Skills for Health

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Integration and the development of the workforce

Skills for Health Working Paper - February 2017

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1. Introduction

Introduction

Health and social care employers are no strangers to new policy announcements. Particularly those that purport to save money, do more (if not better) with less, cut out waste, enhance patient care, make better use of the skills of colleagues. In our austere times, the weight of expectation is always high. Eager to be seen as doing their bit and securing the future of the NHS, policy makers are keen that each innovation should be 'transformative' and at 'scale'.

As a result, policies and initiatives are regularly described as 'fundamental'; part of the most 'significant' or indeed 'revolutionary' change the sector has seen. If people weren't cynical already, they may find themselves becoming more jaded as these announcements pile up and initiatives are replaced with others. In time, the public may even rile against promises that have not been kept. This third paper in our working paper series, Our Health Heroes In Focus,[1] explores how the workforce must develop to support the successful integration of health and social care.

Skills for Health is privileged to have worked with numerous health and social care employers in the UK and internationally, addressing how workforces must develop to enable integration. In the course of our work, we have used a range of approaches from traditional surveys, workshops and consultations, to scenario application sessions and workforce planning techniques including the Six Steps methodology.

1 See also *The Healthcare Support Workforce* at http://www.skillsforhealth.org.uk/images/resource-section/reports/The Healthcare Suppport Workforce.pdf and *How We Can Act Now to Create a High-Quality Support Workforce in the UK's Health Sector* at http://www.skillsforhealth.org.uk/images/resource-section/reports/Support Workforce - Working Paper 2.pdf

1. Introduction

These are our key messages:

- The integration agenda is one that will be present for the foreseeable future.
- One of the most profound areas for the transformation of the workforce is that of shifting the mindsets of those working in health and social care to work beyond traditional boundaries, in different teams and settings.
- It is evident that high-quality integrated care will not be achieved through command and control, but from the concerted effort and the millions of small steps of those working every day in both health and social care.
- The skills of leaders, professionals and support workers will need to be shaped to achieve these everyday steps.
- High-quality workforce planning skills will be an essential feature of success in the move towards integrated care.

This paper is a reflection of the lessons we have learned so far. Our sincere thanks and respect go to all those with whom we have worked over the past couple of years in this important area. We hope this paper, along with the others in this series, provides a useful contribution to the healthcare sector's thinking about the development of its workforce, particularly in this case around the theme of integration.

2. The policy drive of integrated care in the UK and beyond

"The Framework on integrated people-centred health services represents a call for a fundamental shift in the way health services are funded, managed and delivered. This is urgently needed to meet the challenges being faced today by health systems around the world. The fact that people are living longer, along with the burden of treating long-term chronic conditions and preventable illnesses, which often require multiple complex interventions, means that pressure on health systems continues to grow. Moreover, universal health coverage will not be achieved without improvements in the delivery of health services. Unless a people-centred and integrated health services approach is adopted, health care will become increasingly fragmented, inefficient and unsustainable." [2]

Introduction

The move to integrated care describes the shift away from traditional top-down, command-and-control health care to a future where both health and social care services are delivered in a seamless fashion, shaped around the needs of the patient. Trends towards the integration of health and social care can be seen within each country of the UK, and examples exist further afield in Europe and beyond.

Clearly, integration is not a policy fad, to be replaced at some point in the near future. It is, in fact, a continuation of many of the drivers for change that have become increasingly significant over the past few decades.[3] This overall trend is also reflected in the policies and priorities of each country of the UK and further afield.

2 The World Health Organisation (WHO), http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/

3 A full outline of the sector's drivers for change can be found in Skills for Health's *Rehearsing Uncertain Futures* programme at http://www.skillsforhealth.org.uk/resources/reports/research-and-intelligence-library/future-oriented-research

Integration in each country of the UK

England

Within England, the integration agenda was clearly visible in the Care Act 2014.[4] The NHS Five-Year Forward View,[5] released in 2014, also includes a range of initiatives to drive integration. The plan emphasises that the NHS needs to instigate change but would need to do so through new partnerships with local communities and local authorities, with the expectation that these will lead to improvements in prevention and public health. The plan also urges the NHS to *"take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care"*. It also underlines that patients should have far greater control of their own care.

The place-based nature of integration is also emphasised within the Five-Year Forward View, and local innovation between groups of healthcare providers is encouraged. The plan remarks that: *"England is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS."* The Five-Year Forward View makes reference to the development of vanguard sites, multi-specialty community providers (MCPs), primary and acute care systems (PACs) and enhanced health in care homes (EHCH).

It also recognises the need for solutions to be far reaching in scope, and to take on forms that may not have been seen before: *"We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology – radically improving patients' experience of interacting with the NHS. We will improve the NHS's ability to undertake research and apply innovation – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch."*

4 Care Act 2014, https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets

5 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

2. The policy drive of integrated care in the UK and beyond

More recently, the Government has initiated Sustainable Transformation Plans (STP) for England. These five-year plans are organised around 44 areas, which have been identified as geographical 'footprints' through which health and social care services should be developed. Although ongoing pressures on resources cause concern for the long-term development of the plans, the overall move towards this way of organising health and social care is widely regarded to be a positive step in the longer term.

