Unit Seven

Integration of general practice nurses in the community health care workforce from a strategic perspective

Key messages

Once you have read this Unit, you should have an understanding of:

- *how the general practice nurse (GPN) workforce can help achieve public health competences*
- *how nurses working together will achieve more efficient, cost-effective care*
- *the provision of clinical supervision for all branches of community nurses and the encouragement towards sharing experiences.*

National directives for community nursing have firmly emphasised the need to break down barriers between different branches of community nursing in order to deliver effective care from appropriate professionals.[1–3] Anything that encourages more shared working is likely to be beneficial to patients by reducing the number of professionals involved in any one person's care and encouraging consistency of care by creating common standards. Better partnership working does not only apply to GPNs working with other branches of community nursing, but also with local authorities, as advocated in the Department of Health's, *Our Health, Our Care, Our Say.*[4]

Advantages of community nurses working more closely with GPNs

The GPN workforce comprises a rich mix of skills, both generalist and specialist, that are focused on their practice populations. They also have access to a wealth of patient information and histories, disease registers and audit data, and to the rooms, equipment and resources of their practice. They have influence with the GPs they work with, and close, often long-term relationships with whole families in the community.

Integrating these nurses into the wider primary health care team offers many advantages at a strategic level:

- *adds to the skills available to the whole nursing team*
- *saves time by preventing duplication of work and visits*
- *makes better use of surgery resources*
- *increases mutual support among community nurses, aiding retention in the team*
- *enables strategic reviews of services to be carried out, since all elements of the care given can be reviewed together.*

Every specialism in community nursing can benefit from closer working with GPNs. School nurses have common ground and a shared clientele in children and adolescents in need of health promotion, advice, smoking cessation resources, contraception, travel and childhood vaccines, minor illness, injury and mental health support. Health visitors work with the same young families and vulnerable adults. Streamlining the interface between the screening, support, education and public health role of the health visitor and the GPN's care for women and children's practical health needs will reduce duplication, releasing time and

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resources. Specialist nurses and specialist community children's nurses can greatly increase their effectiveness and reach by working in tandem with the GPN who provides care to the rest of the family, rather than duplicating visits, records and assessments.

Some primary care trusts (PCTs) have worked actively to encourage training across the different branches of community nursing in order to create nurses who are truly generic in their skills.

Camden PCT initiated a local incentive scheme whereby GPs who took on the teaching of other students apart from medical students could gain additional incentive points linked to the *Quality and Outcomes Framework*. Post-registration, newly qualified nurses were then placed in the practice for 2 days a week for 30 weeks. The GPs were encouraged to see the value of the transferable skills that these novice nurses could bring, eg smoking cessation and wound management. Once GPs could see these nurses as a useful component of the practice – not just supernumerary students – they were far more receptive to the idea. The PCT initially saw practice managers to plant the ideas. All learning undertaken by these nurses was work-based, but the module was accredited by Middlesex University. The students had to produce a portfolio of clinical learning, which included competences matched to the *Knowledge and Skills Framework*[1].

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Central Liverpool PCT have introduced a new group of nurses into community nursing. The associate nurses are community nurses who have undertaken a 12-month programme that includes 16-week placements with a health visitor, district nurse team and practice nurse. This experience has been largely within the same geographical setting, thereby supporting the nurse and other nurses to assess the shared components of their role. The opportunity for these nurses to work in general practice has lead to the development of a group of nurses with an understanding of and development of skills relevant to this area. In addition, the experience of working with nurses at this level has supported general practices to identify the potential of skill mixing the nursing team. The experienced GPNs have welcomed the opportunity for nursing support that has enabled them to develop knowledge, skills and capacity to undertake minor illness management and increased management of long-term conditions. Post-development programme, these nurses have moved into a number of new roles, including generic roles that continue to support the practice nurse[1].

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Benefits for the PCT

Many of the strategic objectives of PCTs, including those outlined in *Standards for Better Health,*[5] can be more easily achieved through joint working between community nurses and GPNs. For example, public health work, such as health promotion and information campaigns, immunisation programmes and work to mitigate risk factors such as smoking or obesity, are best tackled by nurses who have regular contact with patients over long timescales. GPNs are ideally placed to deliver on these programmes, with their continuous contact with a registered population. Their involvement with whole families, as well as individuals, enhances their impact on lifestyle change, and on the acceptance of difficult decisions such as those related to childhood immunisation.

GPNs are also key to the delivery of care to people with long-term conditions. The integration of community matrons, dealing with the small percentage of people most at risk of hospital admission, with GPNs, who regularly see the much larger group of patients with lower levels of need, and district nurses who will visit those in the intermediate group, is the most efficient way to meet the growing demands of these groups.[6] The GPN's base in a local practice makes her/him readily accessible to people who need advice, reassurance and regular monitoring of their condition. Allowing patients to travel to the nurse where possible, rather than vice versa, is clearly more efficient in terms of both time and money.

GPNs are also valuable contributors to unscheduled care. Many have additional training and skills in assessment, treatment of minor injuries and illnesses, and prescribing, and have the facilities to provide first-contact care to local populations. GPNs were among the first to pilot telephone triage and telephone consultations, and these methods can be combined with clinics, surgeries and visits for all community nurses to maximise the number of effective contacts that can be made.

