

Unit Seven

Integration in the community health care workforce from a general practice nurse's perspective

Key messages

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

- *advantages to general practice nurses (GPNs) of working closely with other health care professionals*
- *the need for health care professionals to work closely together to improve patient care*
- *critical success factors for integration*
- *concept of integrated teams and the need to raise awareness of skills across the whole practice team*
- *use of care pathways to facilitate cross-boundary working.*

Working in partnership with other health care professionals and related organisations is vital for practices to achieve effective services for patients.¹ GPNs tend to be equal in number to other branches of nursing (eg district nursing and health visitors) within a primary care trust (PCT). However, these other branches of nursing are usually more coordinated because they have a shared management structure. This makes communication among nurses easier, and support is therefore more readily available. GPNs are often envied by other nurses because of their comparative freedom to implement new ideas more quickly.

This is because they work in practices, which are much smaller organisations than the PCT. By contrast, PCT-employed nurses can be said to have greater safety nets than in general practice, with protection from a range of PCT policies and procedures.

If you do not actively link to other nurses there is a real danger that your work within the practice will increase unnecessarily because you are not using the skills of others. Everyone who works in, or for, the NHS knows that there is plenty of work out there for everyone. It is not a question of taking over other people's jobs, it is a question of working together as a team so that everyone – the nurses, the patients and the practice – benefit from the right person providing care at the right time. This point has been emphasised in *Liberating the Talents*,² which sets a national direction for community nursing.

*Liberating the Talents*² strongly guides nurses to break down boundaries that may exist between different facets of nursing in order to work more effectively for patients by providing seamless care.

*Liberating the Talents*² describes three core functions for community nurses that apply regardless of title or employer. These are:

- *public health*
- *first-contact work*
- *management of long-term conditions.*

Because most GPs are not NHS employees, but are independent contractors to the NHS they can often be viewed as 'separatist' (autonomous) by nurses. GPNs are ideally placed to dispel this culture of 'us and them' by integrating with nursing colleagues. The *new General Medical Services contract (nGMS)*³ places emphasis on improving quality for patients with long-term conditions. This cannot be achieved without the cooperation and support of other nurses.

These nurses may be involved with house-bound patients and coordination of care across the whole primary health care team is therefore important. Similarly, many patients will have social workers or carers from independent or voluntary organisations involved in their care. The practice should act as a coordinating body for these rather than working in professional silos.

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).

The degree and nature of integration in teams claiming the title varies considerably, and can involve:

- *co-employment – both the GPN and 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 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 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 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 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 practice and the PCT about how this could work and explain the potential benefits.

Tool – Checklist for discussion with community nurse manager and GP about supporting an approach to integrated nurse working

Despite the advantages of closer integration between health professionals, and numerous good examples of teams of nurses working together, there are still places where no such integration exists. Sometimes this is because of the unwillingness of either the general practice employer, or the NHS PCT, to enable it to happen; sometimes because of rapid turnover among the GPNs, and sometimes simply because neither employer realises the benefits that this model of working can bring. The GPN can be a key person in bringing together many of the different people involved in patients' care in order to create harmony.

Advantages of integration between GPNs and community nurses

The advantages of working more closely with other nurses are both practical and professional. From a purely practical perspective, widening the group of nurses acting as part of the primary health care team brings access to greater resources. Community nurses will have access to:

- *equipment*
- *training events*
- *information through the trust that the GPN does not have.*

Similarly, the GPN will often have access to:

- *a library*
- *GPs*
- *GPN journals and circulars*
- *rooms and equipment that the community nurse does not have – by working more closely together, each stands to gain something practical from the other.*

Working together also reduces duplication of effort, where, for example, a district nurse can complete an episode of care for a patient instead of leaving some aspects of it to the GPN. Similarly, combining a clinic with a GPN and a health visitor can save each of them unwittingly seeing the same patient separately. The opportunity now through the practice based commissioning clusters is there to look at service redesign. The information already held by the community nurses can help to improve patient care, for example when it comes to the following:

- *strategic planning for the practice*
- *carrying out a health-needs assessment on the patient population*
- *identifying patients for registers of chronic disease*
- *undertaking audits.*

The professional benefits of working closely together are no less compelling. Functioning as a team allows all members to make best use of their professional skills and interests, by providing different viewpoints and knowledge on particular conditions, patient groups or services, instead of having to do a bit of everything. Working more closely with other health professionals also provides a wider network of professional support to all involved. As a GPN, you can feel isolated as a nurse in a practice of GPs, and even in practices with two or three GPNs, you may find it difficult to provide objective support for each other. In a wider team, it is more likely that you will be able to find someone to share ideas or concerns, or simply someone who can signpost you to a source of information or evidence.

A wider team also provides a larger pool of expertise to tap into, making it more likely that someone will have relevant experience to bring to bear. If you think of yourself as part of a wider team, rather than being limited to the confines of the practice, you will find that you have access to more resources, information and opportunities. Liaising with other community nurses more actively may also alert you to new training and education opportunities that will enable you to move up to a new level within the practice.