Scotland

Health policy in Scotland has long emphasised a desire for increasing collaboration and partnership. Within Scotland, the term 'mutuality'[6] has often been used to provide a distinctive means of thinking about the development of its healthcare system. It seeks to describe a system involving patients as owners and partners, with all the obligations that this entails, rather than users and providers. This agenda also implies a great deal of devolution of decision making into local areas, with delegation and accountability of all parts of the NHS through the 14 regional Health Boards, and collaboration among all parts of the NHS and with other organisations.

According to a recent study, there are a series of programmes to improve integrated care, thus improving care for people with long-term conditions:

- Reshaping Care for Older People and the Change Fund
- Intermediate Care
- Self-Directed Support
- Telehealth and Telecare
- Anticipatory Care Planning

6 Howieson B (November 2015). 'Mutuality in the provision of Scottish healthcare'. *Scott Med J* 60(4):228–32

2. The policy drive of integrated care in the UK and beyond

Wales

The theme of integration can also be seen in the development of the Welsh health sector. One of the hopes for the creation of Local Health Boards in Wales is to assist in drawing together elements of health and social care. It was the aim of the NHS bodies to accelerate the development of new simplified, integrated services.[7]

As in the other nations of the UK, Wales recognises that there is a need for NHS bodies to work closely with the whole of the public sector, as well as the third sector. In the Five-Year Forward View, 'hospitals for the 21st century' form part of 'a well-designed, fully integrated network of care' – with much care moving closer to home and GP teams doing more. In addition, patients will benefit from the planned 'clinical networks', which combine staff from different units, offering people over a wide area the best blend of skills and equipment.

Reviews of progress towards integration in Wales have highlighted that a degree of persistence is required, with integrated care typically taking five years or more to deliver its objectives and become self-sustaining.[8] Barriers are also highlighted, which are seen elsewhere in the UK, where services are reluctant to embrace integrated working. Often this is because they are nervous about the ability of other services to deliver for their clients or they are worried about the possible reduction in their own resources. Persuading them of the desirability of change takes a long time.

7 Welsh Assembly Government (2011). *Sustainable Social Services for Wales: A Framework for Action.* http://gov.wales/docs/dhss/publications/110216frameworken.pdf

8 Ham C *et al* (2015). *Integrated Care in Wales: a Summary Position.* Kings Fund, London

2. The policy drive of integrated care in the UK and beyond

Northern Ireland

Northern Ireland has had a structurally integrated system of health and social care since 1973.[9] It has a single large commissioning body, the Health and Social Care Board, and five large health and social care trusts (HSC trusts) responsible for the delivery of primary, secondary and community health care. As part of a future model for integrated health and social care, a key proposal is to establish Integrated Care Partnerships (ICPs) to join together the full range of health and social care services in each of the 17 areas, including GPs, community health and social care providers, hospital specialists, and representatives of the independent and voluntary sectors.

Heenan and Birrell (2006, 2009, 2012)[10,11,12] have published a number of small-scale reviews of this integrated system and highlighted its benefits and limitations. In Northern Ireland, there is broad agreement among health and social care professions that integration has not necessarily been a marriage of equal partners. The health agenda has dominated from the outset and this disparity persists. Heenan and Birrell also cited the independent review of health and social care services, published in 2005 by Professor John Appleby, which concluded that the success of integrated care varied across trusts and there was little collaboration between them.

9 Heenan D, writing in: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf

10 Heenan D and Birrell D (2006). 'The Integration of Health and Social Care: The Lessons from Northern Ireland'. *Social Policy & Administration* 40(1):47–66

11 Heenan D and Birrell D (2009). 'Organisational integration in health and social care: Some reactions on the Northern Ireland experience'. *Journal of Integrated Care* 17(5);3–12

12 Birrell D and Heenan D (2012). 'Implementing the Transforming Your Care agenda in Northern Ireland within integrated structures'. *Journal of Integrated Care* 20(6):359–366

Integrating health and social care in Europe

The theme of integrated health and social care can also be seen internationally. The International Journal of Integrated Care (IJIC) has drawn together a range of studies, exploring the theme. Further evidence of its broader global appeal can also be seen in the development of the WHO Framework on integrated people-centred health services:

"Putting people at the heart of the health-care experience and focusing on a true and lasting integration of services offered to them is urgently needed to meet the challenges faced by today's health systems, however diverse. The Framework presents a compelling vision of a future in which all people have access to health services that are provided in a way that responds to their preferences, are coordinated around their needs and are safe, effective, timely, efficient and of an acceptable quality."[13]

A 2011 review[14] also identified the theme of integration in Europe: *"Though integration has been part of the policy debate in a number of European countries for the past few years, the situation across Europe varies considerably."* The paper also highlights *"examples where there is no legislation or policy, yet professionals have come together in multidisciplinary teams and filled the policy gap"*. There are also looser integration models that may have led to a pooling or transfer of resources. These may also involve some formalisation of management and governance, along with a manager or co-ordinator appointed jointly by the partners or a shift of responsibilities between agencies.

Closing remarks

The pressures on the health and social care system inevitably required policy makers to look afresh at how these services might be provided. There is considerable momentum nationally, and to some degree internationally, around this theme. The integration agenda not only seeks to reframe how services might be delivered, but also necessitates a redrawing of how people work and the skills knowledge and understanding that they require to undertake this work. Before exploring how we can develop people to make this a reality, the next section of this working paper makes explicit a number of the key principles underpinning the development of integrated care.

