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Integrated nursing teams: in whose interests?

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Within a health service that is primary health care led and emphasizes partnership and cross boundary working, the way in which health professionals and others achieve integration becomes increasingly important. This paper highlights some of the professional literature and research evidence on the benefits for nursing and patient care in primary health care when different nursing specialities work within a formal framework of collaboration. This is set against findings from a study on district nursing and their planned or actual participation in integrated self-managing nursing teams. The paper concludes by arguing that although the underlying rationale for integrated nursing teams would seem to have coherence and plausibility, the findings of this study and others indicate that there are issues which need closer attention. These include how competing managerial and medical agendas have influenced the development of integrated nursing teams, and whether existing patterns of self-management by primary care nurses have been overlooked.

Key words: nursing specialties; nursing teams; patient care

Introduction

Recent health policy reforms assume that the NHS will have a primary health care focus and that health professionals and others will work in partnership to meet the health needs of their local populations (Department of Health, 1997). An emphasis on the integration of services presupposes that practitioners will be able to address what the Audit Commission described as the fragmentation and duplication of roles that is characteristic of primary health care (Audit Commission, 1992).

UK research into the primary health care team consistently identifies the problems of achieving collaborative working (e.g., Gilmore *et al*., 1974; Bond *et al*., 1985; Poulton, 1995; Atkins and Lunt, 1996; Pearson and Spencer, 1997). Writers point to the differences in training (Wiles and Robison, 1994; Beattie, 1995), the centrality of the general practitioner role and the organization of primary health care (Dingwall and McIntosh, 1978; Poulton, 1995) and variations in the way in which health priorities are conceptualized (Øvretveit, 1993; West and Field, 1995). Pearson (1997) suggests that a more accurate description of primary care working is one of loose networks rather than teams. Although there has been an ongoing interest in how primary health care teams operate, less attention has been paid to how teamworking among primary care nurses is achieved. This paper discusses some research into the collaborative working of primary care nurses from different specialist backgrounds. This will then be related to the findings of a study of district nursing work that identified a move to encourage primary care nurses to work formally together in self-managing teams. It describes the competing influences that shaped how these integrated nursing teams were defined and the apparent consequences that this had for the nurses involved. Discussion of the findings examines the extent to which professional and policy aspirations for effective shared working between nurses in primary health care could be realized through the medium of integrated nursing teams. The paper concludes by arguing that organizational changes to improve partnerships between primary

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care nurses could be enhanced if the underlying rationale for co-operation was made explicit and it reflected an understanding of nursing priorities and existing skills of self-management.

Research on primary care nurses' experiences of working together

Research that has examined existing teamworking across and within the different nursing specialities of primary health care has identified common problems. These include practitioners' concerns that their particular role and contribution are not recognized (Haste and Macdonald, 1992; Wiles and Robison, 1994; Rapport and Maggs, 1997), an overlap of responsibility between the nursing grades and specialities with little shared communication (Cartlidge and Harrison, 1995; Scholes, 1995) and an absence of ongoing review of practice within specialist teams (Griffiths and Luker, 1994). One small study of four general practice-based primary care nursing teams (district nurses, health visitors and practice nurses) that was undertaken in north-west England suggested that the working relationship between the nurses was characterized more by referral than by liaison or patterns of collaboration (Quinney and Pearson, 1996). The authors identified how nurses who had patients and clients in common did not tend to document or share their knowledge with each other. Moreover, there was variation between the different nurses in how the same patient's need and care requirements were defined. It was concluded from this research that although there were many opportunities for the nurses of different specialities to work together to improve patient care and share their knowledge, these were neither exploited nor developed.

For over a decade, nursing policy has argued that primary care nurses should receive their education and organize their work so that the specialist knowledge of the team is exploited and areas of overlap and duplication are minimized. This has resulted in the reorganization of specialist training of primary care nurses and, briefly in the late 1980s, the introduction of neighbourhood nursing teams that incorporated both health visitors and district nurses (Department of Health and Social Security, 1986; Department of Health, 1991, 1993; United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1994). A continuing emphasis on needs-led services rather than those that are professionally defined further challenges nurses in primary health care to demonstrate how they can work together more successfully (Department of Health, 1997; Audit Commission, 1999).

