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Re-Imagining Undergraduate Health and Social Care Education; a workforce fit for purpose in a changing landscape of care. A position paper.

Dr Martin King
Manchester Metropolitan University
m.king@mmu.ac.uk

Professor Alison Chambers
Manchester Metropolitan University
a.chambers@mmu.ac.uk

Dr Eula Miller
Manchester Metropolitan University
e.miller@mmu.ac.uk

Angela Hook
University of Salford
a.hook@salford.ac.uk

Laura Jackson
Manchester Metropolitan University
l.jackson@mmu.ac.uk

Dr Russell Gurbutt
Bolton University
r.gurbutt@bolton.ac.uk

Abstract

NHS England's Five Year Forward View outlines new care models and the need for a workforce that has the skills, values and competencies to deliver this vision. This is a position paper detailing the context, method and intentions of an HEE funded project led by MMU in the North West of England, which the authors see as making a key contribution to addressing issues of illness, crisis and loss in the changing landscape of health and social care provision in England. Using an Action Research methodology and drawing together key stakeholders from the sector, the project aims to explore the potential for creating a professional health and social care graduate workforce which meets the needs of an integrated service delivery landscape by identifying key issues to be addressed when redeveloping the undergraduate curriculum.

Introduction

In February 2015 37 NHS organisations and local authorities signed a landmark agreement in Greater Manchester, UK, with the sitting government to take charge of health and social care spending. Greater Manchester is the first local authority in England to take control of its £6bn budget in this way. The coalition of stakeholders is currently responsible for managing the health of the region's 2.7 million inhabitants. The eventual outcome will be a fundamental shift in the way health and social care services are administered. For example, each locality has pledged to minimise duplication of effort and increase financial efficiency by integrating commissioning budgets.

Although the deregulation of public health care provision can be traced to the Coalition government's Health and Social Care Act (2012), the Act was itself an extension of the previous Labour government's neoliberal reforms of the public sector (Speed and Gabe, 2013; Pownall, 2013). Known locally as "devo health", the 2015 deal was the second of three devolution agreements negotiated between the Greater Manchester combined authority and the then Tory Chancellor of the Exchequer, George Osborne, who envisioned Manchester as the flywheel of his "Northern Powerhouse" project.

The focus 'must be on people and place, not organisations', according to the authors of the devolved health strategic plan 'Taking Charge of Our Health and Social Care in Manchester':

> There will be a responsibility for everyone to work together, from individuals, families and communities to the approximately 100,000 staff working in the NHS and social care, the voluntary sector and the public bodies. We want our city region to become a place, which sits at the heart of the Northern Powerhouse, with the size, economic influence and, above all, skilled and healthy people to rival any global city.

The key drivers of devolved health care provision are: A shift towards individuals taking charge of – and responsibility for – managing their own health,the development of a community-based integrated system of health and social care provision whereby GPs, consultants, nurses, the voluntary sector and other organisations collaborate in managing the population's health and the sharing of knowledge and expertise between centres to tackle perceived inefficiencies.

The broader political context to these proposals is the imperative of reducing health and social care spending, initially titled 'Devo Manc', will have to manage a projected £2bn funding shortfall – and devolving power away from government and towards the newly responsibilised and consumer-focused individual. A renewed emphasis on 'care in the community' is also fundamental. The overarching objective

is the empowerment of the population whereby 'liquid modern' imperatives of self-management and self-care come to replace 'solid modern' paternalistic and pastoral modes of governance (Bauman, 2000; Brown and Baker, 2013).

As Pownall (2013) demonstrates, such principles are consistent with reconfiguring the NHS ,nurtured by ideals of austerity, market forces and the decentralisation of power, and argues that such neoliberal policies aim to reduce the state's involvement in the provision of health and social care. The state becomes a commissioner, not a provider, of health and social care provision. The alternatives to the state's previous commitments are premised on increased private and voluntary sector involvement, the delegation of control to locally qualified authorities, and an increased responsiveness to local priorities.

Implementation of such policies will inevitably initiate a major reorganisation of the qualities, training and competencies of the workforce. One significant effect in this respect will be the emergence of an ethic of 'new professionalism' in health care coupled with a concomitant shift away from professional autonomy (Speed and Gabe, 2013). Three novel forms of accountability characterize this notion:

i)   a shift from a training-and-licence based model of accountability to a competency/performance based model;
ii)   a shift from embodied trust based on reputation and empathy towards a new form of informed trust based on externally generated standards of performance;
iii) the development of new team-based models of care, such that 'non-physician clinicians' for example can undertake professional work.

The initiative is in line with The Five Year Forward View (NHS England, 2014) which describes new care models and the need for a workforce that has the right skills, values and behaviours to deliver this vision. The NHS is facing unprecedented challenges in delivering universal healthcare, irrespective of age, health, race, social status or ability to pay. There is acknowledgement that healthcare urgently needs to change from an illness based, provider led system towards a future service, which is patient led, preventative in focus and offers place based care (NHS England, 2014). This provides an imperative to create, at scale, a health and social care workforce prepared for working within a 'place based' care system, out-with organisational boundaries; essentially, this will, more than likely, require a paradigm shift in undergraduate health and social care education.

Integrated health services have been defined as: the management and delivery of health services in order that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, through the different levels and sites of care within the health

system, and according to their needs throughout the life course (NHS England, 2014).

However, there are contested views over the definition and indeed, it has different interpretations. A literature review by Armitage et al. (2009) noted 175 definitions and concepts. NHS England has adopted the phrase 'person centred co-ordinated care'. The Kings Fund (2011) however, make a distinction between real and virtual integration and three levels: micro, macro and meso (King's Fund, 2011), whilst The Nuffield Trust (2011) describe five types (systematic, normative, organisational, administrative, and clinical) and two dimensions: extent and intensity (The Nuffield Trust, 2011).

Funded by Health Education England (HEE) Manchester Metropolitan University is leading a research project entitled: Re-imagining undergraduate education – creating a resilient graduate workforce for an integrated placed based health and social care system – a new paradigm?

The project will explore the case for change in respect of undergraduate health and social care education across the full range of health and social care professional groups. The premise on which the project is predicated questions the extent to which current undergraduate programmes successfully prepare graduates to work in and become effective members of integrated clinical/practice teams. A Greater Manchester (GM) cross sector project team has been created. The project team comprises secondees from the GM universities and GM health and social care sector.

