creating new capacity, processes and relationships between stakeholders and providers. The outcomes comprise any emergent consequences arising in relation to these aims which may be anticipated or unanticipated. Our approach therefore views the aims of the Super Hub as a prospective and emergent programme, without stipulating any single outcome measure for assessing their success, evidenced from different forms of contextual evidence garnered from local respondents (Pawson and Tilley 1997).

Approval and access

Once funding for the project was confirmed in December 2014 we obtained ethics approval from the School of Health and Education at Middlesex University. After this we made application for institutional access and approval from Whittington Health and applied to the NHS Health Research Authority to classify the project as evaluation. The project was registered on Whittington Health’s Quality Improvement Project Register and a Data Processing Agreement was signed. We attended meetings of the CEPN from November 2014 onwards in order to become acquainted with the challenges and progress of the Super Hub and to start to make contact with potential informants.

Sample

The above realist approach was adopted using purposive sampling. A staff survey and in-depth interviews were used to collect quantitative and qualitative data on what is currently working. ‘Snowballing’ from key informants within the CEPN and Whittington Health and associated organisations was also used in order to identify informants for interviewing and surveying.
We undertook a 13-item electronic survey using Survey Monkey which was distributed to the following respondents identified to the project team by Islington CCG, Whittington Health and Islington CEPN (Super Hub Task and Finish Group):

i) District nurses, health visitors employed by Whittington Health (an integrated care organisation (ICO))

ii) Practice nurses and practice managers employed in Islington general practices;

iii) Care home managers employed in Islington care homes;

\[(i) + ii) + iii) = a total of two hundred and seventy-seven staff (n= 277)\]

iv) Thirty-six (n=36) pre-registration BSc Nursing students who had recently experienced clinical placements within Islington during 2014-15. Access to this sub-sample was facilitated through the membership of HENCEL’s project team for developing student placements in general practice (project leads: Kathy Wilson and Sinead Mehigan).

In total the survey population totalled three hundred and thirteen (n=313).

The survey items were developed to focus on the topic of working and learning in an integrated care environment. The interview schedules were developed for different work roles and areas in order to further explore the themes covered by the survey. The survey also asked respondents if they would like to volunteer for a short telephone interview (Appendix One).

In total, the electronic survey was distributed to the above sample seven times by electronic mail from Middlesex University to the sub-sample described in i)-iii)(above) over a period of eight weeks from February to March, 2015, on the following dates: 05/02/15; 10/02/15; 27/02/15; 04/03/15; 09/0315; 13/03/15 and on 23/03/15. The same survey was also distributed by electronic mail on April 1st 2015 to the sub-sample described in iv)(above).

The telephone interviews collected qualitative data. Both qualitative and quantitative data were collected through the use of Survey Monkey software. All of the data collection tools (interview prompts/survey items) were developed by the project team (Appendix 2).

The surveyed population and the interviewees received a Participant Information Sheet. Respondents gave informed consent by virtue of their receipt of the Participant Information Sheet and their agreement to participate in the study as stipulated by Middlesex University’s School of Health and Education Research Ethics Committee. The personal identities and institutional locations of the sample respondents were anonymised for the purposes of data processing, data storage, data analysis and report writing.

All telephone interviews were digitally recorded and transcribed verbatim. Telephone interviews were undertaken with a variety of staff of different skill levels and organisational grades involved in preceptorship, mentorship and integrated care pathways.
Data Analysis

Coding and thematic analysis of the qualitative interview data were completed using NVivo analytic software.

Data analysis of the survey data was completed using the analytic software available within Survey Monkey. Thematic analysis of the qualitative survey data used manual coding and sorting of data by themes.

The qualitative findings from the interview data are presented in narrative form. The quantitative findings are presented in tables. Both the quantitative and qualitative findings are synthesised in separate sections relating to each of the aims of the Super Hub evaluation (see ‘Aims’ above).

The workforce aims, mechanisms and outcomes relating to the Super Hub are then listed in a table at the end of each section. The evidence (verbatim/other sources) was assessed for all outcomes, which were labelled ‘reported’ in cases where outcome achievement was evident, and where not, ‘hypothetical’. A complete mapping of these workforce aims, mechanisms and outcomes is listed in a table at the end of the Findings.
Table 1. The work roles of the survey respondents.

<table>
<thead>
<tr>
<th>WORK ROLE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISTRICT NURSE</td>
<td>0</td>
</tr>
<tr>
<td>COMMUNITY MATRON</td>
<td>5</td>
</tr>
<tr>
<td>SPECIALIST NURSE</td>
<td>0</td>
</tr>
<tr>
<td>DISTRICT TEAM NURSE MANAGER</td>
<td>1</td>
</tr>
<tr>
<td>LEG ULCER CLINIC MANAGER</td>
<td>0</td>
</tr>
<tr>
<td>HEALTH VISITOR</td>
<td>2</td>
</tr>
<tr>
<td>STUDENT HEALTH VISITOR</td>
<td>0</td>
</tr>
<tr>
<td>HEALTH CARE ASSISTANT (Health Visiting)</td>
<td>1</td>
</tr>
<tr>
<td>SPECIALIST POST (Health Visiting)</td>
<td>1</td>
</tr>
<tr>
<td>LOCALITY MANAGER (Health Visiting)</td>
<td>3</td>
</tr>
<tr>
<td>FAMILY HEALTH ADVISOR (Health Visiting)</td>
<td>2</td>
</tr>
<tr>
<td>COMMUNITY STAFF NURSE (Health Visiting)</td>
<td>1</td>
</tr>
<tr>
<td>HEALTH VISITOR (Health Visiting)</td>
<td>1</td>
</tr>
<tr>
<td>PRACTICE MANAGER</td>
<td>4</td>
</tr>
<tr>
<td>PRACTICE NURSE</td>
<td>6</td>
</tr>
<tr>
<td>PRACTICE NURSE (Qualified mentor)</td>
<td>1</td>
</tr>
<tr>
<td>NURSING HOME MANAGER</td>
<td>1</td>
</tr>
<tr>
<td>IF OTHER* PLEASE SPECIFY</td>
<td>12</td>
</tr>
</tbody>
</table>

*Other work role: student nurse, administrator; staff nurse; nursing home manager team infant development manager; nursing development manager; adult nurse; manager; nurse practitioner; family health advisor; and health visiting manager.
Table 2. The work areas of the interviewees.

<table>
<thead>
<tr>
<th>ID</th>
<th>WORK AREA</th>
<th>DATE</th>
<th>LENGTH (MINS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WORKFORCE DEVELOPMENT</td>
<td>05/02/15</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>PALLIATIVE CARE MEDICINE</td>
<td>06/02/15</td>
<td>32</td>
</tr>
<tr>
<td>3</td>
<td>CLINICAL SKILLS EDUCATION</td>
<td>09/02/15</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>DISTRICT NURSING MANAGEMENT</td>
<td>11/02/15</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>MIDWIFERY PRACTICE DEVELOPMENT</td>
<td>11/02/15</td>
<td>38</td>
</tr>
<tr>
<td>6</td>
<td>CARE HOME COMMISSIONING</td>
<td>16/02/15</td>
<td>40</td>
</tr>
<tr>
<td>7</td>
<td>GENERAL PRACTICE MANAGEMENT</td>
<td>17/02/15</td>
<td>26</td>
</tr>
<tr>
<td>8</td>
<td>MIDWIFERY PRACTICE</td>
<td>17/02/15</td>
<td>21</td>
</tr>
<tr>
<td>9</td>
<td>PATIENT ADVICE AND LIAISON</td>
<td>24/02/15</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>MIDWIFERY PRACTICE</td>
<td>25/02/15</td>
<td>11</td>
</tr>
<tr>
<td>11</td>
<td>PRACTICE NURSING</td>
<td>05/03/15</td>
<td>23</td>
</tr>
<tr>
<td>12</td>
<td>HEALTH VISITING PRACTICE</td>
<td>09/03/15</td>
<td>14</td>
</tr>
<tr>
<td>13</td>
<td>GENERAL PRACTICE MANAGEMENT</td>
<td>10/03/15</td>
<td>40</td>
</tr>
<tr>
<td>14</td>
<td>SPECIALIST NURSING (ACUTE)</td>
<td>10/03/15</td>
<td>12</td>
</tr>
<tr>
<td>15</td>
<td>CLINICAL DEVELOPMENT MANAGEMENT</td>
<td>10/03/15</td>
<td>21</td>
</tr>
<tr>
<td>16</td>
<td>PRACTICE NURSING</td>
<td>13/03/15</td>
<td>17</td>
</tr>
<tr>
<td>17</td>
<td>EDUCATION CONSULTANCY</td>
<td>16/03/15</td>
<td>22</td>
</tr>
<tr>
<td>18</td>
<td>SPECIALIST NURSING (INPATIENT)</td>
<td>16/03/15</td>
<td>20</td>
</tr>
<tr>
<td>19</td>
<td>LOCALITY MANAGEMENT &amp; HEALTH VISITING PRACTICE</td>
<td>18/03/15</td>
<td>16</td>
</tr>
<tr>
<td>20</td>
<td>DISTRICT NURSING MANAGEMENT</td>
<td>25/03/15</td>
<td>20</td>
</tr>
<tr>
<td>21</td>
<td>STUDENT NURSING</td>
<td>22/04/15</td>
<td>20</td>
</tr>
</tbody>
</table>
FINDINGS

A total of forty-one (n=41) responses to the Survey Monkey questionnaire were received (Table 1). This represents an overall response rate of thirteen percent (n=41, 13.0%) for both sub-samples. Seven (n=7) survey respondents agreed to undertake a telephone interview.

During a seven week period from February-March 2015 in-depth telephone interviews were undertaken with twenty-one (n=21) respondents (Table 2). These included respondents from senior managerial positions within community nursing, midwifery, general practice, practice development, workforce development, education, medicine, patient advice/liaison and student nursing (cohort representation).

Seventeen (n=17) survey respondents said they were qualified mentors. One (n=1) respondent said they were both a qualified mentor and preceptor.

Survey respondents were asked to consider nine positive effects of working within an integrated care organisation (ICO) to which they could express strong to negative agreement on a five point Likert-type scale. Forty (n=40) responses were received (Table 3).

Overall, these respondents agreed and strongly agreed that working within an ICO had positive effects, with a higher order of agreement than strong agreement being expressed (Table 3). A similar high order of agreement/strong agreement was expressed for the view that working in an ICO would help respondents work more collaboratively with other healthcare professionals. The highest order of strong agreement was expressed for the view that working in an ICO would help respondents work more collaboratively with other healthcare professionals (n=18, 45%) and be valuable because they thought it will enable them to work with others in acute, community and primary care settings (n=15, 39%). The highest order of agreement was expressed for the view that working in an ICO would help respondents develop a flexible workforce who can work across primary, community and acute care (n=21, 54%). There was a lower order of uncertainty expressed about the same positive effects. Very few respondents (n=2) strongly agreed or agreed (n=3) that working within an ICO was too difficult to implement (Table 3).

Data analysis of the qualitative survey responses revealed four attributes of integrated working which respondents thought were of benefit to patients. Integrated working was seen as having the following attributes: ‘coordinated’, ‘on the same page’, ‘person centred’ and ‘streamlined information’ (Q9, Table 4).

Data analysis of qualitative survey responses revealed three factors which respondents thought of as enabling the delivery of integrated care: ‘wait and see..’, ‘effort and drive’ and ‘to help streamline’ (Q11, Table 5).
### Table 3. Working in an Integrated Care Organisation.

