

Unit Seven

Integration of general practice nurses in the community health care workforce from a general practice employer's perspective

Key messages

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

- *the advantages of closer integration between general practice nurses (GPNs) and other branches of community nursing*
- *the importance of a united nursing approach for the purpose of practice-based commissioning (PbC)*
- *the benefits of nurses sharing knowledge and skills to improve patient care.*

National directives for nursing promote integration between community nurses and recognition of skills so that the appropriate person is treating the patient. The advantages of improved partnership working across health and social care have been clearly emphasised.¹⁻⁴ As a general practice employing one or more GPNs, there is much to be gained from taking a broad perspective of the needs of the practice population. Integrating GPNs with the community nursing team and wider services will help maximise resources available to meet those needs. Most practices will be engaged in providing enhanced services, and maintaining high performance in relation to the *Quality and Outcomes Framework (QoF)*,⁵ and both of these sets of activities rely heavily on nursing input. It makes sense therefore to make sure that all available nursing skills are working together for the benefit of the practice population.

Making appropriate use of the skills in the team

A starting point for developing greater integration is to consider exactly who is involved in the wider primary health care team and to gain some knowledge of the varied skills available.

The wider primary health care team is likely to include:

- *district nurses*
- *allied health professionals*
- *pharmacists*
- *social workers*
- *midwives*
- *school nurses*
- *health visitors*
- *community mental health nurses and other nurses*
- *social workers and many others.*

Tool – Record of the wider primary healthcare team is useful in the creation of documents for circulation to identify the wide range of people in the practice team, their contact details, days of work and particular skills.

It is easy to think of people in 'pigeon holes' – the health visitor who works with parents and young children; the district nurse whose case-load is house-bound older people – without realising that they have more to offer than these core elements of their job. Many individuals have more than the basic skills required to do their job, and an effective team will harness all of these. It is worth systematically exploring each person's qualifications, professional and life experience, to see how they could contribute in different ways to the services provided by the team. Identification of informal or ad hoc skills should also be included. The ability to carry out an audit, group facilitation skills, or good knowledge of computer programmes may not appear in a person's list of formal qualifications, but will still be extremely useful to the team.

Collecting this information does not have to be a complex or formal process. It can be as simple as asking everyone to write a list, or having a discussion at a team meeting. However, it is useful to record the information so that it can easily be referred to, and updated as team members change, or people gain new skills. See [Tool – Skills audit matrix](#) to record the various skills that exist within the wider primary health care team.

Do not forget to include the increasing range of voluntary and independent organisations that may impact on the care of patients within the practice. Although it may be unnecessary to record individuals involved in care delivery, it would be valuable to create a local directory of organisations with details about their potential contribution. Having compiled your list of health professionals within the wider primary health care team, you could now ask them all to contribute to the formation of a local directory for shared use. See [Tool – Directory of useful local organisations](#) for information on health professionals and patients.

Community nurses have access to a lot of useful information, both formal and informal. This includes statistics and health-needs assessments relating to the local population; the primary care trust's (PCT's) priorities and plans for health care; and community intelligence on local developments, attitudes, crime and social capital. They also have a wide network of contacts in local authority departments, such as:

- *housing*
- *education*
- *social services*
- *patient groups*
- *local action groups*
- *advisory agencies (eg Citizen's Advice Bureau)*
- *counselling services.*

Community nurses employed by PCTs are also likely to have access to organised training and updating events, library and information resources, and professional support services (including occupational health, clinical supervision and employment advice) that can only be provided by larger employers. It may be possible to negotiate the sharing of these resources with the practice's nurses. At the same time, the practice will have resources that can be made available to community nurses – such as the practice library and publications, computerised patient records, practice rooms and equipment, and disease registers.

As well as practical resources, GPNs working more closely with other community nurses will have the opportunity to discuss professional issues and share nursing developments with a wider group of nurses. This is especially important when there are only one or two GPNs in a surgery. General practice is frequently the first time that a GPN may be working outside an NHS organisation and this mutual support can be very important in combating a sense of professional isolation, and so make them more likely to stay in the practice. General practice employers are sometimes concerned that GPNs who work closely with community nurses will become dissatisfied with their own employment situation. In fact, most GPNs greatly value the autonomy of practice