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 team is likely to include:

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

Use **Tool – Record of the wider primary healthcare team** to create a useful document for circulation to identify the wide range of people in the primary health care 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 caseload 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 for example:

- *the ability to carry out an audit*
- *group facilitation skills*
- *good knowledge of computer programmes.*

These 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 member's 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. Use **Tool – Directory of useful local organisations** to provide information for health professionals and patients.

Critical success factors for improving integration

1. Commitment

It is essential that the key people are really committed to the idea of working with other health professionals to widen the primary health care team. It is easy to pay lip service to the idea of integration, but, without commitment, the team is all too frequently sabotaged by behaviour that undermines the potential of integration. Key people who need to be committed to making integrated teams happen are the GP, the GPN(s), the nurse manager and team leaders in the nursing team. It is worth putting effort into convincing these people to make this commitment before instituting steps such as team meetings or information sharing.

2. Flexibility and openness

Being flexible about how you can work together more effectively is essential. Trying to impose an unpopular model such as weekly meetings is unlikely to realise any of the potential benefits of team working if some people are unable to commit to this ideal. Openness is also very important. If people have any reason to feel that motives are hidden, or information is being shared only selectively, they will resist attempts at integration. Bear in mind that openness may be uncomfortable. If members of the team have different employers, such as the district nurse being employed by the PCT and the GPN being employed by the practice, they are likely to find that their salary level, terms and conditions, and other important factors, may be different. Acknowledging such disparities, and the feelings they may evoke – whether or not there is anything that can be done about it – is part of the openness required of a team that wants to work effectively together.

3. Proactive information sharing

This means that everyone in the team makes a positive effort to ensure that other members are aware of, and can access, key information. Simply saying that community nurses can 'use' the practice's patient records, for example, is meaningless if they are unable to use the practice computer because they do not have passwords. Having the password is no help if there are so few terminals that district nurses never have the opportunity to enter or retrieve data. This is where the commitment is demonstrated – it may mean rearranging rooms, changing clinic schedules, sharing computers or creating new workstations in order to make the rhetoric of shared records into reality. Being proactive about sharing other information may mean agreeing to regular practice meetings that fit in with community nurses' schedules; obtaining extra copies of newsletters or circulars so that every team member can have one; putting up a shared notice board so that fliers for educational events are visible to all; including all team members on 'all staff' e-mail lists; and/or giving all team members their own 'pigeon-hole' for post.

4. Investing in relationships

Improving relationships across different disciplines of branches of nursing takes effort, time, energy and persistence to create and maintain the team. The investment required may be financial, although it need not be vast. Providing extra copies of papers, tea and coffee for meetings and a notice board are not expensive, but all give the message that this is one team and its members are valued. Just as important is the investment of time. This may be time for team activities including:

- *meetings*
- *away-days*
- *Christmas dinner*
- *informal time.*

This is the unplanned time to pause in the corridor and speak to someone; to sit down for a sandwich as a group rather than staying by desks; or to listen to someone who has had a difficult encounter with a patient. All team members, not just a nominal team leader or coordinator, need to invest in the team in these ways.

5. Mutual understanding and respect

This will not just happen automatically, but should arise out of the following four factors:

- *spending time with other team members*
- *sharing each other's information*
- *meeting regularly*
- *talking openly.*

As a consequence of this, people develop a broader perspective, and an understanding of each other's roles, challenges and personalities. Trust within the practice is built on the demonstration of respect between members. Listening carefully, maintaining confidences when asked, responding constructively and providing help, or signposts to help, are key ways to demonstrate respect for others.

Closer working through the use of care pathways

There has been an increasing emphasis over recent years on 'care pathways' (or 'patient pathways') as the basis for care and service planning. This means mapping out patients' care through primary to tertiary care, should this be required. The care pathway should also include what happens when the patient comes home and receives 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 professions who will have a major input into the patient's care along the pathway. It provides an opportunity to review traditional practice and

The advantages of a care-pathway 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.*

ensure that 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.

References

1. Department of Health. *Our Health, Our Care, Our Say; A New Direction for Community Services*. London: Department of Health; 2006. Available at: <http://dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf>.
2. Department of Health. *Liberating the Talents, Helping Primary Care Trusts and Nurses to Deliver the NHS Plan*. London: Department of Health; 2002. Available at: <http://dh.gov.uk/assetRoot/04/07/62/50/04076250.pdf>.
3. Department of Health. *Investing in General Practice: the New General Medical Services Contract*. London: Department of Health; 2003. Available at: <http://www.dh.gov.uk/assetRoot/04/07/19/67/04071967.pdf>.
4. Department of Health. *Practice Based Commissioning: Engaging in Practices in Commissioning*. 2004. Available at: http://dh.gov.uk/PublicationsandStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4098564&chk=uBbP%2Bg