<table>
<thead>
<tr>
<th>Type of response to question: “Working within an integrated care organisation will...”</th>
<th>Strongly agree [%]</th>
<th>Agree [%]</th>
<th>Uncertain [%]</th>
<th>Disagree [%]</th>
<th>Strongly disagree [%]</th>
<th>Number of responses (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Help us to develop a flexible workforce who can work across primary / community / acute care</td>
<td>13 [33.0]</td>
<td>21 [54.0]</td>
<td>3 [8.0]</td>
<td>0 [0.0]</td>
<td>2 [5.0]</td>
<td>39</td>
</tr>
<tr>
<td>B. Help me to reappraise my way of doing things at work/give me new insights</td>
<td>12 [31.0]</td>
<td>17 [44.0]</td>
<td>9 [23.0]</td>
<td>1 [3.0]</td>
<td>0 [0.0]</td>
<td>39</td>
</tr>
<tr>
<td>C. Give me confidence in supporting service users.</td>
<td>13 [33.0]</td>
<td>18 [46.0]</td>
<td>5 [13.0]</td>
<td>3 [8.0]</td>
<td>0 [0.0]</td>
<td>39</td>
</tr>
<tr>
<td>D. Help me make changes in my workplace.</td>
<td>10 [26.0]</td>
<td>13 [34.0]</td>
<td>12 [32.0]</td>
<td>2 [5.0]</td>
<td>1 [3.0]</td>
<td>38</td>
</tr>
<tr>
<td>E. Help me work more collaboratively with other healthcare professionals.</td>
<td>18 [45.0]</td>
<td>19 [48.0]</td>
<td>2 [5.0]</td>
<td>1 [3.0]</td>
<td>0 [0.0]</td>
<td>40</td>
</tr>
<tr>
<td>F. Ensure that the learning needs of my area are identified and met by tailored education programmes</td>
<td>8 [21.0]</td>
<td>17 [44.0]</td>
<td>12 [31.0]</td>
<td>2 [5.0]</td>
<td>0 [0.0]</td>
<td>39</td>
</tr>
<tr>
<td>H. Be valuable because it enables me to work with others in acute / community / primary care settings.</td>
<td>15 [39.0]</td>
<td>17 [44.0]</td>
<td>6 [15.0]</td>
<td>1 [3.0]</td>
<td>0 [0.0]</td>
<td>39</td>
</tr>
<tr>
<td>I. Be too difficult to implement</td>
<td>2 [5.0]</td>
<td>3 [8.0]</td>
<td>13 [33.0]</td>
<td>18 [46.0]</td>
<td>3 [8.0]</td>
<td>39</td>
</tr>
</tbody>
</table>
Table 4. Attributes of integrated working of benefit to patients (n=32).

“Co-ordinated”
- Better access to services
- Timely co-ordinated efficient care
- More responsive, reliable, faster pathways
- One point of contact accessing multiple solutions
- Less stress. Pt happy coming to see P/N and G.P
- Continuity of care - care from home; seamless service
- Better support systems; time management; seen faster. More confidence in the system
- Professionals are working together rather than giving the families conflicting pieces of information
- Working all the same. Better communication between professionals and patients, able to support the family most effectively, early support, early intervention, identifying safeguarding concerns and able to act most effectively.

“On the same page...”
- Better quality if it works
- Provision of seamless care
- Continuous and better outcome
- Shorter waiting time. Personalise care
- Seamless service - information sharing
- Improved patient care and less duplication
- Improved outcomes as everyone is on the same page
- Many benefits, good speedy care delivered to the patient
- Reduced confusion over what data to share and what not to share.
- Care across depts./teams to give more holistic approach to patient care
- Less confusion when so many services are wanting to engage with them.
- Residents are able to be referred to and seen by specialist persons in the Community.
- A seamless service. Better support, better treatment by the right person at the right time.
- Best/ more efficient healthcare outcomes / Reduced rate of re-admission due to poor case management.
- Less duplication, easier to access services better communication and a more seamless pathway. These all lead to increased trust and faith in the service
- Patient/families have better outcomes, they become more independent and less reliant on public services.
- Better outcomes, a speedier service to get them back home quicker, which in turn will speed their recovery.

“Person centred”
- Gives patients maximum autonomy
- Person centred care with compassionate
- Patients feel more satisfied with their care
- Patients would be involved in their care and choices available to them
- Patients become focus point rather than then organisational boundaries
- Care can be focused on the needs of the patient rather than the needs of the organisation
- Feeling as though they have one person to help guide them through their journeys

“Streamlined information”
- Consistent information and support
- Not having to tell their story to many people
- Not having to repeat their story to everyone
- Effective communication - reduced mixed messages.
- Different disciplines having the same info - not acting without available knowledge
- Patients hopefully don't have to repeat themselves as people involved in their care would access their information and act on it as appropriate
- Streamlined information so that a patient doesn't have to repeat themselves and their history to each new professional they meet. If a change in a personal health/situation is identified by one professional, the most relevant person can be notified and action taken for the patient.

24
Table 5. Factors enabling the delivery of integrated care (n=15).

“*Wait and see…*”

Would have to have *some time* to communicate

Already *liaise very closely* with different services both acute and community social and health. However this is sometimes *difficult* due to differences in documentation process.

I think this is *"wait and see"* As I am no longer clinical, this question is best answered by *clinical and front-line staff*

“*Effort and drive, change*”

I want to *make changes*.

*Improving* the health of local people

Not extensive as *already working towards* an integrated care model

As this is very time consuming you would need to make *changes to diaries*.

The last 5 years have been an *ongoing change* - for examples organisations- service changes etc, very much more of the same namely changes.......  

All this takes *effort and drive, change is a good thing* with a common goal and each knowing their part and the scope and purpose of the outcome.

“*To help streamline*”

To *reduce bureaucracy*.

Working hours include *weekend working*  

The *pathway through secondary care needs to be slicker*.

To help *streamline my workload*; to focus on quality and safety.

To be able to *liaise with colleagues for a quicker better solution*.

*Access to services need to be quicker & easier*, with *patients taking more control* of their appointment maintenance
In the remainder of this section, data extracts from the survey and the interviews are presented using thematic headings related to the study aims.
Factors enabling transfer of nursing staff between sectors

Survey respondents identified working across sites, co-working from different locations, 24-hour working and roles (working) across boundaries as all facilitating integration of care (Q8) (Appendix 3).

One survey respondent referred directly to four specific developments which could be of potential value for enabling staff to mutually transfer between sectors:

- More opportunities for hospital staff to have opportunities to shadow and observe within the community environments so that we can learn from one another. Staff in higher positions being more visible on the ground level. Staff from community having opportunity to work in the hospital environment to share good practice. Opportunities to link with other professionals at away days, forums and training days. (Q6, emphasis added)

Another survey respondent also made reference to such initiatives in relation to making changes to their working life in order to deliver more integrated care:

- ROTATION. To work within another department, perhaps one day a week, to understand how it works and the challenges they face (Q8, emphasis original)

One interviewee shared their mixed experiences of ‘ redeployment of staff’ and a new rotational post covering acute and community areas:

- I’ve seen it work and I’ve seen it fail (...) So when we first became an ICO and staff had to, there was kind of redeployment of staff, some staff who came into the community (...) they it found quite difficult, quite challenging (...) they didn’t also appreciate things around safeguarding that you need to be aware of. So that’s perhaps a training and induction issue. But you just have to, it’s something to do with probably the art of nursing and just sensing when something is not quite right in the home, in an environment that you’re visiting. However on the flipside we have a rotational post now where it’s already been, well I suppose you come into the post knowing that you’ll be rotating between community, secondary care and probably GP practice. So you already have that mind set and that’s been working quite well with our current rotational post. I don’t know if, this may sound ageist but it’s a newly qualified much younger nurse that’s come into it now, very enthusiastic, coping very well, very open to new experiences. (p20)

The above view was resonated with another survey respondent/interviewee who was a student nurse and had completed an Islington community placement and was in a position to advance a composite view on behalf of other students. They reported that negative [territorial] attitudes were experienced as emanating from ‘older’ employees in relation to being a barrier to practicing cross-sector working, whereas ‘younger’ staff were experienced as being more flexible and happy to share knowledge/know how with others, including students. ‘Older’ and ‘younger’ were ambiguous terms, which were used alternately to refer to staff perceived of as being relatively advanced in age and/or had been in post for a longer time relative to others.
Community care was also viewed by this student respondent as an understaffed and under resourced sector thus making student placements somewhat disorganised. However, the independence of community work was seen as appealing to many students.

In relation to the pre-registration student nurses one interview participant (a registered nurse) suggested that it would be helpful for the integration of care if universities offering pre-registration education for health care staff refrained from, seemingly, promoting acute care before community care.

_I also think that universities sort of are still telling people that they need to do time in acute trusts when that’s not necessarily the case. (p1)_

The above quote indicates that the messages students receive from those associated with their undergraduate programmes e.g. mentors, peers etc. may shape decision-making over career choices.

In terms of the pre-registration nursing curriculum, there was reportedly very limited teaching on the merits of integrated working, and the understanding of integrated working instead was also reportedly developed mainly during placements as there seemed to be an assumption perceived by the above student respondent that pre-registration nursing students could ‘put two and two together’ and understand the value of integrated care from within the existing curriculum. For example, A&E was used by that student interviewee as an example where they had learned about liaison between specialties. Although integrated care was not a unitary focus _per se_ in specific taught modules, “crossing over and back” was experienced as an advantageous practice and the placement input received was seen as preparing students relatively well for that purpose.

However, another interviewee questioned whether it would be realistic to expect staff across the board to move back and forth between sectors:

_I think it would be very difficult (…) for [certain groups of community] staff to move back into the acute (…) I mean I suppose the thing that would hinder (transfer of staff from acute to community) it is that working in the community is very, very different to working in a hospital environment. In a community you are much more autonomous, you have to work independently, you have to, you don’t have, when you’re out visiting people’s homes, you don’t have that same sort of network around you. If you’ve identified a risk then you have to be risk assessing, it’s very different to, I think it’s a much more protective area in the hospital. So I think the skillsets are different, the skillset that staff would need in the community. (p12)_

Concern around perceived significant differences in cultures and skill sets between the acute and community sectors was a recurrent theme in the interview data although participants were positive in principle to nursing staff transferring between sectors. Acknowledgement of these differences and robust staff training and support to reflect this was seen as essential:
There are lots of training that need to be highlighted, it’s not straightforward because the community (…) they have got their policy, they have got their guidelines, they have got their way of working, whereas, in the hospital, it’s completely different, ……. there are lots of people around, the support network is very different so. (p3)

I think nurses need quite, a huge amount of support to do that [i. e. transfer] and I think it’s particularly around the understanding that you are predominantly on your own out in practice. You have to be able to make decisions on the hoof quickly. In addition you have to remember though that you work in a team and I think that is actually quite a difficult thing. It’s easy on a ward, you can see your team all around you, but I think a lot of the nurses new to community actually feel quite isolated and forget that they actually do work in a team and that that team actually sits in a wider multidisciplinary team (p4)

This participant suggested that forms of joint training could facilitate cross sector working.