The project is about identifying and developing the values and behaviours needed by a future undergraduate health and social care workforce. The assumption at the outset of the project is that such health and social care professionals will need to have both a clear understanding of the system around them and a resilience to be able to manage this with positive impacts for the population. The project makes the primary assumption that there is currently an absence of the right match-up of values and behaviours to make integrated working a reality for pre and newly qualified graduates once they are in employment. The secondary assumption is that employers are using continued professional development resources as a 'sticking plaster' to address this. This is unsustainable and will not allow for transformational change at the scale and pace necessary to enable devolution to deliver with modelled innovative ways of service delivery, demonstrating impact on service delivery. Expectations from HEE in the North West (in GM) are that the project will provide a five year forward view, including predictive modelling for the future workforce, now that many bursaries for health professional programmes have ended or are under threat. The project must also outline what makes 'a good health and social care job' including workforce identity, peer support and opportunities for career and professional progression. Across GM, health and social care pathways will

become integrated across different providers with a greater focus on wellness, early intervention and prevention. There will also be a wider appreciation of people's physical and mental well-being, for instance, work, debt, social isolation and housing. The ten-locality health and social care plans detail the development of a 'workforce fit for the future'. The project team will therefore help to develop a new future workforce from entry criteria onto the undergraduate programme through to the first year in employment. It is, therefore, important that undergraduates understand what is different. People will be at the heart of the process; their care being central to the day-to-day roles once students are either on placement and/or employed post-qualification.

In the current system, however, undergraduate health and social care education remains largely uni-professional in emphasis, focus and delivery. Whilst there is a requirement to include elements of interprofessional learning within the curriculum these are largely on the periphery rather than at the centre.

GM health and social care devolution provides a timely opportunity to place the values and behaviours required for person centred interdisciplinary integrated care at the heart of the undergraduate learning experience. The intended outcome of the work is to produce employable graduates, who have the knowledge, skills, resilience, experience and confidence to work in a place based system. In order to achieve this, it is envisaged there needs to be a radical change in how health and social care is provided.

Current Context

A context for integrated education exists in the work of the International Foundation for Integrated Care working with the World Health Organisation to develop a Global Strategy on People-Centred and Integrated Health Services (http://www.ijic.org/). The WHO recommended five related strategies required for health service delivery to become more integrated and people-centred:

1. Empowering and engaging people and communities;
2. Strengthening governance and accountability;
3. Reorienting the model of care;
4. Coordinating services within and across sectors;
5. Creating an enabling environment.

A focus on optimizing workforce performance drew attention to curriculum improvements incorporating new teaching methods and innovative models for pre-service and in-service training as necessary to translate new competencies into practice. Curricula directed at preparing the healthcare workforce for future roles includes building a range of interpersonal skills for working in team-based health

care environments and highlighting the relational dimension of facilitating change. Workforce training and development requires a specific (yet unspecified) skill set for professionals, which enables them to work in multi-professional teams and across traditional boundaries, deeming change to education as a precursor to moving towards integrated care.

An implication of such educational change signals a greater move articulated by Anderson and Anderson (2001) as requiring a fundamental shift in mind sets, behaviours and ways of working. If this is the case, any curriculum design is, in effect, a vehicle for a paradigm shift and has to resonate with political, regulatory, organisational, professional, service and individual change.

A potential barrier to integration lies in segregated core professional training thus reinforcing professional status and identity (Heenan and Birrell, 2008). Howarth et al. (2006) further comment on other calls from some quarters for a move to inter-professional education to replace single-discipline learning.

Interprofessional education (IPE) is simply defined as 'occasions when two or more professionals learn with, from and about each other to improve collaboration and the quality of care' (CAIPE 1997:5). Over the last 30 years, IPE has become established and shared learning between health and social care professionals is now embedded in most undergraduate curricula and extends through to post-graduate professional development programmes. However, the extent to which this has been successfully implemented is contested (Anderson and Anderson, 2001). Successive governments continue to issue clear policy to encourage collaborative practice (McNair, 2005; Hall, 2005; NHS England, 2014) and partnership working. Although professionals may have informally shared learning experiences and expertise, specifically planned and structured opportunities for IPE were not established in the United Kingdom until relatively recently (Barr, 2007). In the UK, the evolution of Interprofessional Education (IPE) has been integrally linked with political change and social growth.

The factors contributing to poor working relations between health and social care professionals are extremely complex; many professions had their professional roots entwined with status, class and gender (Barr, 2007), promoting prejudice or professional mistrust (Carpenter, 1995). Professional isolation was perpetuated using specialist language or jargon (Chambers, 2012), or keeping individual patient records. Indeed, health and social care students were not only entering their professional training with established prejudice regarding other professions, but qualifying and leaving with their prejudices reinforced (Barr, 2008). This raises the possibility of using education to improve interprofessional understanding and successful collaborative working and is now well documented in the IPE literature; see Hornby and Atkins, (2000); Howkins and Bray (2007); McKeown et al. (2010).

In 1987, the Centre for the Advancement of Interprofessional Education (CAIPE) was established in the UK. The 2001 government white paper Working Together, Learning Together: a framework for lifelong learning for the NHS (DOH 2001) provided a strategic framework and co-ordinated approach to continued professional development, arguing for a shared approach to core skills in educational and practice settings.

There are a number of recent reports, which set out the case for the transformation of the NHS workforce (NHS England, 2014; Imison et al., 2016, Gilbert, 2016) with emphasis on collaboration and a multi-professional approach. The Five Year Forward Review (NHS England, 2014) states that the NHS needs to evolve from an illness based, provider led system towards one that is patient led, preventive in focus and offers care close to home. There is a clear emphasis on the need for new models of care that break down traditional boundaries, that is place based, patient centred with a workforce that meets the needs of 21st Century patients, whose needs range from acute disease based care to multi-morbidity and long term conditions (Imison et al., 2016). The focus is clearly on meeting staffing requirements of existing professions and focusing on best outcomes (Addicott et al., 2013). However, the upskilling of the current support workforce is also seen as a key to change (NHS England, 2014; Gilbert, 2016) as is the development of new roles within vanguard sites (NHS England, 2016).

These documents focus on the reshaping and transformation of the current rather than future workforce but usefully identify a number of factors for consideration when re-imagining what a future workplace-ready workforce might look like. These include lack of role clarity, fragmentation of care, professional resistance, threats to organisational identity, developing better communication skills, resourcing, building on existing models of workforce integration and learning lessons from early adopters (Gilbert, 2016; Imison et al., 2016).

Boundary spanning, i.e. creating relationship and interconnections across organisational structures and professional boundaries is also seen as key to changing approaches to patient centred care (Williams, 2002). There is much useful work detailing factors which can support boundary spanning including work on professional identity (Goodman et al., 2013; Shirley and White-Williams, 2015), relationship development (Aungst et al., 2012; Centre for Workforce Intelligence, 2012; care design (Roberts and Cameron, 2014) and skills development (Centre for Workforce Intelligence, 2011; Cameron, 2014).

All of this work has value when considering what a different kind of health and social care professional graduate might look like in the future. Given the continued existence of CAIPE and units such as the continued Universities Interprofessional Learning unit in Sheffield, there is much existing work to draw on.