13 WHO (2015). *People-Centred and Integrated Health Services: an Overview of the Evidence; Interim Report.* Geneva, Switzerland

14 Robertson H on behalf of the RCN (2011). *Integration of Health and Social Care; A Review of Literature and Models; Implications for Scotland.* https://www2.rcn.org.uk/__data/assets/pdf_file/0008/455633/Hilarys_Paper.pdf

3. Key principles of integrated care

As we have seen, multiple drivers for change have converged to encourage professionals and policy makers to pursue policies that support the integration of health and social care services. This is evident, not only in England, but also in the other countries of the UK, the European Union and beyond. Within the policies and government initiatives, it is possible to identify a series of principles that underpin successful integration. Here we focus on those most commonly raised by employers and stakeholders during our ongoing work:

- The centrality of the patient
- Adopting a population-centred, future-oriented approach
- Adopting a wellness perspective
- The absolute necessity to exploit new technologies
- Living with and dealing with complexity

The centrality of the patient

Whether it's the localism expressed in England or the 'mutuality' in Scotland, the idea that patients and their carers take a leading role in developing and agreeing their care is central to the vision of integrated care. The 'co-creation agenda', as it is often called, is one where it is hoped that patients will be able to bring not only their preferences to the table when discussing their health care but also assets. Such assets could be their own knowledge and skills, their home, support networks, friends and family that they have around them. There is evidence that using such an approach can improve outcomes for patients.[15] It could also reduce the interventions that health and social care may need to make in some areas and improve efficiencies.

15 The Health Foundation (2015). *Head, Hands and Heart: Asset-Based Approaches in Health Care.* London. http://www.health.org.uk/sites/health/files/HeadHandsAndHeartAssetBasedApproachesInHealthCare_InBrief.pdf

3. Key principles of integrated care

Our colleagues have also cited wider benefits with the close involvement of individuals. Firstly, this reduces the risk of the delivery of services being 'dogmatic' and 'one-size-fits-all'. Secondly, with some degree of reciprocation in the service/client relationship, those receiving care will appreciate the value of what is being done to assist. In this post-Brexit context, this reinforces the value that people see in the services being offered and reduces the likelihood of citizens being alienated from what is public service.

Adopt a population-centred, future-oriented approach

For integrated care to be a success, it is important for organisations providing the service to have a thorough and collective understanding of the community served. Such a perspective can be achieved through readily available population projections, such as Acorn[16] or Mosaic[17], and assessments such as those offered by Joint Strategic Needs Assessments[18]. The development of such an approach needs to encompass not just rates of sickness, but also lifestyles and wellness.

Once this has been achieved, those working to develop services can use these insights to collectively formulate the scale and shape of services, and can address the wellbeing agenda as well as support the sick.

Adopt a wellbeing perspective

Helping people lead healthy lives as a means of preventing a range of conditions, through advice and guidance, is a key feature of the integration agenda. General practices and pharmacists are key conduits in providing this support as their premises are often more conveniently located in the community.

In the course of our work with local health systems, colleagues have consistently highlighted the potential role of the wider community providers, such as the voluntary sector and other areas such as housing and policing. The promotion of wellbeing can also be undertaken in a wide range of community settings, such as sports or cultural venues.

The wellbeing perspective also necessitates a parity of esteem between community-based and hospital-based care. The services offered within the community through primary care should be regarded by both patients and healthcare professionals as equivalent to the high-quality care they would expect within hospitals.

16 http://acornhealth.org.uk/

17 http://www.experian.co.uk/marketing-services/products/mosaic-uk.html

18 https://www.gov.uk/government/news/jsnas-and-joint-health-and-wellbeing-strategies-explained

3. Key principles of integrated care

"The human brain must continue to frame the problems for the electronic machine to solve"
David Sarnoff (1891 - 1971),
Russian-American businessman and founder of the National Broadcasting Company (NBC)

The absolute necessity to exploit new technologies

Over the past decade we have seen the rise of technologies that are mobile and allow teams, data and knowledge to be networked in communities. Whether it is enabling patients to monitor their conditions and send the data to a central point, or allowing team members to remain in contact with the centre, the effective exploitation of these is critical to the development of 'place-based' integrated care.

Colleagues were also aware that, for many, the new technologies introduce a new balancing act between promised efficiencies and the possible isolation of individuals. They rightly emphasised that human interaction will remain the key factor in caring. Healthcare professionals were careful not to view the technology as a cure-all, and recognise that it is appropriate in some but not all instances. The challenge going forward will be how well we can embrace the technology to maximise efficiency while ensuring that the workforce is ready for implementation of the technology.

Living with and dealing with complexity

Another consistent message that emerges with colleagues is the growing complexity of the range of institutions that are involved. Different providers will be drawn from a mix of possible backgrounds: health, social care, local authorities, fire services, police and voluntary. Some will be state funded and others private. It is evident that the provision of successful integrated health and social care will be the outcome of a multitude of daily interactions, incorporating the views of competing organisations as well as patients and carers. All of this points towards the need to lead and develop high-quality systems.

Closing remarks: Déjà vu all over again?

While discussing the development of integrated health care, experienced colleagues have understandably highlighted how many of the themes are not necessarily new. Of course, there are similarities between the pressures that we face today and those that we have dealt with in the past.[19] However, understandably, some have expressed a degree of frustration with the ongoing discussions that show little evidence of progress.

