COMMUNITY STAFF TRAINING PROJECT

An investigation of the continuing education needs of community health care staff

Report to the Southwest Thames Regional Health Authority
on a Research Project commissioned by them,
based in the Department of Adult Education at the University of Surrey.

The Research was carried out between April and October 1975 by

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BACKGROUND

The Community Staff Training Project was initiated as a result of major organisational changes which occurred during the last two years. At national level the reorganisation of the National Health Service brought together community and hospital services under a unified administration. At the same time there has been an increased emphasis on care in the community rather than in hospital:

“It is apparent that there could be economic and humanitarian advantages, without loss in the quality of care, if in the future there was a change of emphasis away from the hospital towards care in the community.” (1)

This latter development though must be viewed in the wider context of the interdependence of all branches of the hospital, community health, social and voluntary services.

At Regional level much of the continuing education provision for the community staff of the three London Area Health Authorities has been made by the London Boroughs Training Committee. This provision continued with financial support from the Regional Health Authority at its establishment on 1 April 1974 but was planned to cease on 1 April 1976. From that date provision was to have been planned by the Region for its staff.

These developments led to the realisation by the Regional Health Authority that if continuing education provision and management training were to be in any,way realistic and if existing Regional resources were to be used effectively then a skilled investigation leading to the identification of training needs would have to be carried out prior to the 1976 programme.

The Department of Adult Education at the University of Surrey has had extensive involvement in educational, research and development work with a range of professions, e.g., education, rescue services (police, fire, etc.), health and social services.(2) At the beginning of 1975 the South West Thames Regional Health Authority invited the Department to undertake a small Research Project into the continuing education needs of community health care staff. James Kilty, Lecturer in Adult Education, and Noëlle Garner, Administrative Officer, formed the Research Team to coordinate the work of the ‘Community Staff Training Project’. Parallel with this Project, the Regional Health Authority formed ‘The Steering Party for Post-Basic Training Needs for Community Staff (LBTC)’ to draw up a training programme to take effect from 1 April 1976.

OBJECTIVES

Although the Research Team and the Steering Party (LBTC) were working in the same setting and in a complementary way, there were significant differences in their objectives.

The research Team was concerned to assist the South West Thames Regional Regional Authority in planning its continuing education provision both in the short term and in the long term by:

1) Establishing training needs
2) Identifying some priorities
3) Providing a broad set of questions relating to training needs
4) Providing possible answers, alternatives and suggestions for some of these questions.

Because of the small scale of this Research Project, the sponsors and the Research Team agreed that it should be considered as the first step in an on-going programme of investigation, taking as wide a view as possible.

The terms of reference of The Steering Party for Post-Basic Needs for Community Staff (LBTC) were as follows:

1) To consider the programme carried out by the London Boroughs Training Committee and to examine the means by which this Region can undertake these responsibilities from 1 April 1976.

2) To determine

a) The organisational level at which the various types of training will be most effectively provided
b) The training priorities
c) The training needs common to all health care staff and those which are special to particular groups and levels
d) Existing Regional resources with a view to negotiating with relevant authorities their ability to carry out the implementation of this programme.

3) To produce in September 1975 recommendations for interim arrangements for continuing the present level of training through the Region for the first six months of 1976/77.

On the completion of this preceding work, the Steering Party will receive the report of the Regional Research Team with a view to examining its findings in order to:

1) Determine
a) The organisational level at which the various types of training will be most effectively provided
b) The training priorities
c) The training needs common to all health care staff and those which are special to particular groups :
d) The existing resources with a view to negotiating with the relevant authorities on their ability to carry out the implementation of the on-going programme of training.

2) Produce an on-going plan of training at District, Area and Regional level. Its brief thus included two distinct exercises:

1) To draw up an initial updated training programme (based on the current London Boroughs Training Board provision) scheduled originally to commence on 1 April 1976

2) To receive the findings of the Research Team and in the light of the information given make recommendations concerning the scope, content and nature of the on-going, longer-term regional training provision.

However since the completion of the Research Project, the decision was taken at a meeting of this Steering Party (LBTC) to postpone the cessation of support for the LBTC programme and to put in abeyance for the time being the start of the Steering Party's programme. The Steering Party will now continue with an amended brief to:
1) Examine the training and education needs of staff concerned with community health care as identified in the findings of the Regional Research Team and the Steering Party Report.

2) Make recommendations concerning the ways in which these needs should be met from Regional and other resources and the means by which on- going and developing needs should be identified.
3) Provide a broad estimate of the cost of implementing these recommendations as from the Autumn 1976.
4) Submit a report and recommendations to the Regional Team of Officers by 31 March 1976.

RESEARCH DESIGN

The research design we adopted was that of an educational evaluation. Educational evaluation is the process of delineating, obtaining and providing useful information for judging decision alternatives. (3) It is an action-related process closely linked to the purposes for which it was commissioned; in this case to provide a more informed and rational basis for decision-making about training provision, priorities and investment. Its aim is to lead to improved practice, and it does so by using a wide range of methods to. 'illuminate' problems and issues.(4) (5) The latter are not examined in isolation but in context by means of an open and flexible method of investigation rather than a prescribed set of rules.

The first and most basic educational decisions are about the scope of the provision as a whole. To support these decisions it is necessary to identify needs and unmet opportunities and to diagnose problems which prevent these needs being met. (3a) This work makes easier the later decisions to establish educational and training objectives of all kinds and ways and means to achieve them, bearing in mind the resources available.

It is not the evaluators who will judge the decision alternatives but those who make decisions about educational provision. In supporting and assisting such decisions, the evaluators obtain and provide the information but the delineation of information requirements is a joint task. (3b)

Serving decision-making requires a co-operative mode of enquiry in which the evaluators work closely and continuously with decision-makers in order to provide wide comprehensive bases for informal judgment. (6)

METHODOLOGY

We achieved this collaborative mode of enquiry by arranging, after discussion with senior Regional Health Authority personnel, for the Research Team to be advised and guided <u>at each stage</u> of its work by a Steering Committee composed of representatives of the managerial and training interests of the nursing, medical, paramedical and social services. The terms of reference of the Steering Committee were agreed as follows:

1) To represent the views of other individuals and groups in the fullest sense. To provide data from these groups and to keep them informed of research progress.

2) (a) To collaborate with and advise the Research Team in delineating information relevant to decision-making about continuing education provision.
(b) To ensure that the Research Team is adequately informed about kinds of decisions to be made and the criteria for judging information provided.

3) To liaise as necessary with the Steering Party for Post-Basic Training Needs for Community Staff (LBTC).

The same convenor and some common membership with the Steering Party (LBTC) facilitated the clear and accurate interchange of information consistent with the short-term and long-term objectives of the two committees.

Our investigation was divided into three fairly distinct phases although there was some overlap between them. (4a)

In the first phase we engaged in a process of open-ended familiarisation with and exploration of the area of study.