Joint training, people training together, learning from each other, learning what their roles and responsibilities are, being clear about all those possibilities across different organisations, inter-organisational training. In order to create kind of and develop a common culture and language that is really, really important (p17)

The support needed also extends to emotional support and opportunities to reflect:

I think it is having, being able to come away and have that informal discussion in a safe area, where you can actually be quite honest. (p4)

Leadership was also recognised as an important factor for a successful transfer of staff between sectors:

Leadership can be a hindrance, but equally leadership is extremely important in terms of working across organisations you know in a positive way, if they are actually working together, leadership is really, really important. (p17)

When asked, interview participants enlarged on what they thought would facilitate transfer of current staff between the acute sector and community care as part of facilitating integration in the trust, and what the barriers may be. As well as training the main issues were considered to be at the individual level, such as, staff’s personal choices/interests, hours of work/shift patterns, childcare, financial impact and bad reputations attributed to some wards or teams:

Personal choice, I think some people prefer to work in acute settings. I mean, if you want to work in A & E, or ICU or theatres, then you want to work in
those areas. The hours of work, you know, if you can work three long days for childcare obviously, if you are in the community [you cannot do that] that has a financial impact (…) I think there’s reputation (…) that would impact on whether people would want to work on them [wards/areas] (…) You have to change the training anyway but you also have to recruit into these new posts so that you’re recruiting in people who are interested (…) You can’t force people to do stuff, it’s not going to help anybody (…) And there’s a lot of people who don’t like change. (p1)

The above participant discussed how it could be better to recruit new staff into new posts for transferring between sectors rather than ‘force’ reluctant staff to transfer. Another participant also discussed how new ‘blended roles’ could facilitate staff transfers within an integrated care setting going forward.

So the kind of aim for the future is to be able to create and at least look at the kind of possibility of creating blended roles in the health and social care sector (…) what kind of role would that be and how that would work across disciplines and that’s, I don’t know the true answer to that. We will have to test and see how that is going to work and the benefits and the added value and the kind of you know, whether it is something worthwhile doing or is it too hard, too difficult to do. (p17)

It was also seen as important that pre-registration nursing students be exposed to multifaceted experiences to increase a broader understanding of what it means to work in an integrated setting, and to motivate students to consider working across sectors.

For example looking at kind of student placements within GP practices, or around student nurses actually coming to placements within the district nursing team (…) the possibility of doing the placements more broadly in terms of community placements, rather than focusing on one part of the system or another, actually having the placements across different parts of our system. So that the students actually have a better understanding of a pathway if you like. So that they kind of understand and work with and are placed with district nursing teams, but also part of their community placement is in kind of GP practices and then they actually possibly have placements in voluntary sector organisations that are doing navigation for a pathway for example, etc… So what we would like to see is that people’s experiences are not limited to make them think that it is either one organisation or another, but to make them think of it broadly in terms of whichever organisations that they are going to be in the future working with, they still need to think in a much wider framework and understand what happens in the different parts of that really. (p17)

One participant felt that universities currently promote acute care for placements before other areas although this might not be justified.

I also think that universities sort of are still telling people that they need to do time in acute trusts when that’s not necessarily the case. (p1)
This interviewee summarised their view on the approach needed to facilitate cross sector working as three pronged: the interventions needed to support existing staff in transferring between sectors and also those needed for new staff and undergraduate students.

Three layers isn’t it, it’s like working longer term with the kind of undergraduate students and making sure that their understanding is an integrated understanding [“3rd layer”], rather than one professional, or one organisation kind of focus, understanding [“1st layer”]. Then the second layer is for those people who are going to be coming in new, put in the new job. So it’s new roles, those blended roles that we would kind of look at and look to create and look at whether this is something that is possible. (p17)

Based on the above, reported mechanisms and outcomes are listed below.

Table 6. Mechanisms enabling transfer of nursing staff between sectors.

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities for hospital staff to shadow and observe within the community environments to encourage mutual learning</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Senior staff visibility within localities</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Community staff offered work within the acute sector to share good practice.</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Opportunities to link with other professionals at away days, forums and training days</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Rotations within other departments to learn about working and the challenges faced</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Department of Integrated Care (A&amp;E) as a site for integrated learning</td>
<td>Reported</td>
</tr>
<tr>
<td>Sector-wide student placements between different community nurse disciplines e.g. practice nursing (general practice), district nursing, school nursing and health visiting.</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Three layered approach to promoting workforce integration: existing staff: personal choice as at i)-vii) (above) new blended roles for upcoming vacancies ensuring students’ understanding is integrated one rather than uniprofessional or un organisational in its focus</td>
<td>Hypothetical</td>
</tr>
</tbody>
</table>
Preceptorship and induction to support new RN’s moving into community roles

Preceptorship appears to be more or less structured or well-functioning depending on the sector with, for example, midwifery being well structured whereas it seems to have been more or less ‘lost’ in the community (see quote below). There is currently one ‘acute focused’ preceptorship covering both the acute and community sector which, however, does not sufficiently reflect the specific culture in the community. The difference between the sectors extends to different use of language (or discourse) which complicates integration and training, and this has been acknowledged in the quest to improve induction and preceptorship. For example, this interview participant:

There’s one preceptorship that would cover community and the acute. It may be more acute focused at the moment but that’s been acknowledged and will be changed (...) It’s just the wording of how you’re using terms. (p1)

Induction in community care has been redesigned to better reflect the needs of new staff and is expected to form part of an improved preceptorship for community nurses. For example, these interview participants:

The problem is as well that people are under such pressure that it’s been lost a little bit, the preceptorship and I don’t think it’s from people not wanting to do it, I think there’s always so much coming up (...) a shortage of mentors (...) actually, it’s always been thought of as being a more self-guided thing, preceptorship (...) in the community, I know we have this very clear competency booklet which actually, and we are starting to issue to people, which is a bit like your preceptor isn’t it? (p1)

I think before we get to the preceptorship, I think what we need to do is have more sign off students come to the community to spend longer periods of time in community, which we haven’t had for a while, but I think that’s something we need to look at, which would probably encourage them to want to work in the community afterwards. Then us really looking at building a strong programme to support them and to retain them once they come here, because it can be quite challenging. I will not try to soft soap that, it is challenging. (p 20)

In contrast, as stated, midwifery appears to have a relatively well structured induction and preceptorship programme, adapted to the needs of new midwives, as well as fostering a well-rounded workforce able to work in different practice areas. This preceptee midwife particularly valued the opportunity to acquire confidence during their preceptorship:

It’s [the preceptorship] almost giving you a protected period to build that confidence and I’ve found that the structure, the constant manager that you have, the study days specific to preceptees are all aimed to build your confidence, without somebody holding your hand the whole time (...) I don’t
need that, I just need all of these little things that will eventually build my own confidence. (p8)

In response to a question about how preceptorship programmes could support staff new to community nursing this interview participant suggests that they should:

“be meaningful; they’ve got to be clear about what their purpose is; and they’ve got to be followed by their trust and by the manager in the areas” (p1).

Participants also felt that preceptor programmes need to be tailored to reflect the particular needs of staff in the different areas.

I suppose the programme is [should be] designed for their [community nursing and general practice roles] particular area, their particular workloads, so everything needs to be orientated around their own workload areas, so the hospital have their own preceptorship powered to their hospital theme, so the acute side but the community would have a scheme tailored to the community side but everyone’s got different, although, yes, our main objective is to provide care, but there’s two different ways of providing it: in the community, they are normally more well; in the hospital, there’s more to do with the attitudes, on the (...) in the community, different, so I’m not too sure how to – everyone’s got their own pathways. (p.3)

Preceptor programmes need to allow time for reflection and pastoral support as well as clinical skills training.

We go and see them [the preceptees] and make sure that they are okay and we have a very much open door policy that they can come and discuss any problems or queries with us. (p5)

Although interview participants did not discuss apprenticeships per se, however the following interviewee called attention to the value of skilled health care assistants (HCAs). HCAs were seen as having potential once suitably skilled to meet the heterogeneous needs of the residents so mitigating the need to call outs, for instance, from a district nurse:

So if there is no need for the district nurse to go to residential floors because the healthcare support workers can be trained to do that, then that means, that’s one less you know disjointed care (p 6)

The reason participants did not directly discuss apprenticeships might be because they are not aware of apprenticeships within the health care pathway in their organisation and/or because participants were uncertain about its relevance. However, as noted above particular were aware of their learning and development needs, an awareness which may be applicable to apprenticeships. For example, participants discussed the importance of well-structured and tailored preceptorships that respect super numeracy status together with ensuring the availability of pastoral
support; and how preceptorships need to be meaningful and purposeful. This participant further suggested:

*They've [preceptorships] got to be meaningful; they've got to be clear about what their purpose is; and they've got to be followed by their trust and by the manager in the areas because I think, often, that's the problem as well that people are under such pressure.* (P1)

As also suggested in the above quote, a theme running through the interview data is the generally perceived lack of time and resources, including perceived time deficits for different staff categories to engage with, and mentor, students and new comers of different descriptions in nursing, midwifery and medicine especially in General Practice (GP) settings. This is likely to affect apprenticeships as well given that apprentices need and are entitled to robust support. These participants talked about the daily pressures staff are under and how this can affect the quality of mentoring and support given to students and new staff.

*There’s a sense that everything is just added on and added on and added on.* (p2)

*I think I can see the pressures on both sides: I can see the pressures on managers and mentors in day to day working but I can also see from the new starters’ perspectives, that it’s difficult; they’ve also got lots of pressures.* (p1)

This interviewee also points out that to give students and new staff members a good experience takes time and effort.

*You can give a shoddy experience but if you want to give a good experience then actually that takes time.* (p7)

Although mainly positive, interviewees also found issues in integrated care complex as discussed elsewhere which is bound to have an impact on students and new staff such as apprentices. One participant underlined the difficulties for junior staff in, for instance, networking within an integrated care context which is essential for good patient outcomes in this setting.

*The kind of feedback we’re getting from like junior staff is possibly not fully understanding how that network works and even to the point of recognising resources within their own teams, to get that network to work, if that makes sense. So it’s a lack of awareness I suppose.* (p4)
Based on the above, reported mechanisms and outcomes are listed below:

Table 7. Mechanisms for preceptorship and induction to support new RN's moving into community roles.

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Reported Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured and tailored preceptorship programmes in acute and community sectors using competency booklet involving reflection, support and clinical skills training</td>
<td>Reported/Hypothetical</td>
</tr>
<tr>
<td>More sign off students (i.e. final year of degree programme) coming into the primary and community sector to promote new RN recruitment into those sectors</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Applying learning from sectors where preceptorship is structurally embedded (e.g. midwifery preceptorship reportedly works) - learning to build preceptees’ confidence</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Maximising the network for integrated care by developing preceptees’ understanding of the available resources</td>
<td>Hypothetical</td>
</tr>
</tbody>
</table>
Primary/secondary care relations and developing supported patient journeys.

Survey respondents volunteered a variety of views on the perceived efficacy of the current relations between primary/secondary care within community services, and even whether primary/secondary integration was even desirable. For example:

- More effective links with GP practice, schools, nursery, other health visiting teams within both Islington and Haringey (Q7) (Appendix 4)

- Separate community services from acute services - completely different ways of working. (Q6) (Appendix 5)

The concept of ‘integrated care’ was perceived structurally in two ways by survey respondents:

- working in unison together across all fields, organisations and multi-professional boundaries to provide consistent, evidence-based care and information (Q3);

and:

- integration of services and organisations in order to provide a more co-ordinated approach that meets the needs of individual patients to provide a seamless service focused on the patients’ need rather than organisational structures (Q3).

Integrated care is also seen by survey respondents as utilising the range of skill mix and services in order to create a smooth pathway for patient outcomes. It is thought to need joined up infrastructures, where IT systems can transfer patient information records between services for all disciplines (Q3).

Survey respondents also advised generally that their organisation could improve integrated care by having better IT systems, more equitable HR processes and less bureaucratic pathways (Q6). For example:

- IT systems that can work with each other. Electronic transfer of records/letters/discharge summaries/referrals...to include confirmation of receipt. Book hospital clinic appointments direct from GP practice. Access to medical records to be able to see the pathway of the patient, what has happened to date, to be able to make more informed choices (Q6, original verbatim)

- Review all pathways to cut out needless bureaucracy and duplication of roles - this is cheaper than to introduce yet another IT system (Q6) (Appendix 5)

The process of change was seen as by one survey respondent as extending beyond professional groups and requiring attention to language:
To facilitate the understanding of integrated care and what an integrated care organisation is amongst front line staff, by ensuring front line staff are including in discussions and simple language is used (Q6)

Interview participants discussed their conceptual understanding and experience of integrated care in the trust as well as other related experiences from health care settings. They saw integrated care as complex, albeit positive. Similar to the survey respondents, interview participants differentiated between an ‘integrated care organisation’ and ‘integrated care’, the latter being perceived as a wider concept also encompassing, for example, social services and the voluntary sector.