The themes outlined in this section, such as the centrality of the patient, the adoption of a population-centred, future-oriented approach, and an emphasis on wellness, could unlock the potential to make tangible changes. The availability of new technologies is an important new factor in the mix of developing health and social care. If applied successfully, they could provide the step change that is so often aspired to. But it is widely acknowledged that the extent of the step change is framed by citizens and those who provide care.

A critical theme is the range of barriers and obstacles preventing the development of care, which colleagues working in the sector have often referred to. The sector is often characterised as being 'risk averse' and 'change resistant'. A wide range of historical and structural reasons are offered to explain why this is so; silo working between professions, traditional ways of thinking and the hierarchical nature of the sector are the usual suspects, as well as funding structures.

As we have noted before, the successful development of integrated care will be the result of the changes in the workforce. The need for culture change to enable colleagues to use their valuable skills in different ways is often highlighted. However, culture change is an amorphous concept and can be problematic in terms of developing real actions to support change. Our work with local providers has therefore led us to explore the principles of mindsets, and how we might be able to develop these to support services, as well as skills, knowledge and understanding. The following section outlines some of the key themes around the need to shift mindsets; this is then followed by an exploration of some of the critical skills developments that have surfaced in our work.

19 Thane P (2009). *Memorandum Submitted to the House of Commons Health Committee Inquiry; Social Care.* http://www.historyandpolicy.org/docs/thane_social_care.pdf

4. Changing mindsets

"Cultural intervention can and should be an early priority—a way to clarify what your company is capable of, even as you refine your strategy. Targeted and integrated cultural interventions, designed around changing a few critical behaviours at a time, can also energize and engage your most talented people and enable them to collaborate more effectively and efficiently." [20]

Introduction

The drivers for change are increasing the demand and complexity of health and social care. The previous section highlighted a series of key principles that underpin the integration agenda. It also highlighted the anxiety, held by many of those with whom we have worked, about being able to make change happen in the real world.

A multitude of key workforce development and skills needs, including those of change management, have been raised by colleagues. Many of these are taken up in the following section (5). However, one of the most compelling findings of our work with colleagues is the need to shift the mindsets of those working in the sector. It is argued that, by and large, the skills and people that the sector needs are in many ways in the sector, but they need to work in substantially different ways to make this happen. Once this shift is achieved, real change is more likely.

20 Katzenbach JR, Steffen I, Kronley C (2012). 'Cultural change that sticks', *Havard Business Review.* https://hbr.org/2012/07/cultural-change-that-sticks

Such activities include:

- Enhancing and improving appreciation of different understanding of risk between health and social care providers
- Building relationships beyond traditional boundaries
- Adopting growth mindsets
- Developing a functional level of knowledge and understanding of other roles and organisations
- Achieving parity of esteem
- Understanding whole lives and communities

Enhancing and improving appreciation of different understanding of risk between health and social care providers

It is evident that different parts of the health and social care sectors have differing understandings around 'risk' and risk management. The most contrasting example is between acute care and those working in the social care context. In the former, drawing a great deal of influence from the traditional medical model, there is less tolerance towards risk. Those working in the community shape the question of risk somewhat differently.

These differences are also nuanced within the health sector. Those working in the primary care community differ from those working in acute. In many respects, the understanding of risk is appropriate for the context in which they are working. But issues arise when professionals from different backgrounds are seeking to work together to provide care.

This has important consequences for those seeking to develop a degree of seamlessness between providers in health and social care. If there is no understanding or appreciation of risk between organisations, then reassessments can take place on multiple occasions. Similarly, there have been issues of whether roles that work between different settings can actually be insured appropriately.

In the foreseeable future, it seems unlikely that there will be a single solution with one understanding of risk. However, an appreciation of how and why an understanding of risk might be different between different parts of the service is key. This also has consequences for how realistic completely 'seamless' health and social care might be.

Building relationships beyond traditional boundaries

Another theme consistently raised is how building relationships with organisations beyond those traditionally worked with can help shift mindsets. One practical solution is the need for colleagues to change their work settings and experience new areas of the health and social care landscape that they haven't experienced before. As a delegate remarked at one of the consultations undertaken: *"We build trust when we work with people, it's about working on a project together."*

A strong desire for people working in different parts of the system to work together as a means of reshaping their skills has been evident. Examples of more effective relationships between general practices and pharmacists resulting after time has been spent together is often quoted. Similar anecdotal evidence was also offered about social workers and other healthcare providers.

There are also broader examples of policing and fire services being incorporated into the debates about the development of integrated care. Working beyond traditional boundaries has been more common at senior level, with directors of services having the opportunity to discuss matters with their peers. The challenge is identifying where we can most effectively develop such activities for a broader range of roles at all levels between health and social care.

Adopting growth mindsets

Enabling people to think differently needs to be done carefully. Those working in a system cannot simply be told to open their minds and immediately start to work effectively across new groups of people and organisations. There are techniques that need developing to make this happen effectively. It needs to be done consistently, over time. Those providing health and social care in an integrated environment will need to find meaningful opportunities to step out of their comfort zones and explore new activities.

During our work with local communities, we have seen some practical examples of trainee GPs being given placements in different parts of the system. Examples like this are plentiful, but they fall into the trap of focusing on the primary development of people in their roles; these opportunities would need to become part of the Continuing Professional Development of those working in the sector.