Current Literature

The current literature relevant to this project can be broken down into three groupings, one that looks at integrated working in terms of the current workforce (Hall, 2015; Armitage et al., 2007; Suter, 2009; Brewer et al., 2012). This includes useful examples of models of interprofessional education developed for practice such as the TULIP model (Armitage et al., 2008). There is then a body of literature on interprofessional education (Hammick et al., 2007; Barr, 2008; Walsh, 2005; Wood, 2009). Finally there is work which covers both current practice and the lessons for current and future education (Freeman et al., 2000; D'amour et al., 2005).

Here it is useful to briefly document some of the key issues, ideas and areas for exploration in relation to re-imagining future health and social care education, which emerge from current thinking. D'amour and Oandason (2005) lay claim to the development of the concept of 'interprofessionality' as the development of a cohesive and integrated health care practice for professionals with implications for the education of such professionals, identifying a lack of such interprofessional education as a barrier to collaborative working in practice. Hammick et al. (2007: 736) define interprofessional education as follows: 'interprofessional education is those occasions when members (or students) of two or more professions learn with, from or about one another to improve collaboration and the quality of care'. Freeman et al. (2016) identify three areas needing deployment to develop collaborative practice: the organisation, the group and the individual, while Barr (2008) provides a useful historical context of IPE.

A number of studies identify key components for consideration when re-imagining undergraduate education, including shared vision, good communication, understanding and valuing of the roles of other professionals, a clear understanding of what multi-professional working means, seeing clients/patients as partners in service delivery and concerns arounds professional identity (Freeman et al., 2000; D'amour and Oandason, 2005; Baxter and Brumfitt, 2008). Norsen et al. (1995) identify collaborative skills essential for effective multi-professional working; these include co-operation, collaboration, assertiveness, sharing responsibility, communication and autonomy.

Chambers (2012) explores the notion of the idealised professional self as a lens through which education is experienced and professional identity is formed. Drawing on the work of Vanderstraeten (2000), Burke and Stet (2009) and Williams (2011), Chambers examines the interactive nature of the formation of professional identity and its implications for education. This includes the idea of 'othering' (Hall, 1997) of other professional groups and an examination of how the co-creation of learning environments and the identification of the ways in which interprofessional role

modelling (Gibson, 2004; Chambers, 2012) can help to address this. Competing and conflicting professional discourses exist in both the workplace and educational settings and, as Hall (2005) has pointed out uni-professional site teaching does nothing to counteract this.

Hammick et al.'s (2007) systematic review of interprofessional educators identifies a number of areas for consideration in terms of design and delivery of IPE, including cohort size, resourcing, curriculum design for adult learning, learner choice and the attributes needed for the facilitation of effective IPE, including knowledge of the historical relationship shared by health and social care professionals (Holland, 2002). A Norwegian study by Aase and Dieckmann (2013) adds that there needs to be a significant shift from traditional learning methods as part of a move towards IPE. Hall (2005) examines the idea of the university as multiversity, producing a silo-based system, which contributes to a student's uni-professional view of the world and a place where academic knowledge is fragmented and specialised, with opportunities to teach across boundaries consistently squandered.

Elsewhere the idea of the development interprofessional competency and capability frameworks have been documented (Brewer and Jones, 2012; Walsh et al., 2005; Suter et al., 2009; Wood et al., 2009). Much of this work has emerged from the Combined Universities Interprofessional Learning Unit in Sheffield.

The Centre for Workforce Intelligence (CWF) [2013] states that a good understanding of the roles and responsibilities of other professionals will enable maximum effectiveness and reduce duplication of tasks and roles. NHS England (2014) have also highlighted necessary changes to workforce development in order to meet growing demands which include the shift from hospital to community care, new care models of integrated health and social care delivery and a focus on preventing illness and promoting health and wellbeing.

New and existing roles continue to be developed or extended to address the need to provide specialist care in the community and generalist care in hospital settings (Gilburt, 2016). Much of this has been carried out within practice areas where gaps in service delivery have defined both the problem and the solution. Skill mix changes and extended roles have been prominent to develop an autonomous workforce who can work at a higher level and engage in flexible cross-boundary working, for example the physician associate, advanced practitioner, dedicated liaison and co-ordinator roles with support worker role changes being particularly evident (Gilburt, 2016).

Interprofessional Education: Issues for Consideration

As described by Wilhelmsson et al. (2009) interprofessional skills cannot be taught by others, but instead must be learned in interaction with others. Hallam et al. (2016) call for a pedagogical shift in healthcare education identifying evidence of a change in attitudes and beliefs towards inter-professional practice. 'Tribalism', or the tendency of various professionals to act in isolation from or even in competition with each other (Hallam et al., 2016) is often one of the factors that can prevent professional education moving forwards (Frenk et al., 2010). Power and status can often be issues that prevent collaborative working where inequalities can be seen to exist, notably in entry requirements, training and legal responsibilities (McNeil et al., 2013). Hallam et al. (2016) identify that individuals evaluate more favourably those groups of which they are a member and tend to evaluate other groups less favourably, meaning tensions can exist due to perceived power and status influences. Michalec et al. (2013) found that health care students' attitudes were significantly biased towards in-group favouritism; therefore, any IPE opportunity needs to overcome professional in-group biases. There is a need to consider the personal and social attributes of the participant disciplines and for curriculum design to focus on the differences rather than the collective end (Hallam et al., 2017). In this way, the inherent diversity of students is harnessed as opposed to creating a programme suited to the generic whole. Pecukonis (2014) suggests that individuals must be equipped to develop *interprofessional cultural competence*, a flexible construction of identity where professional sub-groups are valued but that each group feels part of a team with common goals. This is supported by Croker et al. (2016) who talk of a need to develop *interprofessional mutuality* where behaviours include being interested in other professionals whilst bringing a sense of own discipline.

Frenk et al. (2010) recommend that education should adopt competency-driven approaches in promoting interprofessional education in order to break down professional silos and enhance collaborative relationships. Drawing on Barr (2002) and WHO (2010), Grapczynski et al. (2015) advocate for an agreed set of core interprofessional competencies that will strengthen research and educational initiatives and provide clear definition for outcome assessment.