In the second phase we focussed our enquiries as issues began to emerge from the initial consultations which required more sustained and systematic study.

In the third and final phase we clarified and interpreted all the information gathered with a view to establishing some priorities for continuing education provision.

At each of the stages described, we met the research Steering Committee, reported to them, reviewed the progress of work and discussed the direction to be taken in the next phase. We found these regular meetings most valuable as they gave us an opportunity to crystallise our thinking and to consolidate our work in an on-going way.

Throughout the investigation we systematically consulted as representative as possible a range of groups and individuals together with relevant reference documents. Groups and individuals consulted included: practitioners of various professions in the Region, student groups with whom we were in direct contact, managers and administrators, Community Health Council Secretaries, staff of national bodies and institutions (e.g., Joint Board of Clinical Nursing Studies, Central Council for the Education and Training of Social Workers, Council for the Education and Training of Health Visitors), social work trainers and representatives of training institutions. We used a variety of methods; e.g., letter, interview and free discussion based on prepared questions. These questions were initially general and open-ended, but were later formulated as a result of information and ideas arising in the course of our work. The questions were given sometimes as a brain-storming exercise, sometimes in questionnaire form and sometimes verbally. As well as making arrangements to interview individuals with specific expertise, we used whenever possible already arranged professional meetings. We chose these not only to be representative of different professions but also to sample the Region on a geographical basis. In this case the questions were put to them either by the Research Team or by the Steering Committee members who amongst others kept us informed by relevant meetings. In the later stage we used interviews and meetings not only to corroborate findings and clarify issues but also to receive new information.

Examples of some of the questions we asked include:

- Write down as many problems as you can which are currently being faced by members of your profession in their work (a) within the profession (b) with other professional groups.
- Identify as many ways as possible in which hospital staff of all kinds meet community professional workers of all kinds.
- What are the most important skills needed in your job?
- How do you define your role and the role of others with whom you work closely?
- What are the problems and possibilities of team work in providing primary health care?
- What are your priorities for your own personal and professional development?
- What are your hopes and aspirations for the long-term development of the NHS?

On the whole we found this method of collecting information successful in that we were able, through the Steering Committee, to make extensive contacts which would not otherwise have been possible given the small scale of the Project. We found though that people were more willing to make a contribution at a meeting than to send us written replies at a later date. The latter method unfortunately did not prove as reliable as we had hoped.

We were aware throughout our investigation of the difficulties experienced by many health care staff in giving information freely and discussing problems openly in an institutional setting. (7)

Similarly the language used by a person consulted about his development showed clearly the limits of his insights into his own needs. This was particularly true about interpersonal skills, for which we have ample evidence that education opens up new possibilities for staff and students.

We interpreted the information gathered in two ways. Firstly, we used it as the basis for developing a philosophy of continuing education for people concerned with health care. We see this as the starting point to planning any programme of staff development. Secondly, we have concentrated discussion on certain well defined ‘problem’ areas which required detailed examination in order to develop strategies to resolve them. We chose those areas which were given a consistently high priority by many different groups and individuals through our investigation.

EDUCATION FOR COMMUNITY CARE

As confusion is often caused by the use of the term ‘community care’, we felt it essential to clarify at this point in the report the way in which we and others use it.

On the one hand it is often used to describe an antithesis to hospital; e.g., hospital care versus community-based health care. On the other hand it is used in a unified health service to describe the planning, operation and evaluation of an integrated system of health services to meet the ascertained needs of the whole community. In this latter context, the hospitals are properly viewed as a part of the community which they serve.

The brief of this Research Project was to investigate the continuing education needs of community-based health care staff. We accepted,though, that at a time when emphasis has been placed on the concept of integration in the health and social services it would have been anachronistic and divisive to consider the needs of community-based staff in isolation not only from hospital-based staff but from staff of other caring professions and from voluntary workers. We were aware from the outset of the likelihood of the existence of needs common to different groups and therefore of the potential importance of solutions which bring together members of different professional groups. In taking a broad look we were in a position to consider the training needs of all staff, both professional and voluntary, concerned with physical, mental and social care and many of our suggested solutions have a general validity in this respect, notwithstanding the specific needs of particular groups.

Having said that, we were also aware that in comparison with hospital- based staff, community staff are affected by very different environmental, organisational and consequently behavioural factors. For example, managers are further removed, the job requires the ability to make decisions without reference, patients are generally less dependent and interdisciplinary reporting relationships are more localised. As a result different educational approaches will often apply.

A SUGGESTED PHILOSOPHY OF CONTINUING EDUCATION FOR PEOPLE CONCERNED WITH HEALTH CARE

Continuing education of the members of a profession must be set firmly in the context of

1) Initial education (basic training)
2) Long-term personal and professional growth of the individual
3) Long-term development of the organisation

Initially professional education is designed to extend and develop the many competences (knowledge, understanding, attitudes, skills) of new entrants to a level which is at least beyond the minimum demanded by society of that profession and set, maintained and reviewed by the profession.

Throughout working life, qualified professionals should develop further through continuous reflection on their experiences and questioning their actions. They should derive and set goals for themselves from this on- 6 going self appraisal and also from supportive formal and informal appraisal of their competences by colleagues in an organisational setting.

Fundamental in this is the concept of professionals who are self-directing in respect of their own learning and development. This implies that they critically and continuously re-examine and question the competences required for their own growth and that of the profession to which they

belong. Ideally basic training courses should promote this commitment to self-direction and help individuals to greater awareness of their own abilities and confidence to use and improve their skills. The continuation of this process throughout professional life depends in large measure on the creation and maintenance of an environment to facilitate it. This becomes more important as increasing responsibility will require the individual to make a greater contribution to the development of the profession.

The stimulus for this process will sometimes come from the organisation which will have certain expectations of the individual or from subgroups within the organisation.. It will sometimes come from another professional group which is acquiring new expertise and re-examining its own role and responsibilities in relation to other groups. It will also come, as it does in any organisation, from pressures external to the organisation related to its fundamental purposes and goals which will change as society advances. Such pressures for change will always exist and demand continuous appraisal of the need to resist or adapt to them or even to modify them.

The Report of the Committee on Nursing refers to such pressures in a way which can clearly be applied to all the caring professions.

> "We are aware, of course, of the strains and stresses, individual and collective, which often accompany adaptation and reorganisation. Yet we do not believe that there can ever be a definitive phase when processes of adaptation and reorganisation are finally halted. There are bound to be future changes as the process of integration continues, and if these are to be carried through with the minimum strain and stress it is necessary that . . . managers, even more than at present, must take part in the shared management of the resources of an integrated National Health Service. Their role must be based ultimately on a clear conception of objectives arising from regular reappraisal of . . . needs." (8)

Some of these pressures are fundamental and far-reaching, e.g., the changing concepts of normality and health and the increasing expectations by society of the caring professions. Other changes are more circumspect but very important, e.g., integration, the conflict between generic and specialist training and responsibilities and the shortening of time spent by patients in hospital.