This was similarly reflected in the survey respondents’ detailed identification of the different types of integrated care pathways spanning a mixed economy of providers, which they access from their own practice areas. For example:

Health and education (children centres, nurseries etc.) health and health (school nursing / midwifery) health and social care (social services) health and CCG (GP’s) health and voluntary agencies (SOLACE/ Maya8)(Q5)

However, one survey respondent reported that accessing pathways may be experienced as a complex, uncertain and time consuming process, which can also be dependent upon one provider:

Social care referrals and section 47 in the main. Section 17 is not effective because we do not get the data from social care - hit and miss. Accepted eCAF9 referrals to children’s centres for family support workers - but this incurs a time consuming eCAF referral in the first instance to see if it can be accepted. Community nursing team Speech and language Community PEADSICOPE CAMHS Pathways to GPs is dependent on the GP practice. (Q5)

Most interview participants did not discuss details around integrated care which may reflect that it is viewed as a complex concept; and that perhaps options for integrated care are still in the process of being explored and implemented as indicated by these participants:

It’s [integrated care] all new and we don’t quite know what that means really, I mean you known it’s a buzzword (p 13)

The community and the hospital do work closer and we get in touch more [across areas], but it hasn’t come together completely (…) there are lots of training that need to be highlighted, it’s not straightforward. (p3)

---

8 Solace Women’s Aid offers support: for women affected by domestic and sexual violence. Maya Centre offers free counselling and group therapy for women on low incomes. Solace/Maya, The Peel Centre, Percy Circus, London WC1X 9EY. Website: http://www.peel institute.org.uk/

9 The online Common Assessment Framework (eCAF) enables practitioners to share complex information about children securely across agencies
We seem to be very distinct still, very separate and again there can be a real lack of information across from secondary care to us [in the community]. (p 11)

The lack of details in participants’ accounts could also mean that staff may presently find it difficult to fully understand their roles in relation to integrated care. Only interview participants from midwifery and health visiting seemed to have a relatively clear and detailed understanding of integrated care relating to their area; however this may be a reflection of midwifery and health visiting being clearly defined areas of practice traditionally accustomed to an integrated way of working.

One [non midwifery] participant, alluding to the complexities involved, opined that:

*Integrated care means so many different things to different people in different contexts. (*) Hopefully, most of the time, we provide something that doesn’t duplicate but doesn’t let patients fall through the gaps of different organisations. (p2)*

One reason that integrated care has yet to be implemented, according to this interviewee from the community sector, is that ward staff do not fully understand the roles of staff in the community. Specialist nurses, however, are seen as possessing a greater understanding and providing a good link between acute and community sectors for the benefit of service users.

*I think most of us in the community have worked in hospitals even if it was some time ago and so we’ve seen the kind of acute side and therefore the long term care, what you’re trying to avoid is emergency admissions, these acute episodes or the level of deterioration is kind of obvious and so you work kind of back from there. But I think sometimes the other way round, I’m not always sure that secondary care [general ward staff] realises about the sort of long term every day care out there and support the patients need. So I think they are very good at sorting out a problem, the person is here for 2 weeks and we’ve sorted their diabetes out (...) I think the people who are very good actually are the specialist nurses (...) they seem to have more of a link and I think some of them have been, have moved from community back to secondary and some from secondary care, there seems much more of a link. (p 11)*

There is also a lack of awareness in secondary care around what ‘what care homes can or cannot do’ (p 6) affecting patient care. Some complexities such as the complex information interface (c.f. above), according to the above participant, are particularly exacerbated in London, given the often intricate organisational structures, city size and the fluidity of its population.

Interview participants debated factors they regard as important for efficient and integrated working around service users. These can be viewed in terms of different levels i.e. individual/personal levels, local/group levels, organisational levels and pre-registration level.
At the individual and group level it was seen as important and facilitating to be able to form personal relationships and ‘network’ with colleagues in different areas and to “put faces to names”, and ideally, to have physical proximity to colleagues (p4). Moreover, to make an effort to understand colleagues’ roles in their respective organisations and to embrace partnership/team working was considered essential. Particularly junior staff can sometimes find it hard to understand how their network functions and/or how to recognise resources even within their own teams. This is exemplified by one participant:

Junior staff is possibly not fully understanding how that network works (…) predominantly through a lack of awareness of actually, what’s available and how to access that (…) So, yeah for me I think it is proximity and familiarity, that is what breaks the boundaries down (…) I think it’s understanding each other’s role isn’t it and what each other brings. (p4)

Personal accountability was seen by this interview participant as important to ensure seamless patient care in an integrated setting:

I think [it] is about people taking responsibility for whatever flags up when they see a patient and, even if it’s not their job to do about seeing it through, for that to be properly handed over (…) the temptation to think is, oh, I can’t sort that out, and then it doesn’t go any further and that’s really frustrating for patients. (p2)

At the organisational level it was suggested by the following interview participant that communication and efficient systems for communication are important and that the lack of them can be a major barrier for efficient integrated care within and across organisations:

Nobody’s computer system talks to anybody else’s computer system (…) It’s the information interface as patients go from one [area] to the other that’s really challenging and I think it’s about being able to get information rapidly from one place to another, but, at the same time, knowing that it’s going to be received by the right person. (p2)

It was also suggested by one participant that technology is under used:

What if we could do that [personal development] via Webinar’s or video conferencing so people don’t have to leave their base, I think that’s something. I think yes we could [use] IT more. (p 20)

Finally, exemplified by this interviewees, working in an integrated way across sectors requires ‘buy in’ from individual members of staff across the board; in the first quote the discussion is around general practices, some of whom were perceived to be good at collaborating with other teams, and others less so.

Some GPs are absolutely excellent at liaising with us [a specialist team] and working together and we build up a relationship with them and they know that if we phone and say, this needs to be done today, that we mean it needs to be done today and they know we wouldn’t ask if it didn’t. And, equally, they will do what they can but they will phone for help and to discuss things and you sort of get that positive side of everything working together. Other GPs at the
other end of spectrum – there are one or two who [are less helpful] (...) that’s an example that springs to mind of the opposite of integrated working and I think, in terms of training, it’s almost kind of training together to understand about shared responsibility, rather than it being, you know, it’s either your job or my job; it requires actually both of us contributing what we can and having a bit of give and take (...) It’s a combination of attitude and behaviour (...) the fact that some GPs can do it and make it work, makes you feel that the ones who don’t, it’s a lack of willingness rather than impossibility…

.. I do think the smaller your GP practice, the harder it is to be working with lots of other teams, cause if there’s only one or two of you, it must sometimes feel that you’re being bombarded by other teams who want to chat about this, that and the other and I suspect that GPs feel that every specialist team thinks their patients are the most important and they’re the ones left trying to juggle so I think there is something about capacity for GPs, particularly the ones who are either single handed or in very small practices and I guess some of that is systems, but there is something about attitudes and behaviour. (p2)

The interviewee in the quote below also talks about attitudes in terms of ‘goodwill’:

Well what you have I think in cases is what appear to be set in stone, ‘oh no I don’t do this, or I do, do that’ without people being willing and there’s good will when you get together and saying well you know would it be better for this person to do that (...) there’s always flexibility in blurring the boundaries, as long as there’s the good will.

.. Once you get people together in a room, yes you do get resistance, but the resistance tends to break down in my experience (...) it’s about changing the culture you know, changing the ‘well we’ve always done this and they’ve always done that,’ whatever that is and looking at saying well who should be doing this, who is best to do it, what is the best pathway through this for the patient. (p 16)
Based on the above, reported mechanisms and outcomes are listed below:

Table 8. Mechanisms operating in primary-secondary care relations and for developing supported patient journeys.

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interfacing information technology systems</td>
<td>Interoperability</td>
</tr>
<tr>
<td></td>
<td>planned\textsuperscript{10}</td>
</tr>
<tr>
<td>Electronic record transferral.</td>
<td>Interoperability</td>
</tr>
<tr>
<td></td>
<td>planned</td>
</tr>
<tr>
<td>Booking secondary care appointments from general practice</td>
<td>Interoperability</td>
</tr>
<tr>
<td></td>
<td>planned</td>
</tr>
<tr>
<td>Accessing medical records to pathway/activity for choices</td>
<td>Interoperability</td>
</tr>
<tr>
<td></td>
<td>planned</td>
</tr>
<tr>
<td>Reviewing pathways to increase efficiency</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Learning with general practice to share care</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>(capacity/systems/attitudes)</td>
<td></td>
</tr>
<tr>
<td>Taking responsibility for care requirements and handing</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>over</td>
<td></td>
</tr>
<tr>
<td>Specialist nurse conduit between sectors</td>
<td>Hypothetical</td>
</tr>
</tbody>
</table>

\textsuperscript{10} The term “interoperability” is found within many NHS Islington CCG documents available in the public domain (e.g. see NHS Islington CCG Person Held Record and Interoperability Business Case 2014). It implies IT systems which can be accessed from different organisations and by different providers i.e. integrated systems. The NHS England (2014) publication also states that Islington CCG were “now at the point of commissioning this facility” i.e. commissioning the “integration engine” (NHS England 2014, p.49-50). For a brief report on plans for this scheme which allows all doctors and nurses to access and update patient records including patient self-access for controlling their own data, see The Commissioning Review (2014).
Quality assuring the practice learning experience

Survey participants viewed learning and development as essential in order to fully implement integrated care (Appendix 6). Many survey respondents associated integrated care with optimum practice-based multi-professional learning (Appendix 6). For example:

*To train and develop all staff in the same way, to high standards* (Q3)

*Education, social care and health working alongside one another* (Q3)

Some interviewees had no experience of multi professional training whereas some experienced it ‘all the time’ depending on area of work. These participants explained about experiences of multi professional training within specialist nursing and health visiting:

*We do it [multi professional training] all the time (...) We have advanced personal development training for all staff, which is looking at self-care managed models for patients and that’s been a culture roll out throughout the organisation, that’s everybody. We look at, I mean within the specialisms there’s ongoing specific team development every week, every week which is either case specific or subject specific and those sessions are open to wider disciplines if it’s appropriate* (p 14)

*I think it’s [multi professional training] really important to, because you get kind of different perspectives of you know other people’s jobs, their learnings and where they’re coming from and yeah I think it’s very good for networking and cross sort of community and hospital (...) Mostly, my professions are mostly, well actually in the community we do stuff with like children centre workers, like GPs, the um, you know at the hospital obviously there’s lots of other nurses from different sorts of wards and then you know doctors come in as well. So actually we’re quite lucky where we sit because we do the cross, we see quite a lot of, because although we are nurses, you know we’re all nurses by background, we also do a lot of the community stuff as well. So we get to work with lots, not just sort of Whittington organisations, but you know the other local authority ones as well. (p 19)*

Survey respondents associated the phenomenon of integrated care with essential learning and perceived multiple benefits to patient care (Q3).

One survey respondent advised on promoting optimum mentorship in working contexts that were perceived as remote and heterogeneous:

*Better mentorship in general practice- as isolated area of nursing generally, with big differences in standards* (Q6)
Similarly, interview participants viewed learning and development as essential. They discussed this in response to questions around preceptorship and induction but issues around learning and development were also articulated unprompted, which emphasises the importance attributed to those particular issues.