Suggestions for activities for IPE include the use of problem-based learning and simulation techniques where scenarios can provide authentic examples of where the team can achieve interprofessional practice (IP) outcomes from the contributions of the individual disciplines (Hallam et al., 2016). In this way, the IP team is seen as a new entity and can reduce discipline-based tensions and profession specific silos (Williams et al., 2015). However, work carried out by Olson et al. (2016) with occupational therapy and podiatry students demonstrates that 'authoring' one's identity as a healthcare professional begins long before university and that IPE should not be seen as a 'process of inoculation' or limited to short-term university-based interventions. Recommendations include opportunities for students to reflect; become exposed to their profession's unique contribution with a shared curriculum structure and an acknowledgement of the significance of extra-curricular social

activity to enable both professional identity and inter-professional identity formation (Olsen et al., 2016). Grapczynski et al. (2015) highlight the benefits of using a constructivist approach to developing IPE and put forward the Integrated Model for Interprofessional Education (IMPE) that addresses six learning domains (teamwork, roles and responsibilities, communication, learning and critical reflection, client needs and ethics) in order to address the issues raised in the WHO Framework for Action (2010). Blue et al. (2014) call for a multiple methods approach to learner assessment in order to measure skills, knowledge and behaviour over time and in various contexts. These assessments together with milestone projects with team and patient outcomes for each stage of development would connect assessments together. Following on from this work, Reeves et al. (2015) stress the need for the evaluation of IPE to be considered early in the curriculum development and to involve as many stakeholders as possible, including representation from the professions involved, learners and local managers. They continue to identify areas for evaluation, advising that a focus on short-term learner outcomes overlook a number of important components such as context of IPE and the exploration of related activities for sustainability and replication.

Drawbacks of IPE are considered to be increased demands of academic and clinical staff time, timetables may not be synchronized across all health professionals and logistically challenging to implement with an already full academic timetable (Barwell et al., 2013). Lawlis et al. (2014) also identify a lack of skill and commitment from staff at faculty-level who may be inexperienced in interprofessional practice themselves creating barriers to IPE. This can often result in IPE becoming an add-on rather than an integral part of professional development therefore reverting to a siloed approach (Van Kuiken et al. 2016). Van Kuiken et al. (2016) recommend a graded, multi-layered approach to IPE in order to address differing needs of students and faculty at various levels of development. Dalton et al. (2007) suggest that those professions that trend away from the bio-medical model may be more open to IPE due to a more holistic patient approach that encourages collaboration between health care teams.

Examples of models of IPE developed for practice

A common theme through the literature involves a model of IPE that focuses on learning within an authentic practice setting. Pioneering work in Sweden has seen the Linkoping model (Wilhelmsson et al., 2009) replicated and trialled in other areas, including the UK and Australia (St. Bartholomew's hospital and the Royal London Hospital followed by a study by a partnership between St. George's Hospital, University of London and the Kingston and Brunel Universities) [Mackenzie et al., 2007; Brewer and Stewart-Wynne, 2013]. The Linkoping model enables the development of students' own professional identity alongside establishing common values and competencies. The original study included students from medical, social

care, nursing, bio-medical science, occupational therapy and physiotherapy and included academic learning within two modules engaged in by all students to develop a shared frame of reference, shared professional language and common skills and competencies in specific areas for example ethics. A third module was developed as a ward environment where students from all disciplines were given an authentic ward to run on a two-week placement. A review of the twenty years of using this model (Wilhelmsson et al., 2009) summarises their experience for success, which includes the need for constant evaluation, leadership, a sense of ownership and a conviction that IPE is the way forward.

Mackenzie et al. (2007) trialled and evaluated the training ward principles for a small number of occupational therapy students on a three week placement opportunity. Whilst the study did not consider any change in attitude or perception or the long-term effects of shared placement learning, they reported the overall experience might be valuable to the students to gain an understanding of how interpersonal skills may affect communication and teamwork in addition to gaining an understanding of how other team members worked. Brewer and Steward-Wynne (2013) also developed a training ward that provided an authentic, practice-based learning environment where health science students of various disciplines developed interprofessional capabilities by engaging in collaborative practice with their peers and the clients. This was echoed in work by Lawlis et al. (2016), where students studying nursing, occupational therapy and aged care across differing institutions in Australia engage in IPE by utilising non-traditional settings that provided an alternative to and enhancement of placement opportunities. The placement was for a three-week period and evaluations encouraged the development of interprofessional skills and team working skills. The small numbers within the pilot study means that generalisation of findings cannot be made; however, the findings demonstrate the positive change in attitude and understanding supports the need for future inclusion in health professional education curricula.

Simulations of authentic situations is also reflected in the literature. Vilvens et al. (2016) discuss a process of developing a one-day simulation IPE event across Emergency Medical Services, Medical Assisting, Nursing, Pre-Health Education, Radiologic Technology and Social Work in order to address skills that increase patient safety, reduce errors and improve the quality of health care. Evaluations suggest an overall positive outcome.

Current practice and lessons for current and future education

Bell et al. (2008) discuss the issue of professional and cultural differences and state that insufficient attention is paid to the cultural dimension of diverse disciplines working together which can create misunderstanding and even mistrust. Finding common values and goals or a common cause appears to be one of the main factors

for successful integrated work practice. Gilburt (2016) highlights a project in Torbay Care Trust (UK) who have successfully used a whole systems model of integration between organisations in its adult care services. In addition, the Chronic Care Model used in the Gwent Frailty Programme in Wales identifies common vision as one of the essential elements to its success (Barber and Wallace, 2012).

Shirey and White-Williams (2015) explain holding common values and goals can enable stakeholders to temporarily set aside organisational and professional identities. However, losing professional identity is not necessary in order to successfully integrate. Kousgard et al. (2015) found that professionals who are engaged in spanning boundaries usually maintain a strong identity. Lindsay and Dutton (2012) discuss the Pathways to work scheme where occupational therapists, physiotherapists and nurses were able to engage in generic working to create an improved client pathway through the service because of their strong roots within their own professional identities.

The Partnership for Older People in GM (NIHR CLAHRC Gtr Man 2015) project demonstrates how co-location and engagement between members of teams who cross systemic boundaries can influence practice in order to develop change in skill-mix required from within the team itself.

Van Kuchen et al. (2016) have usefully identified a set of care topics (standards of practice, care planning, care team leadership, communication skills, use of health information skills technology and cross-system integration) and competencies (management, access improvement, care co-ordination, patient engagement, performance management, staff enablement, business process improvement) which could potentially form the basis of an interprofessional learning package.

There is much then in the current literature to draw on and feed into the first stage of the project as a basis for exploring views of current stakeholders.

Methodology: Action Research

While traditionally, scientific disciplines have privileged knowing through thinking over knowing through doing (Reason and Bradbury, 2006) the emergence of critical theory and pragmatism (Habermas, 1971; Rorty, 1999) provided a challenge to this paradigm. In privileging reason and action over insight the concept of knowing through doing emerged, resulting in the establishing of action research, a term generally considered to have been coined by Kurt Lewin (1951) as a key methodological approach in the social services (Reason and Bradbury, 2006). Sagor (2000:1) defines action research as 'a disciplined process of inquiry conducted by and for those taking the action. The primary reason for engaging in

action research is to assist the 'actors' in improving and/or refining his or her actions.'