> "Because the social dimensions of (caring), both in the community and in the hospital, are so important in a period of rapid social change, we believe that all (staff) must be aware of the 'normal' as well as the 'abnormal', of the social repercussions of illness in different situations, of the interaction of patient and family and of hospital and community, and of the role of other (colleagues) in the caring profession ." (8a)

The rapid increase in knowledge and skills through research and technological advance, in the physical, mental and social aspects of caring, also demands a response from the professional.

> "It is not only social change or changing patterns of disease and distress which influence . . . care in practice but changes in (specialist) knowledge and performance." (8b)

The contribution by the organisation to the personal and professional growth of individual staff throughout their careers will be through planned and co-ordinated opportunities, especially in rapidly changing situations. These should enable them not just to cope with or to understand the changing situations they encounter but should also enable them to participate in the conception, planning, execution and evaluation of philosophies, policies and practices required to promote, anticipate and meet new challenges.

This is an educative process concerned with developing awareness of new possibilities and the ability to identify new needs. In order to enable individuals to fulfil their roles now and in the future, it will be necessary to develop their abilities to:

1) Identify their own needs, those of people with whom they work, their own and related professions and society

2) Respond to the expectations of the organisation and contribute to the development of these expectations

3) Interpret the significance of what others are doing in relation to themselves

4) Develop awareness of their role as agents for change as well as stability by anticipating future needs

5) Develop these into appropriate aims and objectives for themselves

6) Create and manage environments for the achievement of these aims and objectives

7) Evaluate their success in achieving these aims and objectives.

In this situation it is important that the organisation should acknowledge and be committed to the idea that to get good service from staff they must be considered as well as the patient/client.

> "Our personnel policy is based on an appreciation of the importance of people who work in the National Health Service and on the belief that the greatest benefit to the public can be obtained only by making the most effective use of our staff." (9)

In conclusion, the relationship between initial and continuing education is a dynamic one. Much that was once part of the continuing education of professional staff has been incorporated into the initial course. This will continue to be so. Similarly, as the change in emphasis from training to education continues, initial education will increasingly prepare professionals to meet change in general in the ways already described. It will not however be able to prepare for specific changes and developments which occur on a continuous basis. Continuing education then must expand as changes become more rapid. Clearly however such provision should be formulated in such a way that it can meet changing needs, resources and constraints as they arise.

SUGGESTED CRITERIA FOR TRANSLATING THE PHILOSOPHY OF CONTINUING EDUCATION TO ACTION

Whilst personnel responsible for planning continuing education provision might fully accept in principle the philosophy outlined here, we recognise that it is an altogether more difficult task to take such a philosophy and translate it into a practical reality.

Although we could not possibly expect to achieve in our work a complete set of practical solutions to all emergent problems, we propose some criteria which offer guidance in making decisions and choices. We suggest that they should be tested and developed in practice. We offer these criteria as a checklist below, to be used in the early stages of planning once a need has been defined.

1) In what grades of staff and for how many does this need exist?
2) Can the need be met by individuals carrying out some self-directed activity?
3) If so, will they require other support or encouragement, e.g., a predetermined discussion?
4) Does the same need exist in other Districts?
5) What members of other disciplines or professions have the same need?
6) Can the need be met within the organisational setting or is it necessary to plan a structured educational activity or are both necessary?
7) What would be the advantages/disadvantages of combining with another District in meeting the need?
8) Should the solution planned be ideally for a multi-disciplinary or a single-disciplinary group?
9) What would be the advantages/disadvantages of combining with other professions in meeting the need?
10) What are the practical difficulties of arranging a multidisciplinary activity?
11) Are your channels of communication with other groups sufficiently good to answer questions 4 - 10 above?
12) What proportion of staff will need to be released?

Once the activity/solution has been defined:

1) What resources would be required? Can sufficient resources be provided?
2) Should time be set aside to meet the need within normal working hours?
3) What length of meeting is desirable?
4) Should the meetings be highly structured? If so, by whom?
5) How many meetings would be required over a period of time?
6) How can the effects of the meeting(s) be ascertained?
7) What are the likely effects on standards of care, quality of teamwork, job satisfaction if the need is met satisfactorily?
8) Can the organisation afford <u>not</u> to meet the need?

INTRODUCTION

The principal areas which emerged in the course of our work are presented below under the headings Staff Development, Staff Appraisal, Role, Interpersonal Skills, Research, Law, Technical/Clinical Skills.

They represent a distillation of the complex set of interrelated needs which were brought to our attention by all or most of the individuals and groups consulted. All of these specific needs were corroborated by other members and groups within each profession and by members and groups from other professions.

The first four of these need areas apply to all professional groups concerned with health care, although differences in managerial structure as between nursing, paramedical and medical professions affect the first two.

Each area is developed in this section by a statement about the need; one or more questions related to specific aspects of the problem and some suggestions as to ways of meeting the need. All the questions were asked in one form or another, explicitly or implicitly, by those consulted. The solutions offered represent a range of decisions which could be taken, each in part contributing to remedying the need. In the main these suggested solutions emerged from our consultations. A few are our own suggestions which have been affirmed as being realistic by members of the steering committee and others consulted. We hope that many other solutions will be determined and tested by readers.

STAFF DEVELOPMENT

NEED

> "We aim to provide a comprehensive health service to the community and our greatest resources are people and their skills.
>
> "The standards of the service we offer depends largely upon three things: :
>
> a) Enough people
> b) Enough money
> c) Enough managerial skills with which to make the best use of the people and the money.
>
> "Effective managers know that they can substantially increase their resources by developing the knowledge, capabilities and skills of the people who work for them. . . These managers are concerned with assisting members of staff to achieve their potential in order to:
>
> i. Obtain greater satisfaction from the job
> ii. Make them more valuable members of the organisation." (10)

This responsibility for the development of all members of the caring professions should be shared between practitioners, managers, educational institutions and professional bodies and associations. We are particularly concerned here to explore the part played by practitioners and their managers.

Question 1 How can individual practitioners develop themselves personally and professionally?

SUGGESTED SOLUTIONS

1) By understanding and being committed to the process of self- examination, ie by being critical of their own understandings, attitudes and skills, by questioning what they do and why they do it.

2) By being aware of their own strengths and weaknesses and needs and seeking opportunities to increase their competences.

3) By setting goals for their immediate and long-term personal and professional development.

4) By seeking counsel on means of self-development.

NEED

It is clear from our work that individual practitioners need much greater support in respect of their own development.

Question 2 In what ways can individual practitioners be encouraged to develop themselves personally and professionally?

SUGGESTED SOLUTIONS

Organisational

1) Managerial guidance to help them achieve greater awareness of their own needs and of the many possibilities for their own development (as detailed later).
2) Creation of an environment where individuals are encouraged to voice their own needs and aspirations.