Nevertheless, specific practice learning to purposefully facilitate integrated care and transfer of staff between areas was also seen as difficult to implement and embodying complexity, especially given the different working cultures and networks within acute care and community care:

*The community (…) they have got their policy, they have their guidelines, they have got their way of working whereas, in the hospital, it's completely different (…) there are lots of people around, the support network is very different so, it's a difficult one.* (p3)

Interviewees also emphasised the importance of meaningful training this particular participant not seeing e-learning as meaningful but rather a ‘tick box exercise’. In response to a question relating to which kind of training would support transfer of staff between sectors this participant replied:

*Not e-learning. (Laughs) (…) I think we’re very overwhelmed with e-learning and I don’t feel that, you know often e-learning is more about a tick box exercise rather than actually about the learning of the staff (…) yeah because e-learning you know it fulfils the criteria of the organisation sort of I guess targets, but it’s not necessarily, it’s not necessarily the right thing for nurses and you know, nursing and sort of our jobs is very practical and sitting in front of a computer ticking boxes to say that yes you’ve completed a certain amount of e-learning isn’t particularly beneficial to, you know it fulfils the criteria, but it doesn’t, it’s not necessarily beneficial to the actual individual.* (p 19)

Interview participants also discussed learning and development in the context of future skill mix, costs and limited resources, this participant arguing in relation to specialist nursing that:

*We do need to revisit the education and training for, particularly specialist nurses because we really haven’t got the quality and competence for specialist nurses to recruit from that we used to have (…) we need to invest in it and we need to look at the education providers and the providers of healthcare as to what the future skill mix needs to be developed towards. What outcomes, what patient outcomes are we going to be required to be contracted to deliver and therefore what skills do we need to do that.* (p 14)

The following participant discussed how training/placements for nurses in primary care are costly albeit desirable:

*But actually if it’s costing you [placements for nurses], you think well I know this is good but actually we can’t afford to do it (…) an admin person has got to sit there and do the timetable and liaise with the district nurses, the health*
visitors, to actually see whether they’re available when you’re doing the timetable. It’s very much like doing the medical students timetable. And we worked out how long that took and actually Practices have stopped taking, some Practices have stopped taking medical students from some medical schools because some medical schools pay better than others (...) So and you know it’s awful to say it’s about money, but actually Practices have to survive and we can’t afford … you know Practices can’t necessarily afford the luxury of doing it for nothing. (p 7)

This participant also suggested that nurses are undervalued in primary care and that a reluctance to invest in training for nurses in primary care reflects this:

It seems that nurses are the poor relation and actually in primary care, nurses play a huge role in managing patient’s long term conditions and managing them well so that the patient stays out of hospital. It’s also to help with prevention so they play an enormous part and it seems that there isn’t enough, it isn’t thought of quite in the same way (...) It’s almost disrespectful to nurses (…) and that would be my biggest thing. You know it is wanted, it is needed, but actually please respect the nurses that we’ve got and the fact that we want to bring some new blood into the system and you know they’ve got to be looked after. (p 7)

Based on the above, reported mechanisms and outcomes are listed below:

**Table 9. Mechanisms relating to quality assuring the practice learning experience.**

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi professional training and advancing personal development learning focusing on self-care managed models for patients</td>
<td>Reported</td>
</tr>
<tr>
<td>Within specialism specific team development and/or case specific and/or subject specific open to wider disciplines</td>
<td>Reported</td>
</tr>
<tr>
<td>Revisiting learning and development needs of specialist nurses to invest in with education/healthcare providers</td>
<td>Hypothetical.</td>
</tr>
<tr>
<td>Succession planning in general practice</td>
<td>Hypothetical</td>
</tr>
</tbody>
</table>
Approaches and recommendations for sustainable practice based learning for community nurses.

Survey respondents reported that various sources of digital information were accessed from the workplace.

Table 10. Sources of digital clinical information accessible from the workplace (n=36).

<table>
<thead>
<tr>
<th>Sources of digital clinical information</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whittington Library</td>
<td>47.2%</td>
<td>17</td>
</tr>
<tr>
<td>Google</td>
<td>94.4%</td>
<td>34</td>
</tr>
<tr>
<td>Cochrane Library</td>
<td>13.9%</td>
<td>5</td>
</tr>
<tr>
<td>National Institute of Health Care Excellence</td>
<td>77.8%</td>
<td>28</td>
</tr>
<tr>
<td>University Library</td>
<td>19.4%</td>
<td>7</td>
</tr>
<tr>
<td>Royal College of Nursing</td>
<td>44.4%</td>
<td>16</td>
</tr>
<tr>
<td>Dr Foster</td>
<td>2.8%</td>
<td>1</td>
</tr>
<tr>
<td>EBSCOHOST</td>
<td>5.6%</td>
<td>2</td>
</tr>
<tr>
<td>*Other</td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>

*=Mentor EMC ; Internet; NHS Athens; MEDLINE/British Nursing Index; BNF; iHV

This finding tentatively suggests that the Islington Super Hub is enabling Islington-based nurses to access information.

The advice which survey respondents would give to their own practice is to improve integrated care included: nurses’ awareness of integrated care and the meaning of an integrated care organisation; innovation; investment; more equity in nursing status and voice requiring more nurse leadership, especially in general practice, reduce workload and the containment of change (Q7, Appendix 4).

One survey respondent referred to one of the above themes, specifically in relation to the developments in, meaning of and changes happening viz a viz integrated care:

For Nurses to be more aware of the developments in integrated care, more aware of what it means to be part of an integrated care organisation and the changes happening within primary care and the community in general (Q7, emphasis added)

One respondent also articulated particular views on organisational culture, and how the type of culture may require reallocation of the traditional leadership role in order to enable the potential of particular staff groups seen as critical for developing integrated care:

Treat nursing staff as equals and valuable team members who have a voice and would be pivotal in promoting an integrated service. There is not enough leadership in nursing particularly within a general practice set up. This set up is traditionally run by Dr's who employ support staff and therefore the leadership role tends to be within the doctors domain (Q7)
The above quote also appears to suggest that leadership within particular staff groups may be a key element in the development of integrated care.

Most interview participants seemed to equate an integrated care organisation with “joint working between the community and the hospital” (p4), a close link which was seen as positive. This way of looking at integrated care broadly fits with the survey findings (Q3) which suggest that integrated care is perceived by respondents as working across as well as within organisations or both (Q3).

One interview participant also emphasised the importance of making an effort to understand colleagues and their roles in other areas:

> I think there are also a lot of people working in secondary care who have absolutely no idea what it’s like working in community! And, again, that’s probably not their fault, they’ve probably just never done it (…) it’s just the way the system works in terms of exposure and understanding. (p2)

Based on the above, reported mechanisms and outcomes are listed below:

**Table 11. Mechanisms relating to sustaining practice based learning for community nurses.**

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to digital information</td>
<td>Reported</td>
</tr>
<tr>
<td>Nurse leadership in general practice</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Nursing awareness of integrated care</td>
<td>Reported</td>
</tr>
</tbody>
</table>
Approaches to locality-based multi-professional education.

Survey respondents identified a range of care pathways which were ostensibly used and accessed from their own practice areas. For example:

- COPD CORE teams (Whittington Health; District Nursing Teams with embedded Community Matrons)
- Joint health and social care assessments working relationships with: Palliative Care, District Nursing, Social Services, Acute Team (hospital referrals and discharge planning)
- Midwifery, CAMHS, community children’s nurse, dietician, family support workers- multiagency meetings GPs - GP liaison meetings, speech and language therapists audiology- new born hearing screening, clinical psychologists, Children Centres, Social Workers
- Anti-coagulation Clinic (general practice based)
- Smoking cessation, diabetes, MDT meetings and teleconferences with e.g. D/Ns, community matrons and others.
- Consultant Geriatrician Specialist Pharmacist Reach Team
- Infant feeding
- Test and Learn for the CCG IHCT agenda
- Cross audiology pathways.
- Child Health; Management LTC; Mental Health
- HV-community health services-hospital-GP-Children’s services-schools-social care
- Community/district nursing/ambulatory care/physio/dietitian/mental health.
- COPD Palliative care Diabetes (new service for T2DM)
- Social care referrals and section 47 in the main. Section 17
- eCAF\textsuperscript{11} referrals
- Speech and language
- Community PEADSICOPE
- Health and voluntary agencies ( SOLACE/ Maya )
- Islington safeguarding children, Islington council, hospital and community pathways
- Antenatal - draft only

Although the above pathways were identifiable by survey respondents, confusion was also reported over the essential terminology of what constitutes a ‘pathway’ or an ‘integrated pathway’, suggesting further areas for learning and development:

*There are several, however I am not clear about what defines a “pathway” and which of our pathways are “integrated care pathways (Q5)*

The above quote suggests that further community focussed multi-professional education could be organised around the both the terminology and the identified care pathways currently being utilised.

\textsuperscript{11} The online Common Assessment Framework (eCAF) enables practitioners to share complex information about children securely across agencies
Survey participants also articulated how an integrated team approach helps learning by training/learning together across the organisation, understanding each other’s roles, expertise and perspectives (Q10).

One survey respondent thought that an integrated team approach demonstrates an interest in developing staff and processes in a systematic way, helping retention and attraction of a better calibre of staff (Q10)(Appendix 6).

The interview data show that there is a perception that the presumed benefits of integrated care have yet to fully trickle down to service users with inefficient communication between hospital sections as well as lack of joined up services generally (e.g. in relation to primary care and social services) remaining important concerns for service users and carers.

For example, one interview participant referred to recent guidelines for multi-professional working not having been fully implemented.

*Unfortunately I don’t think that we have achieved exactly what the changes in the guidelines wanted us to as yet (p9)*

Based on the above, reported mechanisms and outcomes are listed below:

**Table 12. Reported mechanisms related to locality-based multi-professional education.**

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>System-wide access to Pathways of Care from the workplace</td>
<td>Reported</td>
</tr>
<tr>
<td>System-wide multi-professional awareness of integrated care terminology and specific care pathways</td>
<td>Hypothetical</td>
</tr>
</tbody>
</table>
Student nurse placements and mentorship capacity in community settings.

Criteria

All Registered Nurses may be seen as potential nurse mentors, given that the Code of Conduct published by the nursing regulator, the Nursing and Midwifery Council (NMC), states in Clause 9:

9. Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, **you must:**

9.4 support students’ and colleagues’ learning to help them develop their professional competence and confidence (NMC, 2015, emphasis added)

The above wording heavily suggests that supporting student learning is a mandatory or essential role for all Registered Nurses.

Existing Capacity

Pre-registration and post-registration student nursing placements are offered to London South Bank University in community nursing (district nursing and health visiting) and in the acute services based in Whittington Health.

Pre-registration student nursing placements are offered to Middlesex University students in the acute services based within Whittington Health.

Post-registration placements are reportedly offered to City University London students in practice nursing which have traditionally been unavailable to many undergraduate nursing students. However, the availability of undergraduate nurse placements in primary care is limited\(^\text{12}\) and as yet cannot fully utilise the existing and growing capacity to mentor undergraduates (see below). This due the difficulty with freeing up capacity in primary care to release mentors (NHS England, 2014).

Potential Capacity

Although difficult to enforce, the ubiquity of the nurse mentor role may become an issue with the implementation of revalidation (King’s College London, 2014) from April 2016 (NMC 2015). Furthermore, the *Shape of Caring Review* (Willis, 2015) suggests that general practice and primary care are major areas for imminent

---

workforce developments, such that, any further revision of the educational tariff paid in support of practice learning should consider future funding arrangements to provide better financial support to mentors (p.48).

