

The integrated nursing team in primary care: views and experience of participants exploring ownership, objectives and a team orientation

Angela Furne, Fiona Ross Joint Faculty of Health and Social Care Sciences, Kingston University and St George's Hospital Medical School, London, and Elizabeth (Pit) Rink, Department of General Practice and Primary Care, St George's Hospital Medical School, London, UK

The development of integrated nursing teams consisting of district nurses, health visitors and practice nurses based in general practice is a widespread recent change in primary care. This development has been justified by promising to meet the need for a more cost-effective service, through a reduction of duplication in nursing work, improvements in the consistency of advice to patients and the provision of accessible and responsive patient care. This paper reports on topic-led qualitative interview data which were collected as part of a multimethod evaluation of various models of evolving integrated nursing teams. The overall aim of the evaluation was to explore progress towards integration by assessing nurse workload, team effectiveness and staff perception of change. The assessment of workload and team effectiveness is reported elsewhere. Staff perception of change was measured by analysis of interview data collected from 12 teams, 9 months after the implementation of nurse integration in two London health authorities in 1998. A total of 33 interviews explored nurses' interpretation of integrated nursing, their expectations relating to their changing roles and activities and their perceptions of key activities and outcomes relating to the implementation of integrated working. Although achievements were identified, including some changes in clinical practice, in general participants reported a partial and variable understanding of the concept of integrated teamwork, and there was uncertainty reported over changes in professional boundaries. A lack of ownership of the process of change and a dearth of team objectives were reported. Developments towards teambuilding were more common than strategic planning to reorganize the workload of the team collectively according to a local population-based agenda. To implement an integrated approach to primary care nursing, we suggest that there is a need for increased ownership and support for teambuilding strategies and skill development. If integrated nursing is to contribute to health improvements, it is necessary that participants agree on patient-focused objectives that orient towards a collective and locally targeted delivery of care.

Key words: integration; nursing; primary care; teamwork

Introduction

Background

Current policy for *The New NHS* emphasizes patient needs at the centre of planning (Department of Health, 1997), professional empowerment through devolved decision making, lowering pro-

Address for correspondence: Angela Furne, Joint Faculty of Health and Social Care Sciences, Kingston University and St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, UK. Email: afurne@hcs.sghms.ac.uk

professional boundaries and continuing professional development (Department of Health, 1999). The focus on public health through the Health Improvement Plan (Department of Health, 1999), the focus on improved quality of service delivery through clinical governance (Department of Health, 1998) and an increased assessment of performance by the Commission for Health Improvement (CHIMP) means that now more than ever, questions are being asked about the shape and organization of the community nursing workforce that is required to meet the demands of new primary care organizations (Latimer and Ashburner, 1997).

The notion of merging the organization of practice nurses, district nurses and health visitors was first proposed in government policy (Roy, 1990) and became a popular management strategy in the UK from the mid-1990s, facilitated by the changes in the contracting arrangements for attached staff to general practice. The policy intention was to bring together general practitioner-employed practice nurses, trust-employed community nurses and health visitors to improve communication, relationships and working together for the delivery of appropriate nursing services and patient care. These groups have been variously called integrated teams or self-managed teams (Department of Health, 1996).

Despite the popularity of the concept of integrated nursing teams there is comparatively little evaluative literature available, with a few exceptions (Black and Hegal, 1995; Rink *et al.*, 1996; Gerrish, 1999). Analysis of this literature reveals the absence of any standardized understanding of teamwork or agreed definition of the concept of integrated teamwork within the nursing context, evidenced by a recent book on the topic (Elwyn and Smail, 1999). This literature indicates different justifications for the implementation of integrated nursing, varied levels of nurse involvement, varied degrees of self-management and leadership models making comparison difficult and suggesting few examples for practitioners to follow. The resulting conceptual confusion may in part reflect the lack of universal agreement and the limited evidence that teams confer positive benefit (Pearson and Spencer, 1997), that care provided by a range of variously trained professionals is cost-effective (Coulter, 1995) and that integrated nursing teams have a positive impact on patient outcome (Bull, 1998). Interestingly, the issue of relative power

between nurses and among the stakeholder groups such as general practitioners and community nursing managers, with their different organizational and professional priorities and management cultures, tends to be overlooked in the integrated teamwork literature. This paper seeks to clarify these issues by examining nurses' perceptions of change, ownership and priorities in relation to the introduction of integrated nursing teams.