Educational

A primary aim of all courses, initial and post-basic, should be to achieve the acceptance by practitioners of responsibility for their own learning.

NEED

Managers and educators clearly have a vital role to play in facilitating and encouraging staff development.

Question 3. How can managers best exercise their responsibility for staff deve lopment?

SUGGESTED SOLUTIONS

Organisational

1) Demonstrating effective leadership by fostering self- determination, a questioning of their own knowledge, attitudes and skills. By being open to possibilities for development in the staff they manage.
2) Adequate dissemination of information about educational opportunities.
3) Adequate dissemination of information about recent developments, impending changes, relevant research reports, current articles.
4) Arrangement of time for regular discussion of issues of current concern.
5) Encouragement of visits for appropriate experience.
6) Using staff appraisal and counselling.

NEED

Our evidence suggests though that managers do not always exercise this responsibility in the most effective way.

Question 4 How can managers be helped to facilitate staff development?

SUGGESTED SOLUTIONS

Organisational

1) Appraisal of managers to include assessing their contribution to staff development (using appropriate criteria for staff development).
2) Managerial meetings to discuss issues of staff development and their responsibilities in this respect.
3) Selection and education of key managers to act as catalysts for change and development.

Educational

1) Development of interpersonal and counselling skills in managers:
2) Acceptance of and commitment to new roles and responsibilities through management courses.

STAFF APPRAISAL

In our experience, both managers and their staff shy away from appraisal systems. Indeed we have found conflicting views on whether or not a formal appraisal system should exist at all. For this purpose a formal system is taken to be one in which managers meet their subordinates at predetermined intervals, using a prescribed form of assessment as a basis for discussion and reporting.

Doubtless, if badly used an appraisal system can have many negative aspects. It can be seen as a critical review of performance based on impression as much as on fact. If can also be linked too closely to promotion, ignoring . the fact that many staff can benefit as much by a lateral expansion of their job as by an upward one.

Clearly the effectiveness of any staff appraisal system depends to a large extent on the understanding, attitude and skills of the people operating it. The view has been widely expressed that staff appraisal and career counselling are essential tools of both individual and organisational development. It is clear from our work that it is an area which needs to be tackled boldly, explored, developed and then operated in the fullest and most meaningful way.

Managers need to be educated to this responsibility which is essentially a caring one in which the individual should not take refuge in ritualised systems and techniques. Staff appraisal entails an honest, human, trusting interaction. It can have and has had in very many instances positive benefits for the individual and the organisation. It can be and has been linked with training and education by finding answers to questions of the following kind:

> How are people developing in their job?
> Which aspects of experience gained have given them the most and the least satisfaction?
> What are their strengths and weaknesses?
> What do they need next?

Information relating to individual training needs, whether they are clinical, professional or managerial, can thus be collected and appropriate action formulated.

This educative approach to appraisal can also highlight organisational problems which are limiting the individual’s performance, e.g., inadequate resources, poor information flow, unrealistic expectations by managers.

In this way, by identifying problems needing further investigation and subsequent action, appraisal can be an on-going developmental exercise for the organisation.

We accept that if manager/staff relationships are good, then continuous appraisal will often follow automatically. We believe however that there should exist recognised opportunities to assess individual needs and aspirations, although this should not be any way reduce the need for informal day-to-day counselling and advice.

We propose the following criteria in setting up an appraisal system:

1) Any system must be in harmony with the shared values of the organisation.
2) Objectives and expectations should be set jointly by appraiser and appraisee.
3) The manager must thoroughly understand and be committed to the system he/she uses.
4) Staff (appraisees) should clearly understand the aims of the appraisal system and the uses to which it will be put.
5) The system should apply to all qualified staff of all grades.

NEED

It is clear from our work that very many of those who are required to operate a staff-appraisal system are unable to formulate appropriate criteria or else they operate blindly a system that is capable of considerable development.

Question 1 How can managers be helped to carry out effectively their responsibility for staff appraisal?

SUGGESTED SOLUTIONS

Organisational

1) By being critical of their own strengths and shortcomings and needs for development.
2) By instituting appraisal by their own staff.
3) By regular meetings to keep staff appraisal under continuous review, including the development of appropriate forms.

Educational

1) Workshops on staff appraisal as part of the training of tutors and managers,
2) Greater emphasis on principles and practice of staff appraisal in management courses.

An example of an outline programme for a staff-appraisal course for middle managers is given in Appendix I. °

ROLE

Conflict, confusion, lack of information and understanding about roles and responsibilities exist particularly in relation to the following disciplines: General Practitioners, Health Visitors, District Nurses, Occupational Therapists and other paramedical staff and Social Workers. The same is true in the hospital setting, for example between doctors and nurses and also between nurses and community workers.

Time constraints prevented us from checking with all possible groups in the National Health Service and external to it about problems relating to role. Nevertheless we have abundant evidence of the gravity of the problems which permeate the whole Service, affecting all groups within it.

In order to highlight this area we offer below, as examples only, brief general descriptions of the principal responsibilities of some of these groups. .

The General Practitioner is the clinical leader of the Primary Health Care Team. He needs to make an accurate diagnosis of the patient's problem and refer the patient as necessary to the appropriate service. It is critical that he has a proper appreciation of the roles and skills of different disciplines and of members of the Primary Health Care Team. Often, like the hospital doctor, he adopts an inappropriate managerial role and does not appreciate the extent of the skills acquired by his colleagues in the course of their own specialised training.

The Health Visitor has a preventive, educative, supportive role which is often perceived as being ambiguous. Although she has specific responsibilities, e.g., for child health, antenatal care and care of the elderly, the Health Visitor sometimes seems to hold an occupational position on the fringes of nursing, educational and social-work territories without being fully identified with any of these spheres of work. She is primarily concerned with health education, the detection of treatable conditions and the prevention of illness. She needs to understand the medical, psychological and social needs of the whole family and help meet these needs through comprehensive counselling and by seeking help from other agencies. (11) In addition to receiving referrals from professional colleagues, she undertakes her own case-finding and is the only Health Service employee to visit people in their homes regularly and uninvited, without the excuse of a crisis.

The District Nurse has a clinical role working under the medical direction of the General Practitioner. Her task can be measured, results assessed and there is usually an identifiable pay-off in that she receives recognition from the patient and relatives. There is greater emphasis now on treating the whole patient rather than a specific condition. She gives and teaches nursing care, helps towards self-care, counsels in respect of accident and illness prevention, interprets implications of medical diagnoses for patients and family, being aware all the time of their multiple needs. (11a)

Occupational Therapists and other paramedical staff need to take a broad, long-term view of the patient's situation. Rather than caring for a sick patient, the Occupational Therapist, for example, uses her skills to help the patient overcome mental or physical disability, adjust to residual disability and achieve maximum personal economic and social independence within the limits of that disability. This applies equally to a Therapist working in the hospital or community situation.