Mindset is a simple idea made popular by Professor Carol Dweck, who made a distinction between fixed and growth mindsets. In a fixed mindset, people believe their basic qualities, like their intelligence or talent, are fixed traits. One way of thinking about this is that they spend their time documenting their intelligence or talent and protecting their status in organisations. The alternative idea of the growth mindset requires people to appreciate that their basic abilities can be developed through dedication and hard work. Their brains and talent are raw materials that need to be applied in order to develop. Skills, knowledge and understanding need to be cultivated and extended through working with others. The emphasis on this growth mindset is something that has become increasingly popular. It is believed that teaching and promoting a growth mindset creates motivation and promotes productivity in the worlds of business, education and sports.

Developing a functional level of knowledge and understanding of other roles and organisations

There is also consensus among colleagues that a great deal could be achieved by people across the system developing, at a minimum, a functional level of knowledge of the roles of others and organisations where they work.

Such development would include the development and maintenance of a directory of services that could be used to direct colleagues around the health and social care system. Such a directory could be subject to user amendment. At another level, this functional knowledge could have other benefits and might assist in the co-ordination of resources and facilities around the system. For instance, a GP surgery may have the real-estate capacity, in terms of space, to host a service.

Whilst this is a relatively straightforward means of developing people's understanding, such initiatives will require ongoing care to ensure that the knowledge and understanding is continually developed.

Achieving parity of esteem

Parity of esteem is seen as another important theme, allowing the development of high-quality integration of services. It implies that the skills, knowledge and understanding of those in different parts of the integrated health and social care system are given an equal status with one another.

This is particularly salient in terms of the relationship between the health sector and the social care sector, the latter of which is often regarded as the poorer relative. Other important features of achieving parity of esteem include equal regard being paid to mental health and physical health provision, and the contribution of non-registered as well as registered members of staff.

The health sector has a history of being hierarchical, and the registered professions have traditionally resided at the pinnacle. Parity of esteem is likely to take some time but there are policies that can be used to assist this development, such as the serious inclusion of this workforce in development strategies, plans and ultimately budgets, which will assist in the drive towards greater parity of esteem.

Understanding whole lives and communities

The traditional approach for those planning has been to begin with indications of the prevalence of conditions and projections about how these may progress in the future. This remains an important component of planning. The list of possible conditions is considerable and projections of their increase can at times be staggering. But without being able to make more sense of these, those working in the health sector can be left feeling totally overwhelmed.

Integrated care demands that planning for communities needs to be developed from a broader appreciation of people's lives and communities. Those working in communities will automatically have a vast range of local intelligence at their disposal. The involvement of patient representatives needs to be built upon. There are creative models of populations and their preferences, developed in conjunction with consumer profiling, that can assist. One of these on its own is simply not enough; they need to be drawn together. This will increase the overall level of knowledge and understanding among all of those working towards high-quality health and social care. There is no point in one part of the system being the sole voice of the population.

Concluding remarks

Colleagues have identified the shift in mindsets as critical for the success of the sector's attempts to integrate health and social care. By its nature, the development of mindsets is an ongoing task. The core theme holds for those in both strategic and delivery roles: step out of your comfort zone, look at problems and activities afresh, and pull your core skills and knowledge into new areas. On the face of it, seeking to develop mindsets is a very theoretical activity. But in reality these are practical and day-to-day solutions, and simply need to be done.

5. Critical skills and skillsets

As we have seen in the previous section, the need to shift mindsets in the workforce is seen as crucial in enabling the development of integrated health and social care. However, colleagues have also recognised the need to engage in the development of skills, knowledge and understanding in a range of areas to make integration a success.

Our work with groups of health and social care practitioners highlights a range of common skills and skillsets. The following themes are not an exhaustive list, but are of value as they have been repeatedly cited in our work and are therefore worth drawing attention to. These include:

- The development of management and leadership
- The refocusing of health professionals and general practitioners
- Developing and finessing wider roles
- The continual development of generic skills
- Technological innovation – strategic and day-to-day implementation
- The rise of the everyday evaluators
- Other emerging skills and roles identified

The development of management and leadership

Local health systems consistently raise the development of management and leadership as a key theme. There is a rich history of literature on this subject and courses designed to improve its quality. It is not our intention to highlight every aspect of the management and leadership challenge here, but to draw out those key themes that have arisen in the debates that we have had with colleagues.

Change management skills

At heart these skills are about the successful transitioning of individuals, teams, organisations and communities of organisations. The aim is to redirect the use of resources, business process, budget allocations or other modes of operation that significantly reshape a company or organisation. In many respects, the wide range of skills around the theme of change management reflects our earlier outlines of the need to assist in the shifting of mindsets. Those involved in leading change need to provide ongoing and authentic frameworks for change that those working in organisations can appreciate and work within. With such frameworks in place, those who are 'followers' can find a level of meaningful engagement with the process of change.

Community/clinical leadership

There is a rich history of the health sector's attempts to enlist the support of clinicians into leadership roles. Their involvement is seen as a key element in informing, and in some respects legitimising, change for both clinical communities and the communities that they serve. In the face of local change, community/clinical leadership will be needed to articulate what the health and social care landscape might look like, to help the community themselves make a shift in mindset.