Integrated nursing teams are a model of practice where the different nursing specialities of primary health care work as one team that is jointly accountable for the management and organization of care (Audit Commission, 1999). These teams are usually based in general practice and involve all or some of the primary care nursing specialities, usually district nurses, health visitors and practice nurses. They represent a change from traditional patterns of practice because, as Atkins and Lunt (1996) observed, the different primary care nursing specialists often work as separate teams within the wider primary health care team.

Research into integrated nursing teams coincides with the early 1990s reforms of the UK health service (Department of Health, 1989a, b). These health reforms devolved a significant amount of the funding for primary health care to general (medical) practice and emphasized the importance of a decentralized service that was needs led, as opposed to one that was professionally defined. In particular, it was the GP fundholding initiative that enabled general medical practitioners to choose to receive a budget to purchase selected hospital and primary health care services (including nursing) on behalf of their patients (NHS Management Executive, 1992). It is against this policy background and change in the organization and focus of the NHS that the research that considers nursing in integrated teams began to emerge.

Research on integrated nursing teams

A review of three different studies that examined integrated nursing teams yielded equivocal results. Ross and colleagues (1995) evaluated the change in the organization of nurses to work within an integrated team in one general practice. A nurse co-ordinator was appointed from among the nurses who worked either for or in association with the practice (i.e., district nurses, health visitors and practice nurses). She had a reduced caseload and the additional responsibilities of working with all the nurses to identify the health needs of the local population and match the skills of the nursing team

to patient demands. The findings indicated that the nurses and the general practitioners they worked with believed that the nurses were better organized, were more likely to initiate and participate in decision making about role development, and that the change had stimulated a more open debate and questioning approach to practice. However, the study which compared levels of nursing activity and nurse and patient satisfaction before and after the change found few measurable changes in practice or outcome. The authors concluded that historic patterns of working and traditional divisions of expertise meant that changes arising from integrated teamworking were likely to be slow. Owen (1996) reported on the evaluation of a pilot project for integrated teamworking within one NHS community trust . The author had been appointed to act as nurse consultant to the newly formed integrated nursing teams, and in the report claimed that after receiving training the teams achieved a flexible service that transcended traditional hierarchical restrictions. However, the results relied on the findings from a questionnaire that achieved a 54% response rate and evaluated 6 months of working. Despite the positive claims made for integrated nursing teams, few changes in practice were documented. Sapsford (1998), after conducting a survey of 105 primary care nurses working to traditional models of practice, examined the working of three integrated nursing teams. These were based within one NHS Community Trust but linked to separate medical practices. A case-study approach (Yin, 1995) was used and the findings were compared with the survey results. Sapsford found little consensus between the three teams with regard to the value of integrated working, and minimal evidence of change in how the participating nurses worked. In particular, she argued that there was little to suggest that this particular model of organization advanced the professional development of the participating nurses. From the research cited (which is limited and very localized), it would seem that there is little shared understanding of how integrated nursing teams should be organized, what the prerequisites for success are, and how that success is judged. Reports of specific nursing teams in the nursing press have been very positive about the benefits of integrated working (e.g., Reid and David, 1994; Young, 1997), although some of the professional organizations have expressed caution and scepticism about why integrated teams are represented as a way forward for primary care nurses (Kline, 1997).

An official review of district nursing (Audit Commission, 1999) included the recommendation that primary care nurses and district nurses in particular should work in integrated nursing teams. The report referred to an unpublished study from Sheffield which over a period of 2 years identified key features that facilitate the organization and working of an integrated nursing team. These included the team working within a general practice base, nurses who had actively chosen to participate in the team and who possessed shared objectives, and the presence of an identified team co-ordinator and outside facilitator. It was also suggested that established integrated nursing teams would be able to manage the nursing budget and have responsibility for the health needs assessment of the practice population.

The research evidence on integrated nursing teams is based on small studies undertaken either with individual general practices or within specific geographical areas. Nevertheless, there is a degree of official endorsement for their continuance, a recognition that specialist nursing practice in primary health care should not be undertaken in isolation, and a commitment to developing patterns of primary health care organization that are based on partnership and collaboration (Department of Health, 1997; Audit Commission, 1999). It is against this backdrop that the second half of the paper presents some findings of a study that offer several insights into the development of integrated nursing teams from a district nursing perspective.