The Pilot Project for Developing Placements for Student Nurses in General Practice, funded by HENCEL (‘The Pilot’) was developed with local stakeholders, which include Islington CEPN linked to Middlesex University London. Across the HENCEL area there are similar CEPN-HEI links:

- Newham CEPN (City University London);
- Tower Hamlets CEPN (City University London);
- Waltham Forest CEPN (London Southbank University).

The Pilot aims to develop and sustain placement capacity in General Practices (GPs) for student nurses from the four local HEIs by instituting quality processes to increase placement capacity in order to enhance the professional development of practice nurses as well as promote general practice nursing as a favourable future career choice for student nurses.

Data provided by Islington CCG\(^\text{13}\) confirms that there in the order of seventy (n=70) practice nurses within the Islington CCG area, nineteen (n=19) of which have completed some form of mentorship qualification funded by the NHS; eighteen (n=18) of which work in general practices. The latter represents a sizeable mentoring capacity for the purpose of providing student placements.

Efforts are underway to update the registered nursing workforce within Islington general practice so that they are fully able to mentor undergraduate student nurses. By May 2015, a total of eleven (n=11) registered nurses working in Islington general practice will have undertaken learning and development to be able to competently mentor undergraduate nursing students, which is 58.0% of the total number of qualified nurse mentors.

**Table 13. Mentor updates in Islington general practice.**

<table>
<thead>
<tr>
<th>Date</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>06.02.15</td>
<td>Andover Medical Centre</td>
</tr>
<tr>
<td>17.02.15</td>
<td>Highbury Grange Medical Practice</td>
</tr>
<tr>
<td>17.02.15</td>
<td>Highbury Grange Medical Practice</td>
</tr>
<tr>
<td>19.02.14</td>
<td>Pine Street Medical Practice</td>
</tr>
<tr>
<td>27.02.15</td>
<td>Amwell Group Practice</td>
</tr>
<tr>
<td>12.02.15</td>
<td>St John’s Way Medical Centre</td>
</tr>
<tr>
<td>12.02.15</td>
<td>St John’s Way Medical Centre</td>
</tr>
<tr>
<td>06.03.15</td>
<td>River Place Group Practice</td>
</tr>
<tr>
<td>16.04.15</td>
<td>Holloway Road Medical Centre</td>
</tr>
<tr>
<td>21.05.15</td>
<td>Elizabeth Avenue Group Practice</td>
</tr>
<tr>
<td>26.05.15</td>
<td>Clerkenwell Medical Practice</td>
</tr>
</tbody>
</table>

Source: Middlesex University London, School of Health and Education.

\(^{13}\) Source: Islington CCG, April 2015.
Student Experience

The composite student nurse experience reported above relates to attitudes to integrated working and viewing the independence of community work appealing for many students. The staff view reported above (and repeated below) underlines the importance of what students should be told about the career possibilities in primary care:

*also think that universities sort of are still telling people that they need to do time in acute trusts when that’s not necessarily the case. (p1)*

Based on the above, reported mechanisms and outcomes are listed below:

Table 14. Reported mechanisms related to student nurse placements and mentorship capacity in community settings.

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Policy: Pilot Project for Developing Placements for Student Nurses in General Practice</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>National Policy: Shape of Caring Review</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Mentor preparation</td>
<td>Reported</td>
</tr>
</tbody>
</table>

The above mechanisms and outcomes for each aim of the Super Hub are listed below.
<table>
<thead>
<tr>
<th>Aims</th>
<th>Mechanisms</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| 1. The enabling factors for the transfer of nursing staff between sectors. | • Opportunities for hospital staff to shadow and observe within the community environments to encourage mutual learning  
• Senior staff visibility within localities | Hypothetical     |
|                                                                      | • Community staff offered work within the acute sector to share good practice.  
• Opportunities to link with other professionals at away days, forums and training days  
• Rotations within other departments to learn about working and the challenges faced  
• Department of Integrated Care (A&E) as a site for integrated learning | Hypothetical     |
|                                                                      | • Sector-wide student placements between different community nurse disciplines e.g. practice nursing (general practice), district nursing, school nursing and health visiting. | Hypothetical     |
|                                                                      | • Three layered approach to promoting workforce integration:  
  • existing staff: personal choice as at i)-vii) (above)  
  • new blended roles for upcoming vacancies  
  • ensuring students’ understanding is integrated one rather than uni-professional or uni-organisational in its focus | Hypothetical     |
<table>
<thead>
<tr>
<th>Aims</th>
<th>Mechanisms</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. The current preceptorship and induction (formal/informal) programmes which support newly registered nurses moving into community roles on registration.</td>
<td>Structured and tailored preceptorship programmes in acute and community sectors using competency booklet involving reflection, support and clinical skills training</td>
<td>Reported/ Hypothetical</td>
</tr>
<tr>
<td></td>
<td>More sign off students (i.e. final year of degree programme) coming into the primary and community sector to promote new RN recruitment into those sectors</td>
<td>Hypothetical</td>
</tr>
<tr>
<td></td>
<td>Applying learning from sectors where preceptorship is structurally embedded (e.g. midwifery)- learning to build preceptees confidence</td>
<td>Hypothetical</td>
</tr>
<tr>
<td></td>
<td>Maximising the network for integrated care by developing preceptees' understanding of the available resources</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>3. The current relations between primary/secondary care in order to both strengthen relationships between sectors and the core training needed for hospital-based nurses to support patient journeys.</td>
<td>Interfacing information technology systems</td>
<td>Interoperability planned</td>
</tr>
<tr>
<td></td>
<td>Electronic record transferral.</td>
<td>Interoperability planned</td>
</tr>
<tr>
<td></td>
<td>Booking secondary care appointments from general practice</td>
<td>Interoperability planned</td>
</tr>
<tr>
<td></td>
<td>Accessing medical records to pathway/activity for choices</td>
<td>Interoperability planned</td>
</tr>
<tr>
<td></td>
<td>Reviewing pathways to increase efficiency</td>
<td>Hypothetical</td>
</tr>
<tr>
<td></td>
<td>Learning with general practice to share care (capacity/systems/attitudes)</td>
<td>Hypothetical</td>
</tr>
<tr>
<td></td>
<td>Taking responsibility for care requirements and handing over</td>
<td>Hypothetical</td>
</tr>
<tr>
<td></td>
<td>Specialist nurse conduit between sectors</td>
<td>Hypothetical</td>
</tr>
<tr>
<td>Aims</td>
<td>Mechanisms</td>
<td>Outcomes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
</tbody>
</table>
| 4. The practice learning experience of a representative sample of community nurses such as specialist practitioners (district nurses/health visitors); non-specialist practitioners; and health care assistants in order to ensure community nurses in training have an excellent practice learning experience. | Multi professional training and advancing personal development learning focusing on self-care managed models for patients  
Within specialism specific team development and/or case specific and/or subject specific open to wider disciplines  
Revisiting learning and development needs of specialist nurses to invest in with education/healthcare providers  
Succession planning in general practice | Reported    | Reported | Hypothetical |
| 5. The current approaches used or recommended to build sustainable approaches to practice based learning for enhanced community nursing learning/development. | Access to digital information  
Nurse leadership in general practice  
Nursing awareness of integrated care | Reported    | Hypothetical | Reported |
| 6. The current approaches to multi-professional education across all localities which contribute to establishing robust community focussed multi-professional collaborative educational approaches across Islington for the benefit of patients and population health. | System-wide access to Pathways of Care from the workplace  
System-wide multi-professional awareness of integrated care terminology and specific care pathways | Reported    | Hypothetical | |
| 7. The number/type of student nurse placements in community settings in order to help increase mentorship capacity in community settings. | Local Policy: Pilot Project for Developing Placements for Student Nurses in General Practice  
National Policy: Shape of Caring Review  
Mentor preparation | Hypothetical | Hypothetical | Reported |
DISCUSSION

Staff agreed that working within an ICO had positive effects, helps collaborative inter-professional working and enables professionals to work with others across all care settings. Respondents further agreed that working in an ICO would help develop a flexible workforce who can work across primary, community and acute care.

The four attributes of integrated working which staff reported to be benefit to patients are concerned with being ‘coordinated’, ‘on the same page’, ‘person centred’ and ‘streamlined’. The three actions enabling integrated care delivery were to: ‘wait and see...’; [have] ‘effort and drive’ and ‘help streamline’.

A range of specific mechanisms and outcomes were identified with facilitating: i) the transfer of staff between sectors; ii) optimum preceptorship and mentorship; iii) the relations of primary to secondary care; iv) the practice learning experience; and v) multi-professional learning and development.

A mapping of aims, mechanisms and outcomes for workforce development and planning emerged from our data which are of prospective utility for CEPN members. In addition, it was suggested that there could be more harmonisation and tailoring of preceptorship initiatives between acute, primary care and community sites and community focussed multi-professional education could be organised around the both the terminology of and the identified care pathways are reportedly being utilised.

Research suggests that in order to drive forward the development of integrated care, leaders and managers need to be aware of the impact of professional engagement, understand its value and drivers, and promote change in ways that appeal to care professionals. There was evidence of the latter in our data, for example, in terms of engagement, the importance of understanding staff motivations and the need to have staff ‘on board’ for organisational developments.

In terms of redesigning current roles, our data also suggests a tripartite workforce development and planning approach which could include the employment of rotational staff. Blended or rotational roles also featured in our data alongside more robust learning and development for existing staff in context of due consideration of personal choices, given that in reality many staff choose where to work based on individual concerns and material circumstances, such that, efforts perceived of as being coercive by mandating staff flow may be counterproductive by increasing staff reluctance or ‘development fatigue’ and thus decreasing the quality of care delivered.

Therefore, the local mechanisms which are perceived of as enabling the transfer of staff between sectors appear to be a balance between those which are structural (organisational or systemic) and those which are personal. For example, whilst many identifiable patterns of working (e.g. ‘rotation’, ‘shadowing’ etc.) are perhaps salient issues for organisational management to ensure (or contractually enforce), there are also the impacts of particular issues surrounding personal choice which operate at a micro-level inside organisations, powerfully guiding individuals’ decision-making, and are reflective of other factors which are perhaps more difficult to quantify, guide and control (e.g. preferences, perceptions etc.).
Furthermore, it may be considered more beneficial in terms of resource management to recruit new staff into new posts which allow for flexible transference between sectors rather than ‘force’ reluctant staff to transfer as suggested by some of our data concerning the ‘age’ of employees. Another suggested beneficial development is for the creation of new ‘blended roles’ that could facilitate staff transfers within an integrated care setting across Care Pathways. This resonates historically with previous workforce development initiatives such as the 1990’s development of flexible workforce in day surgery where the desire was to create a seamless flow of staff between the necessary sites, such as wards, anaesthetics, theatres and recovery, and for which, not all employees exhibited the appropriate aptitude nor the requisite interest (Audit Commission 2001). Similarly, any prospective development in this vein should learn from such experiences, where arguments were based on whether staff would become “jack of all trades”, with little expertise but exhibiting an essential mix of skills in each area. It may be important to recognise how some day surgery units have since reverted to relatively non-flexible staffing.

The mechanisms which are locally perceived of as impacting on preceptorship and induction for promoting newly qualified nurses moving into out of hospital roles, include the strategic development of specific preceptorship which uses language (or discourse) more tailored to those target roles; as well the influential messages students receive from peers/mentors in their undergraduate programmes. There are additional mechanisms such as ensuring preceptorship is organisationally embedded and auditable, workforce capacity and the deployment of protected time. The tailoring of these processes may be significant, both to the individual and to the provider organisation, in terms of measurable outcomes for particular groups of patients and service users.

Multiple factors are perceived of as relating to the primary/secondary care interface and for supporting patient journey. A well-developed theoretical understanding of integrated care has been identified as existing whereby the essential concept appears to be well understood, especially how integrated care is a concept that is variably applicable across organisations, staff groups and patient populations.