Managing dispersed teams

This will be a critical set of skills. Community-based care will involve healthcare professionals working autonomously, travelling between appointments and within people's homes. The model of management, and therefore skillset, will need to be oriented towards a high-skill and high-trust environment as opposed to top-down, low trust and low skills.

System leadership

This is also a theme often highlighted. On one level, health and social care is simply about people looking after people. Yet there is a complex set of interactions between institutions and communities that needs to be worked with.[21]

The refocusing of health professionals and general practitioners

There is widespread recognition that the UK is facing shortages in overall numbers of GPs, and efforts are being made to train and recruit for this profession. Local health systems have also highlighted the need to refocus the role of GPs and other health professionals to make integration succeed. This has also been reflected in a number of policy documents.[22,23]

21 A detailed and interesting outline of systems leadership can be found at http://www.leadershipacademy.nhs.uk/about/systems-leadership/

22 NHS England (2016). *General Practice, Forward View.* https://www.england.nhs.uk/ourwork/gpfv/

23 Royal College of General Practitioners (2013). *The 2022 GP.* London. http://www.rcgp.org.uk/policy/rcgp-policy-areas/general-practice-2022.aspx

Those working in health systems have highlighted how GPs and other health professionals need to hone their skills in a number of areas:

- **Leaders and facilitators in the development of local health systems:** For many, the general practices would make ideal sites for the convening of a range of medical and non-medical services in the community and enable a firm link between primary and secondary care, as well as health and social care.
- **The ability to be partners and develop effective partnerships:** The co-creation of care implies that patients and those who provide care are partners; there is also a need for partnerships between different organisations.
- **For authorities, one of the key tasks will be the projecting of expertise into communities and institutions more widely:** Working as authorities, GPs would be advising on the care that patients need to receive, reviewing patient progress and taking queries from others about problems and issues that might emerge.

Another theme that is commonly raised is the better utilisation of health professionals' and general practitioners' time. This necessitates not only the development of the professionals themselves but also the support workers around them. Two examples of this wider redevelopment are highlighted below. This has been addressed specifically in our second working paper.

Developing and finessing wider roles

Some role development or finessing of roles can also be seen as important features of workforce development going forward.

The health/social care navigator 'family' of roles

The role of navigation – helping patients and carers to find their way through the complex landscape – is key moving forward, both as a role in its own right and as part of other roles.

Such roles could help users find the provider that best fits their needs. While it could be a complete role, the role of navigation could be, and indeed often already is, part of existing roles and occupations.

There are a number of elements to the role of navigator. In some respects, the role would have a degree of advocacy skills, information organisation and brokerage. Navigators will act as 'enablers', assisting clients, especially vulnerable people, to navigate their way through the increasingly joined-up systems of health, social care, education and housing. It is possible in the future that fee-paying versions of the role might emerge, which may have an appeal to those pursuing wellness as part of their lifestyles.

Generic support workers

The need to develop a generalist/generic support worker could also grow in importance. Such roles would work at or around an intermediate level. They would be skilled in a diverse range of technical skills, and could possess a range of skills that are not conventionally associated with a single profession.

They would work towards the needs of patients and work across a range of professional boundaries. The role would operate within the confines of a prepared care plan, but would also have a degree of autonomy. The generic support worker role currently exists within the NHS but would also find a home within the voluntary and independent sectors.

The continual development of generic skills

Historically, generic skills have often been dismissed as soft skills. As a result, they do not have a high profile in the development of the sector's workforce. However, these skills emerge as key to ensuring the future of health and social care provision in local areas, in our work with local health systems.

Such skills provide the glue between individuals and teams in both health and social care. They enable all those within the system to work dynamically with each other. They also enable the accurate exchange of information and help overcome problems collectively.

The nature of such skills, and possibly why they are less regularly highlighted, is that they do not necessarily denote a body of knowledge that can be certificated and protected, but are ways of working that need to be trained and continually developed. The generic skills of customer handling, team working, communication and problem solving have been regularly highlighted and we provide some outline here.

5. Critical skills and skillsets

Customer handling

Customer handling relates to the interactions between clients (or patients) and health and social care providers, and the ways in which clients' care needs are met. Good customer handling requires a mix of good communication, team work, problem solving and management skills. The aim is to provide clients with a positive experience, whether it is in short transactions or in the form of a deeper, ongoing service relationship.

Team working

Effective team working continues to be raised as a critical issue. It is obvious to see why, in terms of developing multi-agency services, this might be the case. Those working in the health and social care context will inevitably be working within (and between) a number of teams – with colleagues, external organisations and communities. Effective team working is also enabled by shifting mindset, as described earlier.

Communication

In the health sector, most of the communication between practitioners and clients is verbal, and usually one-to-one. Practitioners must listen well if they are to be effective, and good communicators will check their own understanding of the issues and reflect what the client is telling them. Written communication skills are also vital to the health sector: to document diagnoses and treatments in patient notes, to log numerical information such as temperature and blood pressure readings, to convey information between practitioners (in the same and in different organisations), to make referrals for treatment, and to communicate with patients about their treatment.

Problem solving

Managers and health professionals need problem solving skills for patient care as well as for managing teams and healthcare functions. In general, the problem solving process is described fairly consistently in the literature. Solving problems requires being systematic, decisive, having self-awareness and being inquisitive, as well as skills of analysis and creativity. Further skills are required when you consider group problem-solving techniques, such as reaching consensus, the advocate method (where small groups work on parts of the problem), and brainstorming. These group-centred techniques also draw on the teamwork, management and communication skills highlighted earlier.