The greatest benefit of integrating GPNs with the community nursing team is the pool of skills that is then made available to the practice. The district nurses, health visitors, community psychiatric nurses and others employed by the PCT will bring a much wider range of skills, qualifications and experience than could be found in a GPN team alone. By encouraging all nurses to feel part of the primary health care team the practice can capitalise on the wider potential of the whole team.

nursing and the close working relationship with GPs, and the freedom from NHS Trust management. Many practices have already negotiated with the employing trust of community trusts that their nurses contribute to QoF-related activities. Where this is done 'over the heads' of the nurses concerned, it can generate resentment and antipathy towards the practice. It is more effective in the longer-term to encourage a genuine integration of nursing teams – giving from the practice's time and resources as well as taking from the community nursing team – and enable the team members themselves to do the strategic planning, skills audit and service redesign.

Integrated nursing teams

This term 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, and can involve:

- *co-employment* – both the GPN and community nurses (district nurse, health visitor and others) are 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 is automatic
- *co-location* – the GPN and community nurses have different employers, but work from the same premises, either in an NHS-owned health centre or GP surgery premises, sharing rooms and equipment. In the best-functioning integrated teams, this extends 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) might be based in different places, but intentionally meet regularly to share information, update knowledge and patient records, and plan the division of work. Some teams have demonstrated that it is 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 primary care organisation) 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.

If you are interested in setting up an integrated team you will need to talk to the PCT about how this could work and explain the potential benefits. Use the following tool to ensure the correct process is followed in order to maximise your chances of success

Tool – Checklist for general practices to support an approach to integrated nurse working

Understanding the community nursing perspective

When looking at how primary health care teams can work more closely together, it is worth understanding some key features of community nursing that underpin their practice and day-to-day approach:

- *as employees of a large NHS organisation, community nurses are answerable to a nurse, locality or primary care manager who influences what they do and holds them to account – so they cannot necessarily make ad hoc decisions in response to requests from a practice*
- *they are subject to changes in nursing and primary care policy decided by the Department of Health, driven by strategic health authorities and operationalised through the NHS organisations. A recent example was the policy to introduce 3,000 'community matrons' by 2007 – experienced nurses who case-manage people requiring the most-complex care at home, with the aim of keeping them out of hospitals. Such policy-driven changes can create turbulence in existing teams, and stress among nurses in established, traditional roles*
- *many community nurses have responsibilities for the teaching and mentorship of pre-registration student nurses doing placements in primary care and post-registration student community nurses, in addition to their clinical responsibilities – this can limit the flexibility they have to change services or ways of working*
- *their employing organisation has formal clinical governance responsibilities, structures and processes*
- *the primary care organisation employing the community nurses has statutory responsibility for the whole of the local population, of which the practice's registered patients are only a subset – so the community nurses are likely to need to spend some of their time working with groups that are outside of the practice population*
- *community nurses who do not have experience of working closely with modern practices may be very anxious about the different culture of general practice. They may not understand the structure of practice payments and partnerships, and the influence this necessarily has on ways of working and recording activity. Some are hostile to what is seen as a financially driven small business, in comparison to the NHS organisations they are familiar with, where the financial aspects are carried out further from the clinical front line.*

Encouraging closer working between GPNs and community nurses

Creating and developing closer working relationships between all nurses who have significant contact with the practice requires an initial investment of time and effort, followed by some helpful behaviour patterns to maintain the momentum.

Remember to include GPNs in the discussions if you have not already talked to them about working more closely with other health professionals.

Talking to the community nurses' manager is an essential preliminary step. If the manager can be convinced of the benefits of closer working, the nurses will have additional impetus to cooperate. Bear in mind that the manager may not be a nurse, but could be a locality or primary care manager from any background, and will be open to the same arguments that convince the practice. GPNs and community nurses working together makes better use of skills, prevents duplication, allows joined-up planning to meet targets and deliver care, and provides vital support for the professionals involved, which encourages recruitment and retention. Be prepared to offer something from the practice's resources, so that the manager is clear that closer working is not simply a way of obtaining extra resources for the GPNs. The intention that the team undertakes a skills audit, service review and strategic planning, as well as working more closely on day-to-day clinical work, should be stressed. This can also be done now through practice based commissioning cluster.

This emphasises that it is intended to benefit the whole community nursing service, in a development process over time, not only to meet the practice's short-term agenda. The discussion should include how nurses could work together more to avoid duplication of activities (eg district nurses taking on all wound management within the practice and GPNs and community mental health nurses running nurse-led clinics on anxiety and depression in primary care). It is important to agree certain strategic or developmental targets that both you and the manager expect the nurses to produce, and to what timescale, so that they are aware of what is expected of them from the start.