However, some uncertainty was expressed over what actually constitutes a ‘pathway’ or an ‘integrated pathway’ and evidence of integration at a micro-level is developmental with midwifery practice appearing to operationally embed the concept. Specific factors identified include the accessibility of the various IT systems across organisations/sectors.

Post-registration placements are being offered to City University London students in practice nursing which have traditionally been unavailable to many undergraduate nursing students, although their availability in primary care is limited and cannot fully utilise the existing capacity for mentoring undergraduates. This due the difficulty with freeing up capacity in primary care to release mentors (NHS England, 2014). However, whilst these capacity issues are material factors weighing against placement provision it is well understood that flexible solutions need to be found locally in order to address the ageing workforce in primary care and to expose students to the advantages of working in primary and community care as it is unclear what students know about the value of these opportunities. However, it has been suggested that prospectively these welcome developments could be realised
through such prospective initiatives as GP-federations or further working alliances between practices that may help to free up mentoring capacity\textsuperscript{14}.

The government funds and promotes apprenticeships as a way of providing training and qualifications for primarily young people (16-24) and urges organisations to engage with young people to offer them ‘on-the-job-learning’. As a consequence, The National Health Service (NHS) is establishing apprenticeship schemes at three different levels which may also facilitate for successful applicants to forge a future career in nursing (Royal College of Nursing, 2015). Apprentices within the health care pathway normally work as healthcare support workers or health care assistants (Skills Funding Agency 2012). Health Education North Central and East London (HENCEL) has produced a tool kit to guide employers (Health Education North Central and East London (HENCEL)) and a framework for good quality apprenticeships has been developed by Unionlearn to ensure that apprentices get the full benefit of the training. The framework, for instance, highlights that apprentices should receive fair pay and treatment and that the employer provide a structured programme of training, mentoring and robust support (Unionlearn, 2013). Of relevance to the apprenticeship initiatives is that our data underlines the importance of well-structured and tailored preceptorships that respect super numeracy status together with ensuring the availability of pastoral support; and how such preceptorship needs to be perceived of as being meaningful and purposeful to those recipients (see also Department of Health, 2010). Similarly, Unionlearn has produced a framework for apprenticeships as mentioned above (Unionlearn, 2013) and locally a successful bid for the Greater London Apprenticeship funding was put together and submitted as a partnership initiative between the London Borough of Islington, Communities Into Training and Employment (CITE), Forest Home Care and the Islington CEPN.

\textsuperscript{14} These issues were addressed in depth at a recent NHS Islington CCG staff symposium entitled “Addressing Challenges in General Practice Nurse Workforce Development”, Thursday 23rd April 2015, Laycock Professional Development Centre, London N1.
RECOMMENDATIONS

The evidence suggests that CEPN members should:

1. Consider prioritising within their own provider organisation specific workforce development mechanisms and outcomes mapped by this evaluation.

2. Discuss the feasibility of adopting a workforce development and planning model which has a tripartite focus that:
   
a) ensures students, preceptees and mentees understand integrated working;

b) offers new recruits blended roles so that new opportunities can be created which precipitate integrated working;

c) offers existing professional and support staff a range of incentives to undertake rotational and/or blended roles.

3. Undertake a feasibility exercise on the potential utility of making new posts more flexible through the developing rotational and/or blended roles

4. Support the creation of blended or rotational roles through learning and development and by creating local incentives.

5. Develop more robust support for the learning and development of existing staff roles based on consideration of personal choice and role preferences.

6. Develop prospective job advertisements, job role descriptors and job interview schedules which explicitly include employee preparedness to undertake work across the range of provider sites and/or within/across Care Pathways.

7. Higher Education Institutions, providers and commissioners should collaborate in order to provide students with experience of integrated Care Pathways using inter-organisational and inter-sectoral placements which further develops student appreciation of the value of primary and community care including general practice.

8. Organise tailored multi-professional education on the terminology and the nature of existing Care Pathways.

9. Locally tailor existing learning and development to include diverse content and narratives from multi-disciplinary practice.
10. Higher Education Institutions, care providers and commissioners should collaborate in order to create interventions which effectively:

a) Dispel myths which may mislead students that they need to work within the acute sector;

b) Demonstrate how specialist nurses link different sectors and sites within Care Pathways to optimise patient outcomes
LIMITATIONS

The study was limited by the need to access settings that are geographically dispersed and by the need to sample ‘hard-to-reach’ sub-populations with busy work schedules and mixed priorities. The low response rate of the staff survey was a limitation indicating that engagement by the sample with the survey was problematic for several reasons, which possibly included their awareness of the CEPN, perceptions of priorities, workloads, survey fatigue and other unknown factors. The response rate improves when the staff sub sample is considered separately. For example, the response rate of the staff sub sample rises to 15.0% (n=41). Conversely, snowball interviewing proceeded smoothly. The time frame for undertaking the study was a limitation given the necessary requirements for gaining institutional access and contracting for data processing. However, these limitations were offset by the workings of the project team, who were geographically distributed across different institutions, and the local knowledge given to the project team by members of the CEPN Super Hub Task and Finish Group as well as the survey respondents and interviewees.
REFERENCES


Buchan J, Seccombe I, O’May F (2013) Safe staffing levels – a national imperative
The UK nursing labour market review 2013. London: Royal College of London

Department of Health (2010) Preceptorship Framework for newly registered Nurses,
Midwives and Allied health Professionals. Retrieved from

Department of Health (2011) Health Visitor Implementation Plan 2011-15 A Call to


Health Education North Central and East London (HENCEL). Apprenticeships,
[online], available:https://ncel.hee.nhs.uk/our-work/apprenticeships/

Health Education North Central and East London (2012) Nursing and Midwifery

Healthwatch Islington (2015) Islington experiences of integrated care and the
Integrated Care Ageing Team. London: Healthwatch Islington.

literature review. Journal of Advanced Nursing 56(2), 144–156.

provider engagement: providers’ perceptions of implementing and delivering

Health.

King’s College London (2014) Sustaining and assuring the quality of student nurse
mentorship: what are the challenges? Policy plus evidence, issues and
opinions in healthcare. 43, June.

organisations in the English NHS? King’s Fund and Nuffield Trust, London:
Nuffield Trust.


NHS Islington CCG Person Held Record and Interoperability Business Case 2014


Nursing and Midwifery Council (2015b) What revalidation is and when it will begin. London: Nursing and Midwifery Council.


Unionlearn. 2013. Charter for Apprenticeships, [online], available: https://www.unionlearn.org.uk/charter-apprenticeships


62
Appendix 1. Survey Monkey Questionnaire.

WORKING AND LEARNING WITHIN AN INTEGRATED CARE ENVIRONMENT

1. Please tell us your job title

2. Are you a qualified mentor/preceptor?

3. What do you understand by the term integrated care?

4. Working within an integrated care organisation will.....
   (Please select ONE option that best describes your experience)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Help us to develop a flexible workforce who can work across primary / community / acute care</td>
<td>A. Help us to develop a flexible workforce who can work across primary / community / acute care</td>
<td>A. Help us to develop a flexible workforce who can work across primary / community / acute care</td>
<td>A. Help us to develop a flexible workforce who can work across primary / community / acute care</td>
<td>A. Help us to develop a flexible workforce who can work across primary / community / acute care</td>
</tr>
<tr>
<td>B. Help me to reappraise my way of doing things at work/give me new insights</td>
<td>B. Help me to reappraise my way of doing things at work/give me new insights</td>
<td>B. Help me to reappraise my way of doing things at work/give me new insights</td>
<td>B. Help me to reappraise my way of doing things at work/give me new insights</td>
<td>B. Help me to reappraise my way of doing things at work/give me new insights</td>
</tr>
<tr>
<td>C. Give me confidence in supporting service users.</td>
<td>C. Give me confidence in supporting service users.</td>
<td>C. Give me confidence in supporting service users.</td>
<td>C. Give me confidence in supporting service users.</td>
<td>C. Give me confidence in supporting service users.</td>
</tr>
<tr>
<td>D. Help me make changes in my workplace.</td>
<td>D. Help me make changes in my workplace.</td>
<td>D. Help me make changes in my workplace.</td>
<td>D. Help me make changes in my workplace.</td>
<td>D. Help me make changes in my workplace.</td>
</tr>
<tr>
<td>E. Help me work more collaboratively with other healthcare professionals.</td>
<td>E. Help me work more collaboratively with other healthcare professionals.</td>
<td>E. Help me work more collaboratively with other healthcare professionals.</td>
<td>E. Help me work more collaboratively with other healthcare professionals.</td>
<td>E. Help me work more collaboratively with other healthcare professionals.</td>
</tr>
<tr>
<td>F. Ensure that the learning needs of my area are identified and met by tailored education programmes</td>
<td>F. Ensure that the learning needs of my area are identified and met by tailored education programmes</td>
<td>F. Ensure that the learning needs of my area are identified and met by tailored education programmes</td>
<td>F. Ensure that the learning needs of my area are identified and met by tailored education programmes</td>
<td>F. Ensure that the learning needs of my area are identified and met by tailored education programmes</td>
</tr>
<tr>
<td>G. Meet my expectations about providing integrated care to service users.</td>
<td>G. Meet my expectations about providing integrated care to service users.</td>
<td>G. Meet my expectations about providing integrated care to service users.</td>
<td>G. Meet my expectations about providing integrated care to service users.</td>
<td>G. Meet my expectations about providing integrated care to service users.</td>
</tr>
<tr>
<td>H. Be valuable because it enables me to work with others in acute / community / primary care settings.</td>
<td>H. Be valuable because it enables me to work with others in acute / community / primary care settings.</td>
<td>H. Be valuable because it enables me to work with others in acute / community / primary care settings.</td>
<td>H. Be valuable because it enables me to work with others in acute / community / primary care settings.</td>
<td>H. Be valuable because it enables me to work with others in acute / community / primary care settings.</td>
</tr>
<tr>
<td>I. Be too difficult to implement</td>
<td>I. Be too difficult to implement</td>
<td>I. Be too difficult to implement</td>
<td>I. Be too difficult to implement</td>
<td>I. Be too difficult to implement</td>
</tr>
</tbody>
</table>
5. How many types of integrated care pathways are used / accessed in your area of practice and what are they?

6. What one piece of advice would you give your organisation to improve integration of care?

7. What one piece of advice would you give to your own area of practice, to improve integration of care?

8. If you have to make changes to your working life in order to deliver more integrated care, please describe what these changes will be:

9. What are the benefits to patients of integrated working?

10. How does an integrated team approach help learning?

11. If you do not have to make any changes to your working life in order to deliver more integrated care, please explain why this might be:

12. What sources of digital clinical information can you access from your workplace? (Please tick all that apply)

13. Would you be interested in undertaking a short telephone interview?
Appendix 2. Interview Topic Guides.

**Topic Guide 1 for managers of preceptorship and induction programmes**

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained), consent

Can you please tell me about your job?
Probes: work title, area of work, a typical day/week, highlights, challenges

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?
Probes: your views, Positives, negatives

Could you talk about how preceptorship and induction are currently organised for nursing staff in relation to primary and secondary care in your Integrated Care Organisation (ICO)?
Probes: In general terms, examples, gaps, positive and/or negative experiences

Could you tell me about the uptake of preceptorship and induction in the past 6 months or so?
Probes: numbers, grades, sense of interest/engagement among nursing staff

What, in your view, helps or hinders transfer of nursing staff between sectors?
Probes: Recent examples/experiences, what helps, what hinders

How do you think preceptor programmes can best support newly registered nurses to move into community nursing and general practice roles?
Probes: think of recent and/or memorable examples in terms of challenges and what worked

Is there anything else you would like to add?