Kemmis (2006) argues for the emancipatory function of deliberate democratic dialogue, after Habermas' (1971) theory of communicative action, based on an approach in which researchers plan, collaborate, gather data and reflect, feeding findings back into a repeat of the cycle. This, argues Kemmis (2006), creates a wider community of inquiry involving a group of persons who do not necessarily know each other face-to-face. Toulmin and Gustavsen (1996) go a step further, arguing that research becomes less of a scientific happening and more of a political event. The cyclical nature of action research, for example, gathering together a group of 'researchers' who may not all necessarily have a 'research' background, engaging stakeholders in the data collection process and then feeding back findings as part of a further consultative process and in line with what Gustavsen (2003) calls distributive action research. The use of multiple data sources from different levels of stakeholder groups is key to this process. Thus, it becomes more important to create many events of low intensity and diffuse boundaries rather than fewer events that correspond to the classical action of a 'case' (Gustavsen, 2003:96). Outcomes are, then, the result of patterns of iteration between the members of the larger research group and the 'real world' nature of the research may also be shaped by social and organisational procedures (Giddeas, 1984; Bourdieu, 1977). Those in the broader team, therefore, may be both subject and object of the research (Kemmis, 2006).

Action learning, then, is conceptualised as a critical and emancipatory approach to research, which has outcomes focused on use in practical situations. This may include improving service outcomes, a focus on practicalities, helping practitioners to arrive at a critique of work settings, can be reconstructive of practice and practice settings and can help to unravel collective misunderstandings. For example, exposing alienation, cynicism and perceived threats on core values. Kemmis (2006:103) states: 'communication brings people together around shared topical concerns, problems and issues with a shared orientation towards mutual understanding and consensus.'

Sagor (2000) identifies four basic themes of action research: empowerment of participants, collaboration through participation, acquisition of knowledge and social change. The key purpose is to build reflective practitioners/stakeholders, address key priorities and build professional cultures. This takes place through a process, which aims to combine change agency with field research using the following stages:

- Select a focus
- Clarify themes
- Collect data via a staged process in which each stage feeds into the next
- Data analysis

The re-imagining project led by MMU has established a collaborative project team to lead the development of the work comprising of colleagues from MMU, HEE, University of Manchester, University of Salford, University of Bolton, Salford Royal Foundation Trust and Manchester City Council. The Team's role is to co-produce and lead a plan to develop the concepts for a new curriculum and then to evaluate and test them.

The re-imagining project is based on the principles of action research outlined here in both approach and design. The initial establishing of a multi-disciplinary project team was based on the principle of creating an initial community of inquiry; bringing together staff who did not all know each other. The multi-disciplinary nature of the team, with representatives from Local Authority, an integrated care organisation and Greater Manchester Universities, comprising individuals with professional backgrounds in nursing, social work, physiotherapy, occupational therapy, health promotion, research and workforce development reflects the topics to be addressed.

In creating an initial communicative space (Kemmis, 2006) the design of the project drew on the work outlined here (Habermas, 1971; Giddens, 1984; Sagor, 2006).

- Selection of focus: The project aims to explore the extent to which current health and social care undergraduate programmes adequately prepare graduates to work effectively in an integrated place based system and to establish whether changes to current delivery of such programmes are necessary. Three broad questions were formulated to shape initial focus group discussion.

- Is the current health and social care workforce fit for purpose? (Problems/barriers/threats to existing ways of working/professional identity issues? – to gain an understanding of what they think the current challenges are).

- What does the future landscape of health and social care look like? (How different to now – how do they see this change happening? – to understand what they believe about future delivery/ways of working e.g. integrated care).

- What do you think will equip undergraduates for the challenges of working within a changing landscape?
(Knowledge/skills/values/competencies/experience of IPL/multi professional working? – to understand they key issues in redeveloping the current curriculum).

- Clarification of themes via an initial literature search. These included an exploration of the current state of play in relation to interprofessional learning, shared vision and good communication practice, exploration of different professional roles, an understanding of what multi-professional working means, collaborative skills needed and professional identity issues.

- Staged data collection process – a number of key stakeholders were identified including strategic and operational managers in GM Health Trusts, ICOs and Local Authorities, University staff and students, service users, carers, GPs and Commissioners. A series of stakeholder focus groups, individual interviews and strategic consultative events were organised over a proposed period of six months with each stage feeding into the next; data analysis occurs at each stage. This process represents Gustavsen's (2007:90) 'many events of low intensity and diffuse boundaries'.

It is envisaged that the result, based on this process, will lead to change. Passmore (2006:47) sees a project 'with a vision in mind of the future one wishes to create' as a legitimate starting point and aim for the action research. This is also in line with the idea of action research as cyclic, participative, qualitative and reflective and as a process of inquiry in which those involved are both subject and object (Kemmiss, 2006) with the aim of changing or refining practice/action (Sagor, 2000).

The aims of the project are ambitious and wide ranging with the potential for outcomes to represent Toulmin and Gustavsen's (1996) political event.

Conclusion

Contextualised by The Five Year Forward View (NHS England) the re-imagining undergraduate education, health and social care education project aims to explore the case for change for professional education in order to create a workforce fit for purpose in the 21st Century health and social care services landscape. Concomitant with the acknowledgment that health care urgently needs to move away from an illness based, provider led system towards a service that is patient-led, preventative in focus and provides place-based care (NHS England, 2014) is the necessary shift in values and behaviours among health and social care professionals. The project recognises at present the absence of a shared vision and the correct matching of such values and behaviours among pre and newly qualified health and social care professionals to make successful, integrated work a reality.

GM health and social care devolution offers an opportunity to harness the values and behaviours necessary for person-centred, interdisciplinary integrated care at the centre of the undergraduate learning experience; and whilst currently the programme

curricula includes elements of interprofessional learning, these are largely on the perimeter as opposed to the centre. The intended outcome of the work is to produce graduates equipped with the requisite skills, knowledge, values and resilience to work effectively in a place-based system care system.

Drawing on existing literature outlined here, the project will use an Action Research methodology (Lewis, 1957; Habermas, 1971; Kenmiss, 2006) using this literature to frame a number of research questions which will be presented to key stakeholder focus groups. These include strategic planners, current health and social care staff at an operational level, current staff and students involved in current delivery models, GPs and service users. Initial work has already revealed a number of issues to be addressed including the predominantly uni-professional nature of current delivery to the graduate population, staff resistance to change, issues of professional identity, development of skills and core competencies and multi-professional working, issues of professional mistrust and lack of role understanding and the renegotiation of curriculum design and delivery. The Five Year Forward View (NHS, 2014) emphasises the need for new models of care that break down traditional boundaries, are patient centred and encourage place-based approaches to staffing. It is envisaged that the outcomes of the project will provide key findings with the potential to help redesign professional education to meet these stated ambitions.