The Social Worker is concerned with problems of social ill-functioning in all their complexity, mental and physical handicap, mental illness and child care and protection.

Voluntary helpers operate side by side with statutory services in hospitals, in other centres and in community work. They provide assistance in a variety of ways but often in complete independence of each other. In some situations jobs are reserved to the volunteer which are not essential to the professional's duties but can be important to the client or patient, e.g., letter-writing, reading, errand-running, escorting on outings or friendly visiting. Volunteers also raise funds to provide aids or amenities and organise meetings to bring pressure to bear on authorities to remedy local deficiencies. Such initiatives, often uncoordinated as they are spontaneous reactions to community needs, rely on the enthusiasm and dedication which is the basis of the voluntary movement. For the volunteer, the distinction between health and social services in the home tends to become blurred, and the sympathetic volunteer is often able to be helpful in circumstances where the statutory regulations scarcely seem to fit. More active cooperation and coordination between voluntary and statutory services is desired on all sides. Community Health Councils, for example, may be able to play an important part in enlarging the contribution the community can make in maintaining the nation's health.

Clearly all these groups and many others work in complementary and overlapping ways. Difficulties arise when members of each profession see a situation as revolving around themselves, often with an uncertain idea of the potential contribution of others and often without a clear understanding of their own responsibility. This important and emotive topic which has recurred so often in our work has been previously explored. For example,

> "It is almost inevitable that any professional group should attempt to define itself in relation to a set of knowledge and skills which are rigidly held to be its exclusive domain. Each of the professions presented on this course has, during its history and in varying degrees, been a party to this general malaise, It is not a matter in the sense of embracing an incorrect definition of the professional: any professional group must possess a set or combination of knowledge and skills not held by other groups or otherwise it would be superfluous.
>
> "This need not, however, be true of the whole of a professional's work. In fact it is arguable that a degree of overlap in the skills of different professions is necessary for two reasons: firstly, for effective inter-professional liaison and understanding and, secondly, for the practical business of managing the diverse patterns of requests for help which are not tidily assembled to suit the expertise immediately available." (12)

We have discerned a strong and urgent need for each discipline to develop an understanding of its own responsibilities <u>in relation to the responsibilities of other disciplines</u>, to work in partnership rather than in competition with others in the best interest of the patient/client. Indeed we would say that a large number of the needs we have perceived reduce to an inadequate conception of the individual's own role and an inadequate understanding, often misconception, of others! roles.

The importance of collaboration between, for example, medical and social workers has been previously stressed.

> "Group practice reaches out into the community to serve people with problems of physical and mental ill-health. In so doing they also uncover problems of social ill-functioning that would not be brought to the notice of other personal health services. We envisage group practice being an important spearhead into the community for the detection of problems of social ill-functioning". (la)

TEAMWORK

Bound up with the question of overlapping roles and responsibilities is that of teamwork. Reorganisation of the NHS has placed the emphasis firmly on a team approach to providing total health care.

> "A characteristic of the Health Service is that the provision of health care is often a team activity. Different skills have to be combined in various ways to meet the needs of individual patients; different professions must come together to plan and co-ordinate their activities to meet complex objectives; and the work of various skill groups has to be co-ordinated within institutions." (13)

Ideally, all disciplines should develop a commitment to this corporate approach,

> "an awareness of the health service as a whole and of its composite parts, and a wider appreciation of the common aim." (1b)

Inevitably difficulties arise when organisational change requires staff to adopt a different professional, working relationship with colleagues; in this case a shift in emphasis from vertical to lateral working relationships. In the context of organisational change there is much changing of labels. We have evidence that many staff are inappropriately keeping old roles, which suggests that considerable education over a period of time is needed for role change to be significant.

It is clear from our work that whilst advantages are perceived in working as a team (e.g., less duplication of effort, better use of resources, better communications, sharing of information), there are still difficulties to be overcome. These appear to relate almost entirely to personality problems and clashes. The following examples illustrate the type of statement that has been made to us in this respect.

> "The powerful individual needs help in working in a team situation."
> "Unless all members of the team give time and thought to good communication, considerable resentment is generated."
> "Poor professional standards by one member of the team can lead to considerable ethical difficulty."

There are two interrelated needs in this context:

1) It is vital that each member of, for example, the Primary Health Care Team should be used to the highest level of his/her skill.

2) Individual contributions should complement each other to maximise the total contribution that can be made by the team.

A certain amount of ambiguity and sometimes resentment exists with regard to the position held by the General Practitioner in the Primary Health Care Team. Whilst the General Practitioner is clearly the clinical leader of the team, it appears that he sometimes adopts the position of and is deferred to as the manager of the team which he should not be. There is an apparent need for increased sensitivity and mutual support and understanding between the nursing and medical members of the team.

COMMUNICATION AND LIAISON

Effective communication and liaison with colleagues, other agencies and senior and junior staff is essential if greater understanding of roles, a sharing of responsibilities through a team approach to patient care and a resulting change in working relationships are to be put meaningfully into practice.

Effective communication needs mutual trust, support and confidence and is hindered by insecurity (e.g., as a result of reorganisation), uncertainty (e.g.,about the future of one's job or one's role), jealousies and rivalries.

Although it is clear from our work that liaison is improving and that increasing importance is attached to it, local differences exist. Liaison needs can be considered in two broad categories:

1) Hospital/community liaison. Hospital and community workers meet in a variety of ways: for example, in working parties, case conferences, at admission and discharge or referral of patients, day hospital contacts, patients' holidays and outings, community visits and placements. This often leads to problems of continuity, follow-up and communication associated with intolerance, jealousy, confidentiality, for example:

   "The District Nurses say that inadequate information is made available to them by hospitals discharging patients. Frequently instructions as to medication are unclear (e.g.,whether to discontinue with medication given or prescribed by General Practitioners before admission to hospital)."

   "Details of discharges are sent directly to the Nursing Administrative Officers on a form which is not seen by the District Nurse responsible for care." (District Nurses' replies to questions)

   In this area we endorse many of those "matters requiring urgent attention" found by others in respect of two-way communication planning for continuity of after-care and liaison with voluntary helpers. (14) (15)

2) Liaison between the Primary Health Care Team and other community staff (e.g.,Social Workers). Problems exist particularly where a number of different agencies come into contact with the client (as in the much publicised cases of non-accidental injury to children). In these instances there often seems to be a lack of feedback, a tendency to maintain too great a confidentiality of information and lack of information about whom to contact concerning a particular problem,

Question 1 <u>How can the different disciplines in the caring professions be helped to a greater understanding of their own roles and responsibilities and the roles and responsibilities of others with whom they work as partners?</u>

Question 2 <u>How can the concept and practice of effective teamwork be fostered?</u>

Question 3 <u>How can members of the caring professions be helped to improve their skills in communication and liaison in the interests of improved patient care?</u>

The issues relating to role, teamwork, communication and liaison are complex, many faceted and inextricably linked. Whilst separate needs can be identified and appropriate questions asked, the solutions we suggest can be applied in different ways to different facets of the problem. It is for this reason that we are grouping all the suggested solutions together at the end of this section.