**Topic Guide 2 for nursing staff who have participated in training to facilitate cross sector working**

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained), consent

Can you please tell me about your job?
Probes: work title, area of work, band, years of nursing experience, a typical day/week, highlights, challenges

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?
Probes: your views, Positives, negatives

What, in your view, helps or hinders cross sector working/role change?
Probes: helps, hinders, think of recent and/or memorable examples of patient journey[s]

What kind of training/support do you think nurses need who move from secondary to primary care?
Probes: learning/training needs, other support
What kind of training/support do you think nurses need who work within care pathways linking primary/secondary care?
Probes: learning/training needs, other support, the ‘seamless patient journey’
Could you talk about your training and in what ways it may have had an impact on your day to day practice?
Probes: examples

Is there anything else you would like to add?

**Topic Guide 3 for primary care managers**

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained), consent

Can you please tell me about your job?
Probes: work title, a typical day/week, highlights, challenges

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?
Probes: your views, Positives, negatives

Could you talk about the range of primary care organisations involved in the Whittington Health ICO?
Probes: GPs, Ambulatory Care Centre

What do you think about the relationship between these primary care organisations and secondary care?
Probes: what helps, what hinders, positive or negative examples in relation to patient pathways

What kind of support do you think nursing staff and support workers need in this area to enable ‘seamless patient journeys’?
Probes: learning/training needs, other support

Is there anything else you would like to add?

**Topic Guide 4 for PALS**

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained – may be particularly important due to the nature of PALS work and this one participant who could possibly be identified), consent

Can you please tell me about your job?
Probes: work title, a typical day/week, highlights, challenges

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?
Probes: your views, Positives, negatives

Could you talk about service users’ experiences of integrated care across primary and secondary care?
Probes: Complaints, common issues/problems, comparison with prior to introduction of ICO if possible, positive/negative experiences, recent and/or memorable examples of patient journeys
How do you perceive the experiences of staff with regard to integrated care across primary and secondary care?
Probes: do staff talk about this, do staff seek your advice/support, in relation to what

What helps or hinders effective patient pathways in your view?
Probes: staff training, other support, staff motivation, work loads

Is there anything else you would like to add?

Topic Guide 5 for community based nurses re practiced based learning

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained), consent

Can you please tell me about your job?
Probes: work title, band, years of nursing experience, a typical day/week, highlights, challenges

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?
Probes: your views, Positives, negatives

What are your experiences of practice based learning?
Probes: what does practice based learning mean to you, have you had any experience of practice based learning

Can you talk about approaches to practice based learning you are aware of in your work place?
Probes: e. g. individually tailored degree programmes, work based learning programmes, work based learning modules

What, in your view, helps or hinders practice based learning?
Probes: increased work pressures, motivation, commitment, support, resources

Is there anything else you would like to add?

Topic guide 6 for nurses who have experience of multi professional training

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained), consent

Can you please tell me about your job?
Probes: work title, area of work, band, years of nursing experience, a typical day/week, highlights, challenges

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?
Probes: your views, Positives, negatives

Can you talk about your experiences of multi professional training?  
Probes: exemplify different participating professions, describe the training briefly, pros and cons of the training for local purposes, how has it had an impact on your practice, would you recommend it to local colleagues

Is there anything else you would like to add?

**Topic Guide 7 for students around cross sector working during community based placements**

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained), consent

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?  
Probes: your views, Positives, negatives

Can you tell me about your experiences in different settings in relation to cross sector working?  
Probes: what settings, length of placements, own experiences of cross sector working, how were you introduced to this way of working, own views on cross sector working, what works and/or what does not work, own support from where

Is there anything else you would like to add?

**Topic Guide 8 for medical staff**

Intro
Brief thank you and introduction, have you had an opportunity to read the information sheet, any questions before we start, agree to audio record (confidentiality explained), consent

Can you please tell me about your job?  
Probes: work title, a typical day/week, highlights, challenges

What does ‘integrated care’ and ‘integrated care organisation’ mean to you?  
Probes: your views, Positives, negatives

Could you talk about your experience of integrated care in the Whittington Health ICO?  
Probes: the relationship between secondary care and primary care organisations, collaborations with different groups of staff, professional roles, what helps, what hinders, positive or negative examples in relation to patient pathways

What kind of support do you think [different groups of] staff need in this area to enable ‘seamless patient journeys’?  
Probes: learning/training needs for medical, nursing staff and support workers, other support

Is there anything else you would like to add?
Appendix 3. Changes needed to working life in order to deliver more integrated care (n=23).

Organisational changes

- Roles across organisational boundaries
- Cluster more disciplines in the same office space
- To deliver fully integrated care might require 24 hour working
- Due to the nature of working life - would adapt to the ongoing changes
- Flexibility to attend participating groups outside of normal working hours
- Already making changes - have taken extra roles to support integrated care
- More time as it takes a lot to be able to get hold of other professionals and due to many of the services having different systems this adds to the challenges.
- Children's centres family support workers to be based in health visiting teams as health visiting is the outreach team.
- ROTATION. To work within another department, perhaps one day a week, to understand how it works and the challenges they face.
- Work across sites within both Islington and Haringey. Spending time days split between different areas such as within children's centres, based at GP practices etc.
- Co working so Health visitors have space to work from Children's Centres

Communication

- Understanding the roles of other members better. Improve communication
- Continue trying to improve communication within multidisciplinary team, primary and secondary prevention sectors.

Delegation

- Will need to delegate some hands on care to others to allow time for coordination of care. This will need a recognition by my managers that our busyness is not measured by how many patients we actually visit

Miscellaneous

- Less paperwork
- Do not be scared with changes
- Reduced workload, more admin support, retain staff we employ
Appendix 4. Advice to practice area for improving care integration (n=30).

Communication
- More regular meetings between IFCs to coordinate
- Meet members of the MDT face to face to build relationships
- Early communication and sharing contact details with all health professionals
- More effective links with GP practice, schools, nursery, other health visiting teams within both Islington and Haringey
- Respecting all involved with care, sharing information and communicating effectively
- Working together to improve experience of patients and service users
- Regular open meetings where all members of staff can air/discuss topics. Already good atmosphere and open conversation at present
- Hang in there, communication will improve and we won’t need to spend as much time chasing others
- Efficient communication within multidisciplinary team. Accurate complete records. Take individual responsibility to promote integration of care.
- Realise that by joint problem solving better outcomes can be achieved; look outward Hold more MDTs
- Liaise with the clients GP to streamline referrals to be made to avoid duplication. Copy in clients GP when making a referral.

Human Resource Management
- Reduced workload
- More staff and time to run clinics
- To 'contain' the number of changes, affects staff morale and productivity
- With more staff it will give practitioners more time to be able to liaise with other professionals
- Support front line staff with dedicated admin support or increase frontline staff numbers (or both)
- Acknowledgement for the increased number of roles colleagues and peers have taken on
- Respecting all involved with care, sharing information and communicating effectively

Information Management
- Less paper and computer work
- Access all that is available to improve care.
- Better sharing of information through IT systems.

Leadership
- Treat nursing staff as equals and valuable team members who have a voice and would be pivotal in promoting an integrated service. There is not enough leadership in nursing particularly within a general practice set up. This set up is traditionally run by Dr's who employ support staff and therefore the leadership role tends to be within the doctors domain.

Learning and development
- Be receptive of changes.
- Continue testing new approaches across health and social care organisations
- For Nurses to be more aware of the developments in integrated care, more aware of what it means to be part of an integrated care organisation and the changes happening within primary care and the community in general
Appendix 5. Organisational advice to improve care integration (n=33).

Co-Location
- Teams should sit together, share caseloads regularly discuss and decide care together
- Some face to face integration- good communication never goes out of fashion or does it?
- More opportunities for hospital staff to have opportunities to shadow and observe within the community environments so that we can learn from one another. Staff in higher positions being more visible on the ground level. Staff from community having opportunity to work in the hospital environment to share good practice. Opportunities to link with other professionals at away days, forums and training days.

Communication
- Quality meetings
- Adopting an open dialogue
- To set a clear ambitious measurable goal
- More effective and proficient communication
- communication is key and relationships
- Better communication and less administration
- Efficient communication within multidisciplinary team
- Focussing on opening communication pathways and encouraging/supporting cross pollination of disciplines
- Listen to the views of the individuals delivering care, not just managers that have not completed full working weeks delivering care
- Please look and listen to your staff - asking sensitive questions in front of senior management does not allow staff to be frank and honest and gives top tier a false sense of security

Human Resource Management
- Retain staff
- Joint quality training
- More training and liaison
- To facilitate the understanding of integrated care and what an integrated care organisation is amongst front line staff, by ensuring front line staff are including in discussions and simple language is used
- ensure your recruitment processes are fair and follow equal ops - thus being open and transparent

Information Management
- Sort out a shared IT system
- Reduce laborious paper work
- Less paper and computer work
- Good It communication systems
- Shared online/documentation system
- Computer systems that talk to each other!
- joint, integrate IT systems, improve information sharing
- ensure all professionals are working from the same systems
- Give everyone access to the same information about service users
- Maybe create/ use one common system to record information? (hospital and community)
- Provide decent IT systems and IT support that allow everyone to collaborate effectively
- IT systems that can work with each other. Electronic transfer of records/ letters/discharge summaries/referrals ...to include confirmation of receipt. Book hospital clinic appointment direct from GP practice. Access to medical records to be able to see the pathway of the patient, what has happened to date, to be able to make more informed choices

Mentorship
- Better mentorship in general practice- as isolated area of nursing generally with big differences in standards

Partnership working
- Respect the differing roles of the various members of the MDT and don't assume that you understand other peoples roles

Pathway review
- Review all pathways to cut out needless bureaucracy and duplication of roles - this is cheaper than to introduce yet another it system

Miscellaneous
- Separate community services from acute services - completely different ways of working.
Appendix 6. How an ‘integrated team approach’ helps learning (n=27).

Learn about..

- Feedback, shared learnings
- It should enable each professional to learn key information about the profession and the patient
- Multiple teams/ different specialties working together and communicating, giving advice to each other helps in order to develop new knowledge/ integrate new approaches/ ways of thinking
- New experiences and the ability to see different perspectives on situations. Gives a wider knowledge base (although this can risk diluting our professional roles and devaluing the specialist skills we hold)
- Common goals & outcomes. Sets standards and expectations. Offers a safer environment for staff and patients. Demonstrates an interest in developing staff and processes in a systematic way. Will help with retention. Will attract better calibre of staff. Will help all disciplines to learn together, to help understand each others’ worklife.

Learning across...

- Help to identify training needs
- Improves communication; responsive to needs; not fragmented care
- By sharing learning across organisations and using a multi-disciplinary approach.
- Multidisciplinary - acquired knowledge skills - collaborative working - joint goals
- Encourages learning across different roles, reducing assumptions increasing communication and dialogue

Learning/understanding from..

- Learn from each other
- Develop training from area of weakness.
- Discussion with other disciplines is helpful
- Support and continuous update from hospital
- Share ideas, aid own knowledge and experience
- Will be able to get insight from others for improvement
- Can learn from all the different services and their expertise
- You are always learning from each other and their knowledge
- Learning from other expertise. Collaborative learning and direction.
- Improves understanding of available therapies and gives care options.
- Understand each roles perspectives, helps with planning future services
- Able to learn from good and bad practice. Improve procedures and strategies in place
- Collaborative working enables holistic thinking and access to the knowledge and skills of professionals from other disciplines
- Can provide training together and this helps understanding and working together across the organisation.
- Understanding of each other’s professional roles responsibilities and accountability Because the skill set is so varied we would all benefit from the knowledge of others within the MDT, this ultimately enhances the patient experience.
- Knowledge learnt from hospital lectures and can be delivered to primary care. Patient satisfaction