References

Aase, I., Aase, K. and Dieckmann, D. (2013) 'Teaching interprofessional teamwork in medical and nursing education in Norway: A content analysis.' *Journal of Interprofessional Care*, 27(3) pp. 238-245.

Addicott, R., Maguire, D., Honeyman, M. and Jabbal, J. (2015) *Workforce planning in the NHS.* London: The Kings Fund. [Online] [Accessed on 11th January 2016] https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

Armitage, G.D., Suter, E., Oelke, N.D. and Adair, C. (2009) 'Health systems integration: state of the evidence.' *International Journal of Integrated Care,* 9(17) pp. 1-11.

Armitage, H., Connolly, J. and Pitt, R. (2008) 'Developing sustainable models of interprofessional learning in practice – The TULIP Project.' *Nurse Education in Practice*, 8(8) pp. 276-282.

Aungst, H., Rube, M., Strange, K.C., Allan, T.M., Borawski, E.A., Drummond, C.K., Fischer, R.L., Fry, R., Kahana, E., Lalumandier, J.A., Mehlman, M., Moore, S.M. (2012) 'Boundary spanning and health invitation to a learning community.' *Journal of Primary Care*, 4(2) pp.109-115.

Barber, K., Wallace, C. (2012) 'Happily independent – configuring the Gwent frailty support and wellbeing worker.' *Journal of Integrated Care,* 20(5) pp. 308-321.

Barr, H. (2002) *Interprofessional education - today, yesterday and tomorrow: a review*. London: Learning and Teaching Support Network: Centre of Health Science and Practice. [Online] [Accessed 18th January 2017] http://www.unmc.edu/bhecn/_documents/ipe-today-yesterday-tmmw-barr.pdf

Barr, H. (2007) (ed.) *Piloting Interprofessional Education: Four English Case Studies*. London: Higher Education Academy Health Science and Practice Centre.

Barr, H. (2008) 'Interprofessional education: from rhetoric to reality.' *The Niigata Journal of Health and Welfar*e, 8(1) pp. 90-98.

Barwell, J., Arnold, F., Berry, H. (2013) 'How interprofessional learning improves care.' *Nursing Times,* 109(21) pp. 14-16.

Bauman, Z. (2000) *Liquid modernity.* Cambridge: Policy Press.

Baxter, S.K. and Brumfitt, S.M. (2008) 'Professional differences in interprofessional working.' *Journal of Interprofessional Care*, 22(3) pp. 239-21.

Bell, K., Hinder, T., Huby, G. (2008) 'What comes around goes around: on the language and practice of 'Integration' in Health and Social Care in Scotland.' *Journal of Integrated Care,* 16(4) pp. 40-48.

Blue, A.V., Chesluck, B.J., Conforti, L.N., Holmboe, E. (2015) 'Assessment and evaluation in interprofessional education: Exploring the field.' *Journal of Allied Health,* 44(2) pp. 73-82.

Bourdieu, P. (1977) *Outline of a theory of practice*. Cambridge: Cambridge University Press.

Brewer, M., Stewart-Wynne, E. (2013) 'An Australian hospital-based student training ward delivering safe, client-centred care while developing students' interprofessional practice capabilities.' *Journal of Interprofessional Care,* 27(6) pp. 482-488.

Brewer, M.L. and Jones, S. (2013) 'An interprofessional practice capability framework focusing on safe, high quality, client-centred health service.' *Journal of Allied Health*, 42(2) pp. 45-99.

Brown, B. J. and Baker, S. (2013) *Responsible citizens: individuals, health and policy under neoliberalism*. Anthem Press.

Burke, P.J. and Stet, J.E. (2009) *Identity theory*. Oxford: Oxford University Press.

Cameron, G. (2010) 'The contribution of housing support workers to joined up services.' *Journal of Interprofessional Care*, 24(1) pp. 100-110.

Carpenter, J. (1995) 'Doctors and nurses: stereotypes and stereotype change in interprofessional education.' *Journal of Interprofessional Care*, 9(1) pp. 151-161.

CAIPE (1997) *Interprofessional Education*: A Definition, CAIPE Bulletin, 13.

Centre for Workforce Intelligence (2011) *Integrated care for older people: examining workforce and implementation challenges*. London: Centre for Workforce Intelligence. [Online] [Accessed 18th January 2017] http://www.cfwi.org.uk/documents/integrated-care-for-older-people

Centre for Workforce Intelligence (2012) *Adult social care workforce intelligence.* London: Centre for Workforce Intelligence. [Online] [Accessed 18th January 2017] http://www.cfwi.org.uk/publications/forecasting-the-adult-social-care-workforce-workforce-intelligence-report

Centre for Workforce Intelligence (2013) *Think integration, think workforce: three steps to workforce integration*. London: Centre for Workforce Intelligence. [Online] [Accessed 18th January] http://www.cfwi.org.uk/publications/think-integration-think-workforce-three-steps-to-workforce-integration-1/@@publication-detail

Chambers, A. (2012) Student Physiotherapists' Narratives and the Construction of Professional Identities, Ed Doc Thesis (unpublished). University of Central Lancashire.

Croker, A., Brown, L., Little, A., Crowley, E. (2016) 'Interprofessional relationships for work-integrated learning in healthcare: identifying scope for ongoing professional development.' *Creative Education* 7(1) pp. 1729-1738.

Dalton, L., Spencer, J., Howarth, H. (2007) *Report of the investigation of undergraduate health science student attitudes toward interprofessional education*. Hobart: University of Tasmania.

D'amour, D. and Oandason, I. (2005) 'Interprofessionality as the field of interprofessional practice and interprofessional education: an emerging concept.' *Journal of Interprofessional Care*, 22(3) pp. 239-251.

Department of Health (2001) *Working together – learning together: a framework for lifelong learning for the NHS*. London: Department of Health. [Online] [Accessed 11th January 2017] http://dera.ioe.ac.uk/13612/1/Working%20together%20-%20learning%20together%20dept.%20of%20health.pdf

Freeman, M., Miller, R. and Ross, N. (2000) 'The impact of individual philosophies of teamwork on multi-professional practice and the implications for education.' *Journal of Interprofessional Care*, 14(3) pp. 237-247.

Frenk, J., Chen, L., Bhutta, Z.A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Garcia, P., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Naylor, D., Pablos-Mendez,

A., Reddy, S., Scrimshaw, S., Sepulveda, J., Serwadda, D. and Zurayk, H. (2010) 'Health professionals for a new century: transforming education to strengthen health systems in an interdependent world.' *The Lancet,* 376(2) pp. 1923-1958.

Gibson, D.E. (2004) 'Role models in career development: new directions for theory and research.' *Journal of Vocational Behaviour*, 65(1) pp. 134-156.

Giddens, A. (1984) *The constitution of society: author of the theory of structuration*. Berkeley CA: University of California Press.