Context

In 1997 three NHS community trusts in London and their respective health authorities (A and B) worked in partnership to explore and implement integrated nursing. They sketched out a framework for integrated nursing teams as a core team of primary health care nurses working together towards a local population-based plan for delivery of nursing care, thereby reducing duplication and providing consistency of nursing advice. Nurse managers and key GPs introduced the notion of integrated teamwork at staff meetings. Participants were free to interpret the definition of integrated teams for themselves and to decide on core membership of the emerging team and methods to take integrated teamwork forward. It was envisaged that nurses' 'grass-roots' awareness of patient needs would equip them to make the decisions as to how care might be improved by integrated working and then develop a more efficient and evidence-based service.

The trust and health authority recruited 12 practices (eight in area A and four in area B) with variation in team structure, size, accommodation and fundholding histories. There was also variation in the level of planning, implementation and support for the evolving teams. Support was provided in the form of a named GP in each practice with whom nurses could communicate, a variety of forms of facilitation, a steering group to oversee team progress, a multidisciplinary training package from a local university, funding for away-days and some training for the facilitators. In area B each group of nurses also elected or appointed a nurse from within the team to coordinate activities. Nurse coordinators developed different roles and responsibilities, came from different disciplines and grades, and some of them worked part-time. Budgets were not devolved, and no extra remuneration or status was given to any participants.

The study: aim and methods

The White Paper Challenge Fund funded an independent evaluation of evolving integrated nurse teams with additional funding from the participating trusts, health authorities and a local non-medical education and training consortium. The aim of the evaluation was to explore progress towards integration by assessing nurse workload, team effectiveness and staff perception of change. Participants' views of teamwork and team effectiveness were assessed using the Primary Health Care Team Questionnaire (PHCTQ) (Poulton and West, 1994). Changes in nurse use of skills were measured by analysis of workload which has been developed and used successfully elsewhere (Godfrey *et al.*, 1997). Interviews were conducted with members of each team (a general practitioner, practice manager, practice nurse and coordinator, as well as managers from each trust, key players from each health authority, and appointed nurse facilitators). The aim of the evaluative interviews was to ascertain participants' views of the experience of exploring this form of change. The main study findings with regard to workload and perception of teamwork and team effectiveness are described more fully elsewhere (Furne *et al.*, 1999; Rink *et al.*, 2000; Ross *et al.*, 2000). This paper reports the findings from the topic-led interviews with one nurse from each specialty from each practice, 9 months after the start of integrated teamwork. Interview topics included participants' interpretation of the concept of integrated nurse teams, their expectations of the process of teamwork, their views on their achievements and the perceived facilitators and barriers to change. The topics for interview were devised by drawing upon literature sources, including Rogers' (1983) account of change management and Pearson and Spencer's (1995) pointers to effective teamwork, which emphasize the following:

- the need for a clear interpretation of the task;
- the need for development to be planned according to a clear model with participation by all members of the team;
- each team member signed up to the team goal and perceiving some benefit from participation;
- each member having a clear role to play with observable outcomes for their input in order that their contribution can be measured;

- clear interpretation of facilitation, management or leadership and support.

Interviewees were selected using a purposeful sampling technique balancing the discipline and grade of nurses. The same interviewer conducted all of the interviews and used probes where necessary to keep interviewees on track with the desired topics. The interviews were confidential, face to face, and took place in the participants' work setting. They lasted 45 minutes on average. Each interview was audiorecorded, the tapes were transcribed verbatim and each participant was allocated a unique identity code including their discipline and an identification number (e.g., DN 109 – district nurse number 109; PN 120 – practice nurse number 120; HV 154 – health visitor number 154).

A thematic content analysis was performed against each interview topic which was allocated a code. When an interviewee discussed their views on a topic (e.g., the concept of integrated nurse teams), the code was placed in the margin of the transcript. Other topics that were raised for discussion by the nurses were marked with unique guiding codes. The relative contribution of the interviewer to the responses was carefully recorded. Common and clearly different issues reported within each topic were sought. For example, if more than one participant reported feeling 'confused' when discussing the topic 'the concept of integrated nursing' this was recorded as an issue. Patterns of issues raised within each interview topic were identified as themes (i.e., for each team, and for nurses from the same specialty). The question of what constituted a theme was peer reviewed internally for verification.