Technological innovation – strategic and day-to-day implementation

Technological innovation represents an important new factor in the development of integrated care. Such innovations will allow local health systems to be networked, allowing the free exchange of data and intelligence within the system. Whether it is patients monitoring their conditions remotely, or colleagues working in the community being able to remain in touch with the centre and seek advice where necessary, innovations in technology provide a number of opportunities that can enable the delivery of integrated health and social care. But, going forward, there is a need for strategic leadership in the application of IT, technical management and support, as well as day-to-day user skills.

Those working to develop services at a strategic level need to think more expansively about how IT innovations can help develop services. The fact that local systems can be networked should open up a range of possibilities around the innovation of services. There will also be some attractive efficiencies from pooling certain areas of resources, such as joining together back office functions of finances and IT services.

- The networking of IT services across local areas, whether they enable the monitoring of conditions or the co-ordination of services, will require a degree of support from technical experts. This support will be key in assisting clinicians in remote working.
- On a day-to-day basis, those working in the local system will need a range of foundation-level IT skills to participate in service provision. Patients and their carers will also require user-level skills to access services.

Anecdotal evidence suggests that this area is often treated as something that exists beyond local systems and is the domain of back room ‘geeks’. It is evident that such skills will need to be an integral part of service development.

The rise of the everyday evaluators

The integration agenda exists to provide improvements to the quality of health and social care provision. With this ambition in mind, there is a need for local systems to be able to make ongoing sensible assessments of the impact that their initiatives may have.

Colleagues acknowledge that not enough evaluation is carried out. There is a great deal of mystique surrounding evaluation, and the associated jargon can be off-putting. Many may feel that these activities are out of their reach. Therefore, there is a dearth of knowledge and understanding about how high-quality, proportionate evaluations might be developed to help assess the impact of the initiatives to integrate health and social care services. Our activities with local systems point towards the need for building confidence around evaluation, and how to undertake, purchase and deal with the findings.

To enable the rise of the everyday evaluators, guidance will need to be developed for each system. It is likely that some of this will be informed by the following principles:

- Where possible, begin evaluation at the start of the programme of work.
- Evaluation needs to be free (as far as possible) from jargon, using plain English to describe complex concepts.
- Proportionality needs to be instilled; a rule of thumb, and indeed treasury guidance, indicates that evaluations should take up 2-5% of the resources for any one programme. The cloth will need to be cut accordingly, unless the project is of greater strategic significance.
- Be practical and appreciate the use of data that is readily available; generating new data is usually costly.
- Welcome negative findings from evaluation – these can be as valuable as those that demonstrate positive outcomes.
- Where you see a potential improvement, make it.
- Write it down and share it, be prepared to be challenged on it and take challenge well.

Studies show that the world's most successful healthcare systems make widespread and systematic use of improvement methods. These encourage learning by doing, using small tests of change to observe, reflect and explore what works best for a particular context. The integration agenda presents an opportunity for colleagues in local systems to evaluate the service improvements that they have sought to undertake. This networking of knowledge could assist in the informing of any step change in the quality of service provision.

Other emerging skills and roles identified

The examples above have been highlighted as important insights into the range of possible future skills needs and role development priorities. The following are the skills and role developments identified as important by colleagues in the context of delivering the integration agenda.

- **Coaching skills:** Focusing on staff development, people within the health and social care sector would need to be able to support one another to develop the services quickly. The ability to support and develop colleagues through coaching is likely to continue to be of use, and indeed grow.
- **Information technology skills:** Information technology will continue to grow in its influence for those providing health and social care, as well as those who are using the service.
- **Compassionate care:** Being able to show compassion for those receiving care; such skills are likely to encompass such attitudes as empathy.
- **Social interaction skills:** Those offering health and social care need to become highly skilled in a wide range of communication-related skills. These include 'recognising signals' and 'understanding body language', as well as verbal skills.
- **Communication skills:** These were also cited – being able to truly listen and think about what the patient or service user might need.
- **Motivational interviewing skills:** These are a very specific set of skills to enable a healthcare provider to work with those seeking to use the services to take action themselves.
- **Skills to enable the patient to pursue 'self-care':** This set of skills looks at how the care professional can help the patient undertake a range of tasks for themselves.

5. Critical skills and skillsets

- **Making every contact count:** Skills will be needed across many roles in the health and social care sector to provide prompts, advice and guidance to patients on a range of mainly wellbeing subjects.
- **Knowledge management:** The services in health and social care will continue to grow in complexity. There is a wealth of information and intelligence about the services being offered, as well as information about how the services are being used and valued by patients and the population.
- **Personal assistants:** This is emerging as a role in the health and social care sector, enabling people to make use of personal care budgets and employ others to undertake personal assistant activities.
- **Coaching skills:** This skill focuses on coaching patients to make choices, take decisions, improve their own health and become empowered.
- **Advice and guidance:** These skills were focused on advice and guidance on encouraging people to join the sector to undertake work in health and social care.
- **Role modelling and professionalism:** Helping people to 'learn how to learn' in health and social care; this skill was highlighted as modern careers demand that people learn new skills as they develop, therefore skills, knowledge and understanding would need to be developed on an ongoing basis.
- **Person-centred advice and guidance:** Providing such support will rely on those working with patients to listen to their needs, and provide tailored advice and guidance.
- **Marketing skills:** For example, developing a directory of services to focus on the compilation of intelligence about services that are available.
- **Care as a profession:** This is about careers advice and promoting the care sector as somewhere for rewarding jobs, and where roles might be developed.
- **Key workers:** These act as a central point of contact for the family and can help co-ordinate the work of other agencies. The key worker role would be to carry out an assessment with the family so that, together, they can identify the family's needs and the objectives they want to achieve. Both parties can then develop a Family Action Plan to help achieve the goals.