A study of the definition and experience of district nursing work during a time of policy change

A case study of district nursing work that drew on qualitative methods of enquiry was undertaken during a time of policy change within primary health care (Goodman, 1998). The policy change was the introduction of purchasing of district nursing services by general practitioner fundholders who received devolved budgets to purchase services on behalf of their patients (NHS Management Executive, 1992). This particular approach to the organization of services in primary health care has since been superseded by primary care groups and

primary care trusts whose membership consists predominantly of GPs alongside nursing, social care and lay representation (Department of Health, 1997). Many of the principles that were developed within fundholding have been incorporated into the new structures, in particular, the importance of basing resources and services around the local population's health needs and using local practitioners' knowledge to inform that process. A more detailed description of the policy background, research approach, data collection methods and analysis is provided elsewhere (Goodman *et al*., 1998). The following research aims of the study are relevant to this paper:

- to describe the experience of district nursing within GP fundholding settings;
- to examine with district nurses, managers and GP fundholders their perceptions of GP fundholder purchasing as an influence on district nursing work.

The study was undertaken in two phases. In the first phase, 61 semi-structured interviews were undertaken with district nurses, NHS managers and GPs (all fundholders) based in 12 different sites across England and Wales. In total, 36 of these participants were qualified district nurses. These interviews explored with participants their understanding of district nursing work, its definition, and how they perceived the policy change of GP fundholding. From each site a contract/service agreement held by an NHS trust with a GP fundholder for the purchasing of district nursing services and relevant trust literature were also examined. The second phase of the study consisted of a period of observation over 3 months and further interviews. These involved two district nursing teams (eight nurses and three health care assistants) and their fellow primary health care team members, based in two of the sites that participated in the first phase of the study.

The move to self-managing teams

Of the 12 sites studied, it was apparent that eight community NHS trusts were actively supporting or considering models of self-management and integrated teamworking for primary care nurses. Three of the 12 sites in the first phase of the study had introduced self-managing primary care nursing teams of which the district nursing teams were a part. Each team model was slightly different. The characteristics they shared in common were that they were responsible for their own budget (including salaries), they received support but not management from a designated nurse external to the team, and the management of the team came from one of its members. These practitioners were responsible for all the primary care nursing specialities in the team. For two of the sites, one of the nurses was the designated team leader and had a reduced caseload in recognition of the additional administrative load she carried. In the third site this responsibility was rotated around the individual team members. Only one of the sites had introduced integrated nursing teams for all their primary care nurses. The others only had self-managing teams who were attached to GP-fundholding practices.

Of the other sites that were studied, two had pilot projects in place where one team of primary care nurses attached to a GP fundholder practice was working as an integrated nursing team, two were developing integrated teams in partnership with fundholding practices, and one had devolved more responsibility to a clinical co-ordinator who had responsibility for particular nursing specialities and worked with a reduced caseload. The remaining four sites were aware of the trend to self-management but at interview they had nothing in place or planned.

Motivating factors for the introduction of integrated nursing teams

There was a general consensus from all the study sites that within the last few years district nurses had assumed more responsibility for day-to-day management of the team (e.g., in organizing off-duty and annual leave). However, participants consistently saw the move to integrated working and self-management by primary care nurses as having been initiated by GP fundholders. The recurrent theme was that GPs were unconvinced of the role of the nurses' managers and saw them as a brake on the nurses' patterns of working and an unwanted 'on-cost' within the contract price that the fundholders paid. It was a view that was not contested by the district nurses, who almost uniformly had difficulty in articulating what the managers did on their behalf. There was no evidence to suggest

that the impetus and trend to self-management came from the nurses themselves.

In whatever ways the move to self-management was interpreted, negotiated and implemented, the district nurses across the sites – in contemplating the possibility of experiencing the new responsibilities – were mostly unsure about its implications and resentful of its encroachments on their clinical work. Within two of the sites where the budget was held at team level, responsibility for spending did not mean that the nurses were able to use the savings they had made as they wished. Both the Community trusts and the GP fundholders regarded the money as theirs. There was a responsibility to ensure that they did not overspend, but little authority over what they did with the money that they had. As the following example demonstrates, the district nurse was the designated team leader for a self-managing team and responsible for the team budget, but it had little real meaning for her:

CG:
And how much money are you looking after?

DN:
It's about £20 000. I have regular meetings with the finance department or whatever but it's very disorganized.

CG:
And that £20 000, that's for dressing and . . .?

DN:
And staff.

CG:
What, £20 000?

DN:
Oh, maybe it's £200 000 [*laughter*] – Oh, I don't feel as if I can handle it, obvious isn't it? I'm doing it for health visitors as well.