The key difficulty with this type of analysis is striking a balance between making a theme from detailed responses and losing the specific nuances of an individual's comments. As themes increase in size to encompass a general feeling they become more distanced from the quotes of individual respondents. It is here that qualitative data becomes most vulnerable in terms of validity or trueness to the participant's intentions for interpretation. Quotes have been retained as exemplars of the range within the themes for this reason.

Results

The data reported here provide an exploration of the nurses' perception of the team prior to inte-

gration, their plans for change, their progress (including facilitators of and barriers to change) and any outcomes. The responses are categorized according to each team or nurse discipline. The examples are selected to present both those which indicate common views of the experience of participating in integrated teamwork and those which indicate more extreme and independent views.

Integrated teamwork: nurses' interpretations and expectations

Exploration of nurses' understanding of integrated teamwork revealed a diversity of interpretation and expectations. Some nurses reported that the concept was vague and ill defined, with few known examples of good practice, and little in the literature to help. For example, *'To be honest it was all very vague. I don't think I ever got to the point of exactly how it would be'* (PN 26) and *'Difficult to understand what it would mean and how it would work'* (HV 42). Some nurses expressed enthusiasm, yet were unable to articulate clearly what integration meant or represented. Other nurses defined integration as working together with improved awareness of roles and skills, gathering clinical knowledge and information, improving working relationships including trust and support and developing openness through communication. For example, *'It's about getting an improved understanding of each others' role'* (DN 134), *'discovering what skills and expertise others have'* (HV 154), *'finding out what's going on in treatment'* (PN 120), *'It enhances the work of team members'* (HV 122), *'It can improve trust and respect for others'* (HV 132), *'It provides support'* (HV 154) and *'It's about exploring how nurses from different disciplines could work together as one team by improving referrals'* (PN 133).

Nurses also reported changes in the way in which they planned care. For example, *'In an integrated team nurses are much more willing to refer to nurses from other specialties, to seek advice and to share knowledge and equipment'* (HV 154). Integration was also reported as an exploration of role boundaries. For example, *'It's about knowing where we all stand'* (DN 105) and *'working together as a nursing team rather than all blending into one'* (HV 143). Occasionally positive views were coupled with a hint of scepticism. For

example, *'We'd all be this super nurse. We'd all be a happy family'* (DN 80).

Some nurses reported integration as a method to improve management of the nurse resource in terms of cost-effectiveness and efficiency. For example, *'too many things get done by too many different people and it's not cost-effective, so it's about streamlining the service'* (PN 205), *'reducing overlapping and duplicating'* (PN 145), and *'providing consistency of advice to patients'* (HV 122). In contrast, some nurses reported reservations about a possible hidden agenda such as cost cutting especially in the form of developments towards a generic role. *'We don't want it to be a cost exercise'* (HV 7) and *'At first there was some suspicion to the news, people not wanting to be generic nurses'* (HV 143).

Towards integration: nurses' plans and progress

Interviews explored whether there was a clear goal that was shared among the whole group team and a plan for reaching it. Interviewees did not appear to be aware of a clear set of objectives and many nurses were unable to identify a team goal in terms of reorganizing care delivery patterns. Despite a lack of apparent objectives and difficulty in recruiting all members of the team on all occasions, these nurses were able to describe areas where perceived progress was being made, even if not according to a clear plan. The perceived progress has been summarized as a list of key achievements in Box 1.

Box 1 Key achievements towards integrated nursing teamwork

- Improved communication
- Improved awareness of roles and skills
- Drawing on the knowledge of the team
- Improving liaison, coordination of activities and referrals
- Increased role flexibility
- Practice population needs assessment
- Developing common protocols
- Improved communication

Improved awareness of roles and skills

Nurses reported an initial lack of understanding of each others' roles and skills. For example, *'You work in your department and don't know exactly what others do. We were fairly ignorant of the nature of the work and the depth of training we had'* (PN 27). Developments were reported as occurring either through a formal review of skills, observing each other at work or making presentations. Positive views from nurses emerged to illustrate this. For example, *'From the profile you could see we had a lot to offer'* (HV 122). Some criticisms were made. For example, *'It was only partially useful since half the team members have since left'* (nurse co-ordinator (NC) 126) and *'We drew up this huge list of skills we've got but we haven't used it in any way'* (HV 93).