Gilbert, A. (2016) *Supporting integration through new roles and working across boundaries*. London: The Kings Fund. [Online] [Accessed 18th January 2017]

Gilburt, H. (2016) *Supporting integration through new roles and working across boundaries.* The Kings Fund: London. [Online] [Accessed 11th January 2017] https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Supporting_integration_web.pdf

Goodman, C., Davies, S.L., Dickinson, A., Gage, H., Froggatt, I.G., Marbey, H., Victor, C., Masey, H., Martin, W, Iliffe, S. (2013) *A study to develop integrated working between primary health services and care homes*. University College London: Service Delivery and Organisation Programme. [Online] [Accessed 15th September 2016] https://njl-admin.nihr.ac.uk/document/download/2008899

Grapczynski, C.A., Shuurman, S., Booth, A.D., Bambini, D., Beel-Bates, C, (2015) 'The integrated model for interprofessional education.' *Journal of Allied Health,* 44(2) pp. 108-114.

Greater Manchester Combined Authority (2015) *Taking Charge of Our Health and Social Care in Manchester. Summary.* [Online] [Accessed 14th June 2017] http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Summary.pdf See also http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Final.pdf

Gustavsen, B. (1996) 'Development and the social sciences: an uneasy relationship' *In* Toulmin, S. and Gustavsen, B. (eds.) (1996) *Beyond theory: changing organisations through participation*. Amsterdam: John Benjamins, pp. 5-30.

Gustavsen, B. (2003) 'Action research and the problem of the single 'case'. *Concepts and Transformation,* 8(1) pp. 93-99.

Habermas, J. (1972) *Knowledge and human interests*. London: Heinemann.

Habermas, J. (1974) *Theory and practice*. London: Heinemann.

Habermas, J. (1987) *The theory of communicative action, vol 2: lifeworld and system: a critique of functionalist reason*. Boston, MA: Beacon Press.

Hall, P. (2005) Interprofessional Teamwork: Professional Cultures as Barriers, *Journal of Interprofessional Care*, 19, Supl, 188-196.

Hall, S. (1997) [ed] *Representations: Cultural Representation and Signifying Practices*. London: Sage.

Hallam, K.T., Livesay, K., Morda, R., Sharples, J., Jones, A., de Courten, M. (2016) 'Do commencing nursing and paramedicine students differ in interprofessional learning and practice attitudes: evaluating course, socio-demographic and individual personality effects.' *BMC Medical Education,* 16(80) pp. 1-9.

Hammick, M., Freeth, D., Koppel, S., Reeves, S and Barr, H. (2009) 'A best evidence systematic review of interprofessional education: BEME guide no. 9.' *Medical Teacher*, 29(8) pp. 735-751.

Heenan, D. and Birrell, D. (2006) 'The integration of health and social care: The lessons from Northern Ireland.' *Social Policy & Administration*, 40(1) pp. 47-66.

Delaware Center for Health Innovation. (2015) *Health care workforce learning and re-learning curriculum.* Unknown place of publication: Delaware Center for Health Innovation. [Online] [Accessed 18th January 2017] http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Workforce-Learning.pdf.

Holland, K. (2002) 'Interprofessional education and practice: the role of the teacher/facilitator.' *Nurse Education Press*, 2(3) pp. 221-222.

Hornby, S. and Atkins, J. (2000) *Collaborative care: interprofessional, interagency and interpersonal.* Oxford: Blackwell.

Howarth, M., Holland, K. and Grant, M.J. (2006) 'Education needs for integrated care: a literature review.' *Journal of Advanced Nursing*, 56(2) pp. 144-156.

Howkins, E. and Bray, T. (2007) *Preparing for interprofessional teaching: theory and practice*. Oxford: Radcliffe Medical Press.

Imison, C., Castle-Clarke, C. and Walter, R. (2016) *Reshaping the workforce to deliver the care patients need*. London: Nuffield Trust.

Kemmiss, S. (2001) 'Exploring the relevance of critical theory for action research.' *In* Reason, P. and Bradbury, H. (eds.) (2008) *Handbook of action research: participative inquiry and practice.* London: Sage, pp. 91-102.

King's Fund. (2011) *Integrated care: what is integrated care? What is it? Does it work? What does it mean for the NHS?* Unknown place of publication: The King's Fund. [Online] [Accessed 18th January 2017] https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-summary-chris-ham-sep11.pdf

Kousgaard, M.B., Joensen, A.S.K., Thorsen, T. (2015) 'The challenges of boundary spanners in supporting inter-organisational collaboration in primary – a qualitative study of general practitioners in a new role.' *BMC Family Practice*, 16(17) pp. 1-9.

Lawlis, T., Wicks, A., Jamieson, M., Haughey, A., Grealish, L. (2016) Interprofessional education in practice: Evaluation of a work integrated aged care program *Nurse Education in Practice* 17 161-166.

Lewin, K. (1951) *Field theory in social science: selected theoretical papers*. New York: Harper and Row.

Lindsay, E., Dutton, M. (2012) 'Promoting healthy routes back to work? Boundary spanning health professionals and employability programmes in Great Britain.' *Social Occupational Therapy,* 70(8) pp. 358-361.

McKeown, M., Malitia-Showa, L. and Downe, S. (2010) *Service user and learner involvement in education for health and social care: promoting partnership in health*. Oxford: Blackwell.

National Collaboration for Integrated Care and Support. (2013) *Integrated Care and Support: Our Shared Commitment.* Unknown place of publication. National Collaboration for Integrated Care and Support. [Online] [Accessed 21st September 2016]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

McNair, R. P. (2005) 'The case for educating health care students in professional as a care content of interprofessional education.' *Medical Education*, 39(2) pp. 456-464.

Michalec, B., Giordiano, C., Arenson, C., Antony, R., Rose, M. (2013) 'Dissecting first years students' perceptions of health profession groups: Potential barriers to interprofessional education.' *Journal of Allied Health,* 42(4) 202-13.

National Voices. (2015) *A narrative for person-centred co-ordinated care. NHS England Publication*. Unknown place of publication. NHS England publication. National Voices. [Online] [Accessed 18th January 2017]
https://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

NHS England. (2014) *The five-year forward view*. Unknown place of publication. NHS England publication. [Online] [Accessed 21st September 2016]
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfor-web.pdf.

NHS England. (2016) *New care models: vanguards – developing a blueprint for the future of NHS and care services*. Unknown place of publication. NHS England publication. [Online] [Accessed 18th January 2017]
www.england.nhs.uk/vanguards/futurenhs. Accessed 21/09/16.