In this site the district nurses perceived that they had very little professional support and were now having to acquire skills in budget control and personnel management. This was something they admitted that their fundholders had not anticipated would be a consequence of the change. The following district nurse perceived that her need to be involved in patient care was being superseded by managerial responsibilities:

DN:
They have dumped much more on to me . . . I can see what is going to happen. I am going to become a very cheap I grade [*top clinical nursing grade*], that's what's going to happen. I am going to end up with my own secretary in 3 or 4 years' time, and not much patient contact.

Only in one site did the integrated nursing team members report positive benefits from self-management. They were supported by a professional unit, were able to use their budget as they wanted, and they reported working together and 'helping each other out':

> We do work very well together as a team. Some of the health visitors have helped me out with dressings and things like that, when I had a very tricky day. We help them out by doing the babies on a day when they can't do it. We all help each other out like that. So you know, we work really well as a team, a big team, but also we are encouraged to manage ourselves in our own individual team. So the district nurses are very much left to their own devices to go in any direction we want to.
>
> (*District nurse team leader*)

In this example, although the experience of integrated working was viewed positively, the focus of the collaboration was substituting for other team members in times of crisis. Furthermore, the district nurses worked as a team within the team, and they had reciprocal working arrangements with other district nurses in the area. District nursing, unlike its practice nursing counterparts, could not so easily mimic the GP model of a single practice focus where the work is shared and accommodated between members of one group. The activity of district nursing overlapped with the other nursing specialities, but it functioned in different locations and with collaborations that extended beyond the immediate team.

Is self-management not such a radical change?

Self-management and budget holding represented a shift in how district nursing work was organized, and a closer alignment with other nurs-

ing specialties and GP practices. However, it emerged from the district nurse interviews that this change was less dramatic than it had been argued to be by the managers and GPs. Many of the district nurses were already managing themselves, if not across specialities then within their own teams. This appeared to have arisen partly through deliberate trust policy and partly by default. Community NHS trusts had lines of responsibility and methods of communication, but they did not always work well, particularly where there had been multiple reorganizations. Therefore the district nurse took responsibility. The following comment made by one practitioner (there were no integrated nursing teams where she worked) illustrates a shared experience of district nurses in their dealing with managers – a mixture of being given more responsibility and, by circumstance, having to take it:

> Most of the time when we want our manager for any particular reason, the manager isn't there, or [is] at another meeting. They always say you can contact us, you can bleep us, you can phone us, it's not always an appropriate time when you want to discuss things, so we see fewer and fewer hours of our manager, although when she is here she is a very amiable sort of person. I personally feel we are becoming our own managers and our peer support groups as well.
>
> (*District nurse team leader*)

Other district nurses reported managing continence supplies budgets and being aware of what they spent on dressing and the resources required for medical loans. During the second phase of the study, both of the team leaders from the two sites (one of which was negotiating the introduction of an integrated nursing team with one fundholder practice) had a range of managerial responsibilities. These included supervision and management of their team, dealing with staff sickness, arranging cover, interviewing for staff nurse and health care assistant vacancies on their team (with their manager), formal appraisal of staff, and representing the team at interprofessional meetings. Their contact with managers was observed to be sporadic, and appeared to occur only when clarification of an issue was needed, or in order to receive and relay information. The pressure from GP fundholders for self-managing teams appeared to arise in part from a belief that managers were too involved in the daily management of primary health care nurses. When GPs likened district nursing work to that of the practice nurse in another setting, this belied an assumption about how district nurses operate and the type of managerial supervision that they received. However, integrated nursing teams were increasing the management responsibilities of practitioners, especially with regard to the management of budgets. For two district nurses who had assumed budgetary responsibilities as leaders of their integrated teams, the loss of a management tier above them was reducing their patient contact. Contrary to what GP fundholders claimed and said they wanted, district nurses in self-managing teams were not automatically being freed to practise.