6. Concluding remarks

The integration agenda and related ideas, such as the STPs, represent a concerted effort by policy makers to reshape the nature of health and social care throughout the UK. It is an approach that has echoed around the world in terms of dealing with higher demand, restricted resources and expectations. For many, it holds a long-term prospect of making savings as individuals and communities that can help shape services and, where appropriate, take control of their own care.

The integration agenda has a range of principles that turn the traditional way of thinking about health and social care on its head. These include changing a system that treats sickness to one that promotes and enables wellbeing, and is place-based and patient-centric. Such a shift will reshape how services are configured, and will have an impact on how patients and carers experience health and social care.

Ultimately, the successful achievement of integration will depend on the workforce changing from the bottom up, and leaders throughout the system helping people work in ways that they may not have done in the past. Throughout our work with communities seeking to develop integrated care, there is a strong sense that mindsets need to be changed to make the system work in new ways. For once these mindsets are shifted, colleagues can shift into new areas and treat the communities they serve differently, with more involvement and more empowerment.

Colleagues rightly highlight that those working in health and social care already have a deep reservoir of skills and experience. Much of this will continue to be relevant and will remain key to the future. But the mindset shift will enable this expertise to be applied in the right direction.

That is not to say that workforce and skills development need not be undertaken. This paper has highlighted a range of development needs that have arisen in the course of our work, in the form of leadership, customer service skills, evaluation skills and more. New roles and responsibilities have also been identified; many of these, of course, have been highlighted in this working paper. Our previous paper highlighted the need for the roles of those working in the health sector to be well developed with clarity, and to ensure people are making as strong a contribution as they can. This remains an important part of any recipe for future development. The overarching need for high-quality workforce planning for local systems has also become evident.

Great workforce planning

Without doubt, integrated care demands great workforce planning on a number of levels. The first is at a system level.

Begin at the system level

System-wide planning is needed to develop the ability of institutions to interact together in order to provide health and social care. In reality, much of this is about having a structured debate with a wide range of people about the future, from within the system, that serves the community in question.

Planning for an integrated future needs to involve a wide range of stakeholders from both health and social care, local authorities, housing, the fire service and those working within the voluntary, private and public sectors. Communities need to come together and think in a structured way about the possible future shape of services.

Structuring the debate can take many forms. The Six Steps methodology is a useful means by which communities can structure their discussions about the workforce development. This approach is useful to many as it identifies those elements that should be in any workforce plan, taking into account the current and future demand for services, the local demographic situation and the impact on other services, while helping healthcare professionals to work within their budgets.[24]

Scenario application sessions are also a useful means of structuring conversations about the possible future shape for health and social care systems. These sessions use a number of scenarios; usually three or four. They are designed to be credible, plausible and challenging 'futures'. Generated using high-quality intelligence and the facilitated views of colleagues and stakeholders within the sector, they offer a tool for debate and discussion, and the development of service and workforce plans in the sector. Using the scenarios enables groups of colleagues, often from different parts of the health and social care sector, to rehearse and create resilient plans for the development of services.[25]

24 More details of this approach can be found at http://www.skillsforhealth.org.uk/resources/guidance-documents/120-six-steps-methodology-to-integrated-workforce-planning

25 More details of this approach can be found at http://www.skillsforhealth.org.uk/services/item/468-scenario-planning

6. Concluding remarks

Take the long view

Great workforce planning does not culminate in a single event, report or set of priorities. It is an ongoing, regularly refreshed conversation. There is a need for integrated care communities to regularly look at how the workforce in their area is developing and to regularly sense-check whether the direction of travel is working.

In practical terms, high-level strategy development might take place every two to three years, depending on the degree of change that is being expected. In between these, health and social care systems might scan the horizon for events and trends, both expected and unexpected. Individual organisations can also develop their organisational plans while referring to the strategies, priorities and direction of travel.

Build resilience

One of the common frustrations of the workforce planning cycle is that it does not always fit in with the plethora of initiatives and demands for plans from those directing the development of health from a national perspective. And those working in health and social care are often exposed to ambitious tasks and short deadlines. As a result, some are deterred from taking the long view. The point is, unless a long view is taken at some point, those working in the system will always be on the back foot responding to fire-fighting tasks. The long view empowers systems; having this as a standing issue means the organisations are in a state of near-readiness.

A number of personal qualities were highlighted as key for those seeking to engage in the process of workforce transformation:

- Having a vision – being able to take a longer term perspective on the changes you are trying to achieve
- Having stamina – what is being attempted is a marathon rather than a sprint
- Knowing it's about people – the care that they receive
- Being aware that the workforce truly is the most important resource available to the sector

And one final quality is important: being brave – you will be asking people to think and do differently, and they will challenge you. But that's good, because you are challenging them.

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