Sharing resources

One of the benefits that PCTs can offer a general practice when community nurses are working more closely with the practice is professional support for the GPNs. Access to the community nurses' meetings, library, journal circulation and training opportunities would be a real benefit, particularly to smaller practices. Personal professional support, which is crucial to inducting new nurses, and retaining employees in the longer-term, can be even more difficult to provide in a practice context with only a few nurses.

Even a team of GPNs in one practice can find it difficult to provide objective professional support for one another, as they are all working in the same situation and numbers are likely to be small. A PCT offers the opportunity to include GPNs in a much wider network of community nurses, where they may find a mentor, advisor or clinical supervision group that can provide more objective support and a 'safer' space to share professional issues and learning. This will become even more important once the new white paper of regulation and revalidation for nurses is implemented.

There are advantages in this shared approach for the whole team. Clinical supervision across various branches of nursing combines the benefits of shared experience with the advantage of a range of perspectives from differently qualified team members. The process of sharing practice experiences in clinical supervision, and identifying and discussing the professional issues they raise, can help to build trust between members, and eliminate the 'us and them' culture of PCTs and practices, with a beneficial effect on day-to-day working.

Forms of integrated teams

The term 'integrated team' has been in use since at least the 1980s, generally to describe primary care nursing teams that include both nurses employed by GPs and those employed directly by NHS community services – whether those services were provided by health authorities (to the early 1990s), community units or community trusts (until the late 1990s) or PCTs (currently). However, the degree and nature of integration in teams claiming the title varies considerably, as described below.

- *Co-employment – both the GPN and community nurses (district nurse, health visitor and others) being employed by the NHS community service employer, with the GPN deployed to work in the GP's surgery. In this model, sharing of training, clinical supervision, employment rights and benefits would be automatic.*
- *Co-location – the GPN and community nurses have different employers, but work from the same premises, either an NHS-owned health centre or GP surgery premises, sharing rooms and equipment. In the best-functioning integrated teams, this would extend to joint planning of work and use of patient records, inter-nurse referrals, and shared training and clinical supervision sessions, with the community nurses joining GPs and GPNs on any practice 'away-days' or planning sessions.*

- *Cooperation – the community nurses and GPN(s) are based in different places, but intentionally meet regularly to share information, update knowledge and patient records, and plan the division of work. Some teams demonstrated that it was possible to extend this cooperation to include most of the elements listed under 'co-location', above, in spite of having different bases.*
- *Ad hoc information sharing – in this minimal model, the two sets of nurses are aware of each other's schedules and ways of working, and share basic information, passing on messages and meeting on an ad hoc basis.*

In addition to these variations, there are 'self-governing' integrated teams, where the leadership, budget and management responsibilities (including recruitment) are devolved from the employing organisations (practice and PCT) to the team. The team leader or coordinator may be appointed or elected, or team members may take turns to take on this responsibility. Other integrated teams take on some of these elements of self-governance, but not all of them, remaining more closely attached to their employing body.

The type of integration model that is most appropriate to suggest to local general practices will depend on the history of relations between the practice and the PCT, the experience of the nurses concerned, and other changes that may be occurring within the organisation. If you are making an approach to propose implementing or further developing an integrated nursing team, remember:

- *the GPs are the GPN's employers, and would expect to be consulted before the nurses are approached*
- *it is worth offering a range of options for the degree of integration*
- *there is a wide variation in GPN roles and levels, which will affect what they can offer to the team, and how much support they will need to do so*
- *the GPNs may be resistant to changing employers as there are many advantages to direct employment by, and close working with, a GP*
- *the practice based commissioning clusters may also be players in this decision making*
- *the sharing of resources should involve 'give and take' between the practice and the PCT*
- *any integrated team will evolve over time, so the model you start with does not have to be permanent – closer working may be possible when trust and experience has built up*
- *it is worth putting down the key points of the agreement in writing afterwards.*

Closer working through the use of care pathways

There has been an increasing emphasis in recent years on 'care pathways' (or 'patient pathways') as the basis for care and service planning. This is one way to achieve closer working relations between community nurses, other health and social care professionals, and practice staff. The planning of a care pathway should bring together representatives from all the professionals who will have a major input into the patient's care to produce the agreed pathway. It provides an opportunity to review traditional practice and ensure that

The advantages of a care-pathway approach are that:

- *all patients can receive an equitable service, regardless of where they present or who sees them*
- *service quality is improved and monitored*
- *all relevant professionals, in all areas of care delivery, share a common understanding of the locally agreed pattern of referral and treatment*
- *discrepancies in treatment based on individual clinician preferences or beliefs are reduced*
- *evidence-based and good practice is embedded in service specifications*
- *new and locum staff have clear pathways to follow when managing patients.*

each step on the pathway is evidence-based, and consistent across the geographical area.
Producing or improving a care pathway will involve more than just the nursing team. GPs, hospital staff, allied health professionals and sometimes social services staff will also need to be involved in the planning of the pathway. The development of care pathways can greatly enhance teamwork by making best use of each individual's skills, sharing information and records, and working together both operationally and strategically. These are the essential building blocks for the whole multidisciplinary team in implementing a care pathway.

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