The practice needs to stop considering itself as an insular business, but as a contractor who works with others to achieve the ultimate aim – improvements in patient care. Certain factors will contribute to success:

- *make all team members feel welcome in the surgery – know their names, have information on their clinic and visit schedules to hand so that you know when you are likely to see them, and ask to be introduced to students they may have with them*
- *try to provide community nurses or other health professionals linked to the practice with a room, desk or share of a space that is recognised by all surgery staff as belonging to the team – it can be marked with a wall chart for recording holidays, a notice board for shared bulletins, circulars and fliers, and/or in-trays for their work and post*
- *ensure that the practice manager engages in actions that help keep the team together and feeling valued; include the whole team in surgery news, journal circulation, domestic arrangements (such as for contributing to coffee funds), and decisions about surgery matters such as the purchase of equipment*
- *set an example to surgery staff by your own attitude to the community nurses, making it clear that you include them, value their skills and want to develop the team*
- *encourage the community nurses and GPNs to think of themselves as a nursing team with their own coordinator or team leader – whether or not this is the GPN – and support that person's position by recognising it formally: invite the coordinator to practice meetings, and consult him/her on matters relating to the team. It is equally important not to undermine the team leader by using the easier access to the GPN(s) as a substitute, or to ask your GPNs to do something that conflicts with team decisions*
- *make sure that patient records, practice information and access to it are genuinely shared with community nurses – otherwise duplication of effort will have to occur. This means giving the community nurses access to the practice computer system (and possibly installing one or more new workstations for them),*

as well as access to any paper records and disease registers used in the practice. Agree with the nurses how and when these will be used, and for what purposes – then allow them to do so, making sure that surgery staff do not put obstacles in the way. Safe, effective and efficient care within a practice requires shared records, and the importance of this must be emphasised to all

- *arrange for nurses to attend practice meetings in order to contribute to strategic planning, make the best use of the combined skills and knowledge of the team, and build good working relationships*
- *arrange for any new community nurses to spend time with different members of the practice (partners, practice manager, peripatetic staff, allied health professionals) and to have access to some of the practice's planning documents to get a feel for how the practice works, who's who, and how the surgery runs on a day-to-day basis.*
- *The practice could provide placements for students completing their initial training. (See education and professional development unit).*

Behaviours that help the wider practice team to develop and keep the momentum going include:

- *attending any of the team's meetings that you are invited to*
- *sharing practice news verbally whenever possible*
- *having occasional informal coffee breaks or lunches with the team*
- *reading and commenting on nursing strategies and plans (and encouraging nurses to read and comment on the general practice's plans and strategies).*

It is also important to maintain contact with the nurses' manager in the PCT so that any issues can be addressed early and a consistent approach to care can be developed by both employers.

Maintaining the momentum PBC and the integrated nursing team

As PBC continues to develop, the input of all health professionals will be very important. They will have relevant information on patient groups, care pathways and service standards, and will be able to identify areas of care that could be streamlined or provided in primary instead of secondary care. The development and provision of new services outside of hospitals, with the potential to save money for reinvestment in the practice's services, will depend largely on nurses and allied health professionals expanding their roles. GPNs will be unable to deliver and anticipate all the care required within a practice. With a larger number of nurses, a combination of skills and experience, working practices that span home and community settings as well as the practice base, and a network of social services, agency and independent sector contacts, the wider primary health care team is ideally placed to expand its services. Without this cohesion and experience of working together across a health community PBC is unlikely to achieve maximum success.

Closer working through the use of care pathways

There has been increasing emphasis in recent years on 'care pathways' (or 'patient pathways') as the basis for care and service planning. This requires an oversight of the whole patient journey, including what should happen when they are referred on to secondary care, and maybe on again to tertiary (specialist) care – and also when they come home again and receive further care or follow-up in primary care. Logically, such planning should bring together representatives of each of these care settings, and from all of the professionals who will have a major input into the patient's care along the pathway. It provides the opportunity to review traditional practice, and ensure that each step on the pathway is evidence-based and consistent across the geographical area.

The advantages of this approach are that:

- *all patients receive an equitable service, regardless of where they present or who sees them*
- *service quality is improved*
- *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.*

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 multi disciplinary team in implementing a care pathway.

References

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