Drawing on the knowledge of the team

A common theme was that being part of a team enabled access to the collective expertise and experience. For example, *'The facilitator assisted us with how to draw on the practice nurse for asthma and the district nurse team for wound care or incontinence'* (DN 134) and *'I feel we complement each other. I don't know it all'* (HV 122).

Improving liaison, coordination of activities and referrals

There was a recognition that improved understanding of others' roles and responsibilities was helpful with regard to making appropriate referrals and assisting coordination. For example, *'I inform the patient to see the practice nurse for suturing'* (DN 134) and *'I am promoting a new family planning clinic for the practice nurse'* (HV 154).

Increased role flexibility

Bryar (1994) noted the need for new and developed roles in nursing. Greater working with and across disciplines and developing flexibility in team members' roles was also reported. For example, one community staff nurse worked 2 days with the district nurse team and 2 days with health visiting although there was reported *'suspicion among health visitors. They thought I might be taking some of their job away'* (NC 143). There were examples of informal and planned work with nurses from another discipline. In some cases collaborative working was discussed or planned rather than practised. For example, *'One of the early*

examples of real integrated nursing was in October with the immunizations for the flu. Everybody just joined in – district nurses, practice nurses, health visitors and the doctors as well' (HV 93), *'Because the practice nurse and I talk more about things, I've been able to make plans, which would incorporate the role of the practice nurse'* (HV 132), *'We do a baby clinic with the practice nurses'* (HV 42) and *'Once we helped with a dressing for a baby, for a mum with a hysterectomy'* (DN 105). Others reported improving teamwork within a discipline as well as helping out within limits. *'I'd be a bit worried about doing things I wasn't comfortable with, like Doppler's, I don't get regular exposure'* (DN 80).

Practice population needs assessment and developing joint guidelines or protocols

There was some variation in the extent to which population needs assessment was reported and there was variation in the level of completion reported across teams. A range of positive and negative comments were made. The most positive and most negative views were expressed as follows. *'It has provided us with a better understanding of what's out there, what to look for'* (DN 105), *'I hope it will make the basis of a working group'* (HV 143) and *'without good computing facilities we were fumbling in the dark really'* (DN 43).

The development of common protocols was mentioned in two of the 12 teams. *'We've done a wound protocol'* (DN 14) and *'We have regularly updated common protocols on the computer system'* (PN 30).

Improved communication

Perceptions of improvements in communication were reported in all of the teams. The most detailed example of improvement was as follows. *'We delegate responsibilities among team members to coordinate communication. One nurse is responsible for keeping a noticeboard, another to keep nurses updated on training opportunities; another is responsible for coordinating meetings. There is also a noticeboard in reception for meetings, notes on each others' desks and use of the community nurse message-books. I keep a folder of everything the team is working on, making sure issues are all written up'* (NC 133).

Nurses were establishing team meetings which can be useful for teambuilding (Bennett-Emslie

and McIntosh, 1995). Some nurses met with their discipline to discuss issues arising from the whole team, but limitations on time due to work pressures and the part-time nature of their work, as well as the conventional ways of working of the different disciplines, were reported as barriers to successful meetings. *'Meetings take up time which could be spent catching up on paperwork'* (HV 132), *'Nurses are watching the clock, on edge, to leave to get on with pressing clinical work'* (DN 134) and *'There's summer vacation, workload pressures and the part-time nature of practice nurse work and because of the way health visitors work we feel things move on without people being able to give input at times'* (HV 93).

Clear contributions and measurable outcomes?

The progress reported above demonstrates a few measurable moves towards mutual understanding, collaboration and changes in delivery of care, including areas where each individual contribution could be identified. Nurses reported that the process of change was as important as the outcomes, as well as the opportunity to learn from and reflect upon experience and to accept that these things take time. *'I'm a bit concerned that there's a lack of measurable activity over the year. We may not have achievements in boxes saying, "Tick, Tick, Tick. We've done this. We've done that"'* (NC 143), *'We don't feel that we have done much which is tangible. After recounting all the little achievements I readjusted my judgement. Yeah. Slow and steady. We just keep plugging away. We should have some measurable outcomes by next year'* (NC 133) and *'These things take time. You have to be realistic about time scales. As long as we are making progress'* (HV 154).