SUGGESTED SOLUTIONS

Organisational

1) Regular case conferences between community health, social services staff and other personnel when appropriate in a given district with particular reference to role, communication, liaison and teamwork problem-solving.
2) Greater openness in sharing of information about a patient/ client even though this may be "confidential" in nature. Trust between members of a team is vital if they are to work together effectively.
3) On-going team staff meetings to appraise effectiveness, discuss and share problems and plan ahead. This is particularly important when there has been organisational change - administrative unification must be accompanied by functional integration.
4) Increased participation by staff in planning and preparing for organisational changes which will fundamentally alter their working relationships.
5) Making available, wherever resources permit, the sort of accommodation and efficient clerical support needed to underpin the complex work of a team.
6) Exchange visits between hospital and community.
7) Establishment of more effective and rapid channels of communication.

Educational

1) Using Postgraduate Medical Centres as a meeting place for team seminars involving General Practitioners.
2) Multidisciplinary study days on role awareness.
3) Multidisciplinary study days or seminars on the care of specialist groups where different agencies have contact with the patient, e.g., patients suffering from cerebrovascular accidents or multiple sclerosis.
4) Systematic development of interpersonal and communications skills (see later).
5) Incorporation in basic professional training of interdisciplinary modules, problem-solving exercises, critical-incident analyses, simulations, etc.
6) Interdisciplinary elements in teacher training for the professions.
7) Development or collection of a bank of appropriate exercises for study days.

INTERPERSONAL SKILLS

Certain basic interpersonal skills are fundamental to the practice of all health care professionals. These skills affect good relationships with patients and clients, colleagues and members of other professions. It has become evident however in the course of our investigation that these are poorly developed.

Taking the definition below as an ideal to be achieved, then the language used by practitioners about interpersonal skills, together with the information we received about interpersonal problems, indicated clearly that reality falls short of this ideal.

We would define interpersonal skills as follows:

1) Being sensitive to the way in which the other interprets his experience
2) Being sensitive and being able to handle the difficulties, restrictions and rigidities of others
3) Being appreciative, accepting, supportive, caring and facilitating of the presence and authentic needs of the other whatever his defences
4) Being authentic, honest, genuine, open in the relationship.

By the nature of their work, care staff are involved with distressed or potentially distressed people who are no longer independent and self- sufficient. Traditionally the Health Service has coped with this by opting for a system in which staff are trained to be “objective”, not to acknowledge their own feelings and to avoid personal involvement in the patient’s distress. Implicit and explicit in statements we have received is a consensus feeling that such a system avoids rather than confronts the problem and that greater emphasis should be placed on meaningful interaction between individual staff and patients. To facilitate this, staff must be helped to develop their own potential and their awareness of interpersonal skills. Sensitivity is needed to ensure that these skills are developed in a positive and constructive way.

If staff are to be helped systematically to develop interpersonal skills, then there is a need to have even greater skills in the background for support and back-up. The implication is that a core of “trainers” within the profession needs to be established so that the Health Service will eventually be in a position to use its own resources in developing these skills in staff. Undoubtedly the basis for this already exists.

Question 1 <u>How can health care staff be helped to develop greater interpersonal skills?</u>

SUGGESTED SOLUTIONS

Organisational

1) By encouraging staff in the work situation to deploy their own personal, human resources in dealing with patients rather than relying too heavily on systems.
2) By holding regular group dynamics workshops for all grades of staff in a familiar working environment drawing initially on outside help. These could be organised on both a single-disciplinary and multidisciplinary basis.
3) By emphasis on principles of colleagueship in work, including openness in examining interpersonal relationships.

Educational

1) By training the trainers within the profession so that the systematic development of interpersonal skills becomes part of the “culture” of the profession. An example of elements of a possible short course is given in Appendix II.
2) By systematic development of interpersonal skills in basic nurse, medical, paramedical and social work education, in post-basic and postgraduate courses of all kinds.

RESEARCH

In consulting all grades of staff during the course of this investigation, we have ascertained a very clear need for far greater research awareness and research skills in health and social services staff. This is particularly acute in the nursing profession:

“While it remains necessary to continue to emphasise the need for intelligent management in the interests both of the patient and of the nurse, we consider that it is also necessary to emphasise the need for research. We have been given ample evidence that in nursing and midwifery education insufficient attention is paid to research as a continuing activity. Nor is there enough emphasis on research as a prelude to innovation. Nursing should become a research-based profession. While, as in other professions, the active pursuit of serious research must be limited to a minority within the profession and there are benefits to be gained from a coordination of what research is being carried out, a sense of the need for research should become part of the mental equipment of every practising nurse or midwife.” (8c)

Managers have expressed to us the importance of reliable information and research back-up as a basis for making decisions about service needs, Management needs or educational needs. Often this sort of support. is either lacking or underdeveloped. Often however it is the practitioner who is unaware of already published material or, if aware, is unable to fully comprehend the implications of the research as a basis for action. Moreover much research is not of the kind relevant to action. A wider concept of research responsibility than the traditional one of the practitioner as a data collector in medical research is needed.

At the broadest level, staff need to be able to think and question critically and constructively, to define problems, find out what is known about them and develop strategies to resolve them; or at the very least to support and assist others in the process. They must then be able to understand the implications of research findings for their own situation.

The practitioner’s role and responsibilities to research can be defined as to

1) Read and interpret reports of research in their own field to keep up to date and base their own practice on research findings; to do this they must be familiar with research concepts and language
2) Identify areas within the scope of their work where research is needed: by being aware of situations in which lack of information is a serious detriment to effectual decision-making
3) Collaborate intelligently with researchers and be aware of ethical implications which may not be apparent to research workers
4) Discuss with patients/clients any research in which these are being asked to participate.
   In addition, educators/trainers should:
5) Use research findings as a basis for deciding what and how to teach and incorporate research findings into their teaching and in the way they teach
6) Help students to develop the ways of thinking, questioning, observing, analysing and testing which are consistent with an understanding of the research process.

In addition to 1 - 4 above, administrators/teachers should:

7) Be able to decide research priorities and to make the most effective use of available research resources
8) Initiate and facilitate research and have a sufficient appreciation of research methods to know when and from whom specialist advice should be sought
9) Monitor the progress of research projects in respect of the agreed objectives.