National Institute for Health Research: Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester. (2015) *NHS Greater Manchester primary care demonstrator evaluation: Final report, Manchester: Collaboration for Leadership in Applied Health Research and Care*. Unknown place of publication. National Institute for Health Research. [Online] [Accessed 7th

November 2016] http://clahrc-gm-nihr.ac.uk/our-work/organising-healthcare/demonstrator/

Norsen, L., Opladen, J. and Quinn, J. (1995) Practice model: collaborative practice. Critical care nursing clinic, *North America*, 7(2) pp. 43-52.

Shaw, S., Rosen, R. and Rumbold, B. (2011) *What is integrated care? An overview of integrated care in the NHS: research report*. London: Nuffield Trust. [Online] [Accessed 18th January] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/what_is_integrated_care_research_report_june11_0.pdf

Olson, R. E., Klupp, N. and Astell-Burt, T. (2016) 'Re-imagining health professional socialisation: an interactionist study of interprofessional education.' *Health Sociology Review,* 25(1) pp. 92-107.

Passmore, W. (2001) 'Action research in the workplace: the socio-technical perspective.' *In* Reason, P. and Bradbury, H. (eds.) (2008) *Handbook of action research*: participatory inquiry and practice. London: Sage, pp. 38-47.

Pecukonis, E. (2014) 'Interprofessional education: a theoretical orientation incorporating profession centrism and social identity theory.' *Journal Law Med Ethics,* 42(2) pp. 60-64.

Pownall, H. (2013) 'Neoliberalism, austerity and the Health and Social Care Act 2012: The coalition government's programme for the NHS and its implication for the public sector workforce.' *Industrial Law Journal,* 42(4) pp. 422 - 433.

Reason, P. and Bradbury, H. (2006) 'Introduction: inquiry and participation in search of a world worthy of human aspiration.' *In* Reason, P. and Bradbury, H. (eds.) (2006) Handbook of Action Research, London: Sage, pp. 1-14.

Reeves, S., Boet, S., Zierier, B. and Kitto, S. (2015) 'Interprofessional Education and Practice Guide No 3: Evaluating Interprofessional education.' *Journal of Interprofessional Care,* 29(4) pp. 305-312.

Roberts, L. and Cameron, G. (2014) *Evaluation of the integrated communities 2 programme (incorporating the integration discovery community): evaluation report*. London: OPM. [Online] [Accessed 18th January 2017] https://www.opm.co.uk/wp-content/uploads/2014/07/OPM-AQuA-Report-FINAL-05JUNE-2014.pdf

Rorty, R. (1999) *Philosophy and social hope*. London: Penguin Books.

Sagor, R. (2000) *Guiding School Improvement with Action Research*. [Online] [Accessed 7th December 2016] http://www.ased.org/publications/books.100074/chapters/What-Is-Action-Research%

Schion, D. (1987) *Educating the reflective practitioner: towards a new design for teaching and learning in the professions.* San Francisco, CA: Jersey.

Shirey, M.R., White-Williams, C. (2015) 'Boundary spanning leadership practices for population health.' *The Journal of Nursing Administration*, 45(9) pp. 411-415.

Speed, E. and Gabe, J. (2013) 'The Health and Social Care Act for England 2012: The extension of 'new professionalism'.' *Critical Social Policy,* 33(3), 564 – 574.

Suter, E., Arndit, J. Arthur, N., Parboosingh, J., Taylor, E. and Deutschlander, F. (2009) 'Rose understanding and effective communication as care competencies for collaborative practices.' *Journal of Interprofessional Care*, 23(1) pp. 41-51.

The Parliamentary Office of Science and Technology. (2016) *Integrating Health and Social Care*. Unknown place of publication: The Parliamentary Office of Science and Technology. [Online] [Accessed 18th January 2017] http://researchbriefings.files.parliament.uk/documents/POST-PN-0532/POST-PN-0532.pdf

Toulmin, S. and Gustavsen, B. [eds.] (1996) *Beyond Theory: Changing Organisations Through Participation*. Amsterdam: John Benjamins.

Valentijn, P.P., Schepman, S. M., Opheij, W. and Bruijnzeels, M. A. (2013) 'Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care.' *International Journal of Integrated Care*, 13(1) pp. 1-12.

Vanderstraeten, R. (2000) 'Autopoiesis and socialisation on Luhman's reconceptualization of communication and socialisation.' *British Journal of Sociology*, 51(3) pp. 581-598.

VanKuiken, D.M., Schaefer, J.K., Flaum-Hall, M., Browne, F.R. (2016) 'Integrated interprofessional education into the curriculum: challenges and solutions for a university without a medical centre.' *Journal of Interprofessional Education and Practice,* 2(1) pp. 5-11.

Vilvens, H., Hendersen, C., Maloney, B., Roman, T., Trotta, D. (2016) 'Improving health care collaboration and communication: integration of inter-professional education opportunities for undergraduate students.' *Journal for Research and Practice in College Teaching*, 1(1) pp. 1-6.

Walsh, C.L., Gordon, F., Marshall, M., Wilson and Hunt, T. (2004) 'Interprofessional capability: a developing framework for interprofessional education.' *Nurse Education in Practice*, 5(2) pp. 230-237.

Wilhelmsson, M., Pelling, S., Ludvigsson, J., Hammar, M., Dahlgren, L., Faresjo, T. (2009) 'Twenty years experiences of interprofessional education in Linkoping-ground-breaking and sustainable.' *Journal of Interprofessional Care,* 23(2) pp. 121-133.

Williams, J. (2011) 'Teacher telling tales: the narrative mediation of professional identity.' *Research in Mathematics Education*, 13(2) pp. 131-142.

Williams, P. (2002) 'The competent boundary spanner.' *Public Administration*, 50(3) pp. 102-124.

Wood, V., Flavell, A., Vanstolk, D., Bainbridge, L. and Nasmith, L. (2009) 'The road to collaboration: developing an interprofessional competency framework.' *Journal of Interprofessional Care*, 23(6) pp. 621-629.

World Health Organisation (2010) *Framework for action in Interprofessional education & collaborative practice Geneva: health professionals network nursing and midwifery office.* Geneva, Switzerland: Department of Human for Health. [Online] [Accessed 18th January 2017] http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf?ua =1

Brown, B. J. and Baker, S. (2013) *Responsible citizens: individuals, health and policy under neoliberalism*. Anthem Press.

Greater Manchester Combined Authority (2015) *Taking Charge of Our Health and Social Care in Manchester. Summary*. [Online] [Accessed 14th June 2017] http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Summary.pdf See also http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Final.pdf

Pownall, H. (2013) 'Neoliberalism, austerity and the Health and Social Care Act 2012: The coalition government's programme for the NHS and its implication for the public sector workforce.' *Industrial Law Journal,* 42(4) pp. 422 - 433.

Speed, E. and Gabe, J. (2013) 'The Health and Social Care Act for England 2012: The extension of 'new professionalism''. *Critical Social Policy,* 33(3), 564 – 574.