Discussion

Organizational development in primary care is essential to achieve the aims and aspirations of *The New NHS*. The community nursing workforce is a vital part of these aspirations, and therefore uncovering and illuminating the perspectives of nurses who are participating in a small part of this change agenda is relevant. These interviews reveal participants' views of the experience of integration and they identify clear themes which are reflected

in the literature on teamwork, collaboration and change management. Our analysis uses the collaboration framework of Hudson *et al.* (1999) which we refer to elsewhere (Ross *et al.*, 2000)

Integrated nursing: vague and ill-defined

The trust managers and general practitioners in health authorities A and B hoped that integrated teamwork in nursing would empower nurses if it was delivered from the 'bottom up'. Managers and general practitioners provided some joint support for integration in terms of access to training and facilitation for practice nurses, district nurses and health visitors, as well as moving some nurses on to one site. Despite the professed aim to give nurses authority and the 'freedom' to develop flexible models of teamwork using local knowledge, these findings suggest the existence of some contradictions and tensions between the stakeholder view and that of the nurses, particularly with regard to the perceived expectations and constraints of integrated nursing teams. The lack of consensus about the meaning, scope and implications of integrated nursing teams in terms of devolving responsibility and management may reflect the current instability in the organization of primary care nursing services as boundaries are renegotiated in response to changing professional roles (Williams, 2000) and to meet the needs of primary care groups and trusts.

The nurses varied in their interpretations of integrated nursing. Some were welcoming while others were sceptical that this was an exercise in dumbing down of the nursing workforce with the introduction of generic roles by the back door. The diversity of views that emerged from this data is not surprising given the pluralism of community nursing (structural, professional and personal) represented in the mix of our respondents, the different value bases of district nurses, health visitors and practice nurses (Traynor, 1994) and the shifting role boundaries (Williams and Sibbald, 1999).

A clear sense of purpose or directionless change?

Hudson *et al.* (1999) have discussed the need to articulate a clear sense of purpose in order for teams to work. This was problematic for many of the nurses who were interviewed in this study. A lack of clear and shared expectations of integrated teamwork, little convincing evidence of the benefit

of integration, limited time and variable access to facilitation or training led to a dearth of action plans, limited objectives, little clarity regarding individual roles and responsibilities and few identifiable outcomes.

Developing objectives is a necessary step in any process of change (Rogers, 1983) and successful functioning teams require shared goals (Poulton and West, 1994). Managers' objectives for integration were to reorganize the nurse resource according to a community or local population focus, with improved cost-effectiveness and efficiency being achieved through a reduction in duplication and a more 'joined up' service. Although these nurses did make attempts to reduce duplication and improve responsiveness by improving communication and referral, this was the extent of their progress.

Ownership of the change: 'led from the top'

The data suggest that the nurses did not have a sense of ownership of the change in their organizational structure and it was generally perceived as being led from the top. The structural changes necessary to facilitate nurse integration, such as sensitive attention to the integration of nurses working within different employment and contractual contexts, the provision of sufficient resources (time, information and support) and the provision of clear political intentions, were also regarded as missing. This suggests a lack of understanding by managers of what nurses require to foster change and devolved responsibility for decision making. A top-down approach is a common experience associated with the introduction of change and has been noted to be a feature of the implementation of integrated nursing elsewhere (Forester and Kline, 1997) which can lead to resentment and resistance and may be a significant factor in impeding change (Babington, 1993). In this context, with the varying expectations, priorities and organizational loyalties of all of the nursing groups which were expressed strongly by health visitors and perceptions of being peripheral to the decision making may have been a barrier to positive change. These results have been described more fully by Ross *et al.* (2000).

The lack of ownership and the consequent difficulties that these nurses reported may be illuminated further by other interrelated factors. The lack of access to convincing or critical information on integrated teamwork seemed to be

coupled to feeling inadequately equipped with the necessary skills, knowledge and experience to evaluate the concept of integration and its implications for professional identity. This suggests that these nurses were not in a position to make a collective decision either to lead integration or actively to resist the suggested change.