Discussion

It has been suggested that the changes evident within the NHS represent trends that are evident within all major organizations which emphasize nonhierarchical working relationships and workers who are self-motivated, self-monitoring and self-regulating (Handy, 1995; Kelly, 1996). The move to 'allow' district nurses as part of the wider primary care nursing team to be responsible for their own management and nursing budgets could be regarded as an opportunity for nursing to be freed from the control of others (Walby *et al*., 1994). It also created the opportunity for nurses to develop a collective voice with primary health care, and to develop a nursing perspective on the health needs of the local population (Latimer and Ashburner, 1997). However, the study findings would suggest that for many of the participants the self-management was illusory and imposed from above. It was an initiative that was triggered by a belief that primary care nurses were over-managed and that a model of working that mimicked the partnership of general practice was preferable. None of the participants identified the innovation as something that nurses had initiated, or suggested that they had been instrumental in its development. For district nurses in particular it posed problems of increased administrative responsibilities and patterns of working that did not acknowledge existing collaborations with nurses outside the integrated team. It also ignored the level of self-man-

agement in which they were already engaged. Traynor (1996) suggests that developments such as integrated teamworking are examples of the simple business wisdom that even a small amount of control greatly improves performance. He regards it as a 'wily' rhetoric that masks a deep and penetrating control of the work-force by management (and in this case GPs, too) and one that fails to accept that nurses' construction of autonomy is not necessarily the same as that of management.

Where working within the integrated nursing team was seen to have achieved improved working relationships, their 'success' was dependent on the support and benevolence of others – that is, their trust managers and the GPs with whom they worked. Williams *et al*. (1997) suggest that *individual* examples of nurse-led initiatives and increased autonomy are not a foretaste of what is to come. On the basis of their review of the situation of nursing in primary care, they conclude: 'Thus nursing continues to be shaped predominantly by external factors; the role of doctors and the economics of care' (Williams *et al*., 1997: 77).

The way in which integrated nursing teams were being introduced and planned across the eight sites of the study was reported as being due to the external stimulus of GP fundholding and community trust management.

The need for a collective approach

In principle, nursing self-management within a primary health care team has the makings of a prototype collective. Ferguson (1992), in her study of an organization that worked as a collective, identified the principles that characterize such organizations. Workers have a common purpose and view themselves as responsible for the production process, decisions are taken together, and there is no manager. She describes this self-efficacy which the members of the collective feel as empowerment and crucial to the organization. Empowerment is a difficult concept to define, but it was what trust managers who had introduced (or were planning to introduce) self-managing teams identified as a particular advantage of the innovation. Ferguson (1992) acknowledges the multiplicity of meanings associated with the word. She suggests that it covers a sense of responsibility and reliability, self-directed action for the benefit of the community of which one is a part, being autonomous and at the same time only achieving that autonomy through being part of the collective venture. It is the sense of common purpose that gives the work meaning and makes it more attractive than work in which the worker is part of a hierarchy whose leaders do not need or want the workers except for their contribution to ensuring that the service is delivered. Equivalent empowerment of the primary care nurses and district nurses in particular was difficult because the organization of the team was a devolved responsibility which did not (and could not) lead spontaneously to self-governance. The hierarchies therefore remained intact.

Conclusion

Recent primary health care policy has aimed to address the problems of fragmentation, instability, inequity and bureaucracy, and to introduce systems of care that promote integration and partnership across disciplines and agencies (Department of Health, 1997). One particular cornerstone of the reforms is the decentralized responsibility to practitioners and others for the commissioning and operational management of services for local populations (NHS Executive, 1999). Rafferty (1998) notes that when the goals of nursing coincide with the needs of government, then policy that is most likely to affirm the nursing contribution will result. The policy imperative is for strategies that promote integrated working and inter-agency collaboration. For decades, nursing policy and research have advocated that nurses in primary health care need to exploit their shared knowledge as well as specialist expertise to improve health care. Integrated nursing teams would address this need for collaboration. However, on the basis of the research reviewed and the findings presented it would seem that for integrated nursing teams to be effective, greater emphasis needs to be placed on the development of a shared philosophy that allows practitioners' priorities to be articulated. In the case of district nursing, it is the ability to provide care that draws on the skills and support of other nurses. Billingham and Perkins (1996) emphasize how important it is for nurses to have a shared philosophy of practice, and organizational support that promotes it, in order to survive in a changing health service. Models that increase the administrative and financial responsibilities of practitioners

without developing a sense of mutual responsibility and accountability risk creating isolated teams who may substitute for each other but who are unable to respond together to meet changing needs for health care. It is important that primary care nurses work together irrespective of speciality differences (Bryar, 1994; Latimer and Ashburner, 1997; Sturt 1997). However, the way in which such working together is achieved needs to take into consideration the different pressures within primary health care that shape the way in which collaborative working is defined and organized.

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