Some appropriate members of staff should:

10) Acquire skill in the application of research techniques
11) Become research workers capable of designing tools for research, of leading research teams and of taking part in planning and formulating research policies
12) Where trained research workers are part of the establishment of the organisation, they should be used to assist in teaching of research method and also be given the opportunity to develop their own specialist skills. (16)

Certainly, few nurses have the ability to carry out this wide range of responsibilities. It is also our impression that in general, nursing education as it stands does not foster and develop the questioning attitude which is the essential starting point for research, the logical thinking which underlies the research process or the willingness to accept the possible need for change without which research findings cannot be implemented. Nor does the "system" appear to encourage this attitude. There is some evidence to suggest that this is equally true for other professional groups.

Question 1 <u>How can health care staff be helped to acquire research awareness?</u>

SUGGESTED SOLUTIONS

Organisational

1) Organised flow of research reports through the system,
2) Encouragement of staff by those responsible for their development to read and evaluate research reports.
3) Regular discussion of research reports focussing on the validity of the findings and on implications for service,
4) Development of procedures to translate research findings into action.
5) Regular meetings to discuss implications of current research for initial and continuing education.
6) A greater emphasis on action-research, designed from the outset to involve those who would ultimately translate findings into action and designed to point the way to such action,

Educational

1) Inclusion in initial basic training of research awareness aims.
2) Inclusion in all continuing education and teacher education courses of research awareness and appreciation as an important dimension wherever relevant and appropriate.
3) Study days and seminars with the specific aim of developing research awareness and research skills,

THE LAW

A range of needs about understanding the law and allaying the community health care staff's fear about involvement in the legal process have been suggested to us by a number of sources. These needs include:

1) Understanding of their own position with regard to the law and knowledge of their rights, e.g., in respect of privileged information.
2) Knowledge of the different courts (e.g.,family court, coroner's court, magistrate's court) with which they might have contact and of different court procedures,
3) Knowledge of how to conduct themselves in court, e.g., how to make a statement, give evidence, etc.
4) Some knowledge of legislation relevant to their professional role, e.g., Family Law (separation, divorce, adoption), industrial relations, etc.
5) Sufficient information to be able to advise clients as to where and how they can obtain legal advice and help.
6) Updating in changes in legislation relevant to their work,

Question 1 How can community health care staff be helped to understand and _ accept their legal responsibilities and acquire confidence to meet them?

SUGGESTED SOLUTIONS

Organisational

1) Provision of detailed summaries of all aspects of the above,
2) Dissemination of information about papers available and about changes in legislation.
3) Study days, seminars, discussion on new legislation,
4) Preparation of individuals involved in legal processes of all kinds with subsequent analysis.
5) Observation visits to courts for specific cases, followed by discussion.

Educational

1) Group discussions on specific responsibilities
2) Regular short courses on "the law and the professional", We suggest that these be given by a lecturer in law with special interest in caring staff or by an appropriate specialist speaker, e.g., Coroner, Registrar of a County Court; nurse, doctor, social worker with special interest and experience. Before any such courses, dissemination of introductory notes on our legal system would be helpful.
   For examples of possible study days on relevant aspects of the law, see Appendix III.
3) Inclusion in initial courses of study sessions, e.g., talks, discussions, projects, case discussions, simulations, designed to meet the above.

TECHNICAL/CLINICAL SKILLS

NEED We have found expertise well developed in assessing and meeting needs in the area of technical and clinical skills, However it has become apparent that, because of the ever-increasing rate of change and development, many practitioners are being asked to undertake techniques not covered by basic training. There is a great need to provide opportunities for learning new techniques on an in-service training basis.

Question 1 How can community health care staff be helped to keep up to date with technical/clinical skills?

SUGGESTED SOLUTIONS

Organisational

1) Creating opportunities for staff concerned with community health care to receive updating on the latest approaches, equipment and treatment to give them an understanding of the problems encountered by patients so that they can give adequate psychological support.
2) To improve liaison with hospital nurses, doctors and others on continuity of treatment for patients about to be admitted or discharged.
3) Dissemination of information about recent developments of treatment.
4) Development of a flexible on-going in-service programme with good information flow so that groups with specific needs can be programmed into already arranged sessions forming part of another course.
5) Regular appraisal of the effectiveness of clinical proced- ures and of the systems used in administering treatment.

Educational

Short courses, seminars, practical sessions on recent advances in treatment.

NEED A situation exists where members of staff are being asked to carry out medical procedures previously carried out by medical staff. Clarification is needed of where the responsibility lies

1) For delegation of the procedure and to whom
2) For any liability resulting from the procedure.

We note that this problem together with related problems of role exists within the Service and that there is great variation in its extent and degree.

Question 2 In what way can these clinical responsibilities be established?

SUGGESTED SOLUTIONS

Organisational

1) The establishment of a clear statement of policy on the principles underlying action by the employing Authority.
2) Dissemination of summaries of these policies and respons- ibilities both verbally and in writing to all employees.
3) Feedback on the operation of such policies.
4) Discussion of responsibilities within the Primary Health Care Team, within individual disciplines and between disciplines using prepared case studies as a basis for discussion.

Educational

1) Multi-professional elements to be established in training courses where possible.
2) Exploration of issues of responsibility and liability in initial training courses through case discussion, simulation, role play, critical incident analysis, etc.

CONCLUSION

We have identified needs in certain key areas which have been consistently highlighted throughout the Region by all professional health care groups consulted (see Appendix IV). We have not been able to assess with precision the extent of these needs. Doubtless there exists great variation between Districts, within Districts, from working group to working group and from individual to individual. Similarly there will inevitably be variation in the priority which rightly should be given to different solutions.

Nonetheless we recognise that it would be easy for the individual manager or practitioner to be complacent and say, this problem does not exist for me (or my staff) but it clearly does for my colleagues. Rather we suggest that each individual assumes the responsibility for establishing whether or not the needs we list do exist and then assesses their extent, however difficult the process.

In considering solutions to current problems and in making recommendations we wish to stress that we are not proposing that there should be more courses, more money spent on continuing education and more staff released from service. We are suggesting above all an attitude, a way of thinking critically and constructively about the planning and: provision of opportunities for continuing education and staff development, and an imaginative approach in exploring all the possibilities available.

We recommend that those in a position to assess and meet expressed needs, particularly managers, be open to the possibility that they can and should create opportunities of different kinds and at different levels along a spectrum ranging from educational activities through to changes in organisational practice. Professional meetings and self-directed study would lie somewhere between these extremes. For example, many of the new competences required can often best be acquired in the context of day-to- day work, e.g., discussion, demonstrations, reading. Others can only be acquired through structured learning experiences, e.g., multidisciplinary and specialist courses, at relevant levels either close to or removed from the place of work.

We stress that course attendance may sometimes be an easy but ineffective solution. For example, whilst there would be some value in arranging for a speaker with specific expertise and knowledge to address a group of staff on a particular problem area, listening is not a solution in itself in this case. Individuals must then be able and willing to use the knowledge and understanding gained to improve their competence and effectiveness in the work situation.