Working towards teamwork

Despite these difficulties, notable progress towards teamwork was achieved through reported improvements in communication, understanding of roles and skills, increased trust and support and a generally improved orientation to working together through helping out, improved liaison and referral. These findings support those of Gerrish (1999), who reported that it was only a minority of teams that were able to move beyond a focus on team processes to community-based outcomes and improve 'real' communication (Habermas, 1991) where nurses and the stakeholder groups are clear in articulating the reasons for change as well as being willing to understand and accept underlying values, assumptions and differences (Wilmot, 1995). Perhaps these nurses focused on team-building because it did not make contact with those difficult issues concerning the devolution of resources, merging of budgets and shifts in power base which they were not in a position to influence.

This qualitative component formed an important part of this multimethod evaluation of integrated nursing teams. This paper focused specifically on the reported experience of nurses without discussing the convergence with the results from the teamwork questionnaire and workload analysis as this has been reported elsewhere (Ross *et al.*, 2000). The interviews allowed nurses to raise their own concerns and issues and not be driven by a research-led agenda. Although they covered a diverse range of topics from reported interpretations, emotions, actions, reflections and expectations, the analysis binds the views of three nurse disciplines from diverse organizational structures demonstrating variable progress towards effective teamwork. It was a limitation of this study that the themes were only validated by peers from the research team and not by the participants. Although we make no claims for generalizability from this small qualitative study, there are some issues flowing from the data that merit further exploration. Future work could explore with a

larger sample of different nurses from each nurse discipline their relative agreement with these reported opinions and could possibly explore any variation across disciplines. There may be some benefit from using certain of these themes as a launch pad for others to reflect on, or comparing them with views from other models of integrated working, particularly in the light of recent statements from the centre (Department of Health, 2000).

These findings raise questions about the need to consider teambuilding within organizational and professional contexts which take account of the real constraints of limited time, heavy workloads, anxieties about uncontrolled change and insecurity related to genericism and changes in professional boundaries. Integrated nursing care delivery is a huge agenda that requires change on many levels (individual, professional, team and organizational). Consideration must be given to the time required to gather ownership of change, assess critically the implications of change, develop new skills and work towards patient-focused care.

Box 2 Recommendations

- Planning for change through protected time, depth discussion about role boundaries, skills in the team and justification for current methods of working
- All participants agree a working definition of integrated teamwork
- Set team objectives orientating to a population-based system of care delivery and provide training in the skills necessary to deliver it

References

- Babington, L.** 1993: Cautionary notes on innovation in nursing practice. *Nurse Administration Quarterly* 17, 22–26.
- Bennett-Emslie, G.** and **McIntosh, J.** 1995: Promoting collaboration in the primary care team – the role of the practice meeting. *Journal of Interprofessional Care* 9, 251–56.
- Black, S.** and **Hegal, D.** 1995: *Working together in primary care: Primary Health Care Research and Development* 2001; 2: 187–195
- an integrated team approach.* Colchester: Essex Rivers Healthcare NHS Trust.
- Bryar, R.** 1994: An examination of the need for new nursing roles in primary health care. *Journal of Interprofessional Care* 8, 73–84.
- Bull, J.** 1998: Integrated nursing – a review of the literature. *British Journal of Community Nursing* 3, 124–29.
- Coulter, A.** 1995: Shifting the balance from secondary to primary care. *British Medical Journal* 311, 1447–48.
- Department of Health** 1996: *Primary care choice: an opportunity.* London: HMSO.
- Department of Health** 1997: *The new NHS: modern, dependable.* London: The Stationery Office.
- Department of Health** 1998: A first-class service: quality in the new NHS. London: The Stationery Office.
- Department of Health** 1999: *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and health care.* London: The Stationery Office.
- Department of Health** 2000: *Making a difference – integrated working in primary care.* Leeds: NHS Executive, Nursing, Quality and Consumers Directorate.
- Elwyn, G.** and **Smail, J.** (editors) 1999: *Integrated teams in primary care.* Oxford: Radcliffe Medical Press.
- Forester, S.** and **Kline, R.** 1997: Integrated nursing teams. CPHVA Professional Briefing 9. *Health Visitor* 70, 229–31.
- Furne, A., Rink, E.** and **Ross, F.** 1999: *An evaluation of evolving integrated nursing teams in Merton, Sutton and Wandsworth Primary Care Services. Final report.* London: Faculty of Health and Social Care Sciences, Kingston University and St George's Hospital Medical School.