If however a structured educational activity is agreed as being the most effective solution, then it is clearly possible for a number of needs to be met within the context of one apparently specific educational activity. Let us take the example of a study day, the aim of which might ostensibly © be to update community nursing staff on a new technique or treatment.

Such a study day could contain the following elements:
1) Development of research awareness. The new technique has probably been developed as a result of research work. Staff could therefore be introduced to this background and encouraged to read relevant literature by means of handouts or short reading lists.
2) Staff development. Implications of the new technique for both the individual and the organisation could be explored in group discussion.
3) Interpersonal skills. These skills could be developed either implicitly or explicitly in the course of the study by discussion, role play, group work, etc.

We recommend therefore that:

1) Individuals and groups be committed first to working through problems and deploying their own resources in solving them
2) Managers and colleagues be committed to helping the individual in this process
3) Multidisciplinary and joint hospital/community staff activities be sought where appropriate in view of the well established benefits in liaison and communication.

We recommend also that at an early opportunity Regional Conferences of the following kinds be set up:

1) Educators and trainers from within the Service together with teachers from all those institutions which have provided resources for learning for NHS staff should meet to:

   a) Define course goals (aims and objectives) from our identified needs
   b) Identify specific and general ways of achieving these goals
   c) Collect and design resource “materials” and devise “training the trainers” courses

2) Teachers from all caring professions should meet together with teachers from the rescue services and education services to examine:

   a) Implications for the basic training of each group working together to serve the community.
   b) The kinds of specific local interdisciplinary collaboration possible. S

3) Senior members of educational institutions should confer to attempt to produce a policy of support for the continuing education of health care staff.

Involvement of selected practitioners and managers for la) and 2a) above would allow the checks necessary to ensure ultimate and widespread agreement on matters related to the development of the professions and the Service as a whole.

In conclusion we make the point that we have not attempted, within the scale of this Project, to give complete answers to all the questions we have raised about priorities in planning continuing education provision. On the contrary, in taking this initial broad look it has been our intention to open up possibilities for further questioning and more detailed investigation and suggest a framework for a continuing programme of research and development.

RESEARCH STEERING COMMITTEE

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Mr S Briscoe, Principal Training Officer

Mrs M M Connolly, Area Nurse (Child Health Services)

Mrs E M Dawson, Head Occupational Therapist

Miss G Hookway, Regional Nurse

Miss B Jacob, Area Nurse (Child Health)

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Mr A A H Phillipps, Regional Education and Training Officer

Dr J Radway, Area Medical Specialist (Child Health)

Mr D Rye, Director of Nurse Education

Miss R O Talbot, District Nursing Officer

Dr P Westcombe, Community Physician

Noelle Garner

James Kilty

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Noëlle Garner

James Kilty

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APPENDIX I

Outline programme of a suggested staff appraisal course for middle managers

Method:

a) Brief lecture inputs followed by and including discussion
b) Case studies
c) Analysis of difficult professional encounters
d) Role play and other experiential exercises
e) Analytic projects

Content:

a) Rationale of self-appraisal: other-directed vs self-directed philosophies; external social control vs cooperative group monitoring; appraisal of whom, for whom, by whom and why.
b) Criteria: inter-job vs intra-job criteria; intrapsychic, interpersonal, technical, organisational criteria; criteria setting, exclusive and inclusive methods; publication of criteria; application of criteria.
c) Method: appraisal by authority, peer appraisal, self-appraisal; appraisal reports, appraisal interviews; questionnaires, rating scales; degrees of staff involvement - exclusion and inclusion; before, during and after.

Length: Two days

APPENDIX II

A suggested short course for training the potential trainers in interpersonal skills

Method:

a) Brief lecture inputs including and followed by discussion
b) Group dynamics with ground rules
c) Role play and other exercises
d) Exercises in communication and different categories of intervention in discussion/consultation/counselling

Content:

a) Elements of interpersonal communication: speech, voice, relative position, posture and gait, gesture, facial expression, gaze, touch
b) Intervention categories*: e.g., prescriptive, informative, confronting, cathartic, catalytic, supportive; social styles and strategies
c) Process analysis: task and process; tacit norms, role differentiation; decision-making; leadership styles; authority and conflict; effects of stereotypes upon response; the effect of denied and buried feelings on interpersonal behaviour; the hidden agenda; the varieties of defensive process

Length: Four days

*See Six Category Intervention Analysis, John Heron, Human Potential Research Project, University of Surrey, February 1975

APPENDIX III

The Law - Possible Study Days

1) Introductory Day - aims

a) To alleviate the apprehension experienced when health care staff are required to attend courts, give evidence or make statements in connection with matters likely to lead to litigation
b) To understand the legal problems which can arise when health care staff are required to enter other people's property
c) To appreciate the nature of assault and battery with particular reference to consent to undergo treatment and to assault upon staff

2) Professional Problems - aims:

a) To understand the importance of the law of negligence including professional negligence: to appreciate the significance of contributory negligence and the value of indemnity and to value legal advice given by professional associations
b) To understand the liability of employers for the civil wrongs of employees
c) To understand the law regarding nuisances with particular reference to those affecting sick persons
d) To value the importance of keeping notes
e) To give advice in the matter of witnessing wills

3) Family Law - aims:

a) To enable health care staff help relieve pressures on patients brought about by family or matrimonial worries. Many such worries and anxieties are founded upon false or outdated ideas, and suitably informed non-lawyers can help to alleviate them.
b) To be able to solve practical problems arising out of the health care workers' fears that they have reasons for suspecting criminal activity, including such offences as non-accidental injury to children.

APPENDIX IV

Sources of Information

Groups

Community Health Council Secretaries (1)
A Community Health Council Conference
Surrey Council for Social Work
Directors of Nurse Education (1)
Steering Party (LBTC)
District Community Physicians (2)
General Practitioners (2)
Occupational Therapists (1)
Physiotherapists (1)
ANOs, DNOs (3)
District Nurses (3)
Hospital Nurses (3)
Health Visitors (3)
Project Coordination Officers (1)
Further & Higher Education Teachers (providing courses for S.W.T.R.H.A.) (1)
Community Health Nurse Tutor Trainees
Hospital Nurse Tutor Trainees

G. P. Trainees ,
G. P. Trainers
(1) Individuals and Regional Meetings
(2) Individuals and Area Meetings
(3) Individuals and Various Meetings

Individuals

A Social Work Trainer
A Former LBTC Chairman
A Project Officer (King's Fund)
A S.N.O. (post-basic training)
A Management Education Research Worker
A Lecturer in Law
A Community Health Nurse Teacher Trainer (Rcn)
A Secretary of a Voluntary Service Council

Officials of the

J.B.C.N.S
C.C.E.T.H.V.
N.A.M.H,
R.C.G.P.
N.I.S.W.
C.C.E.T.S.W.
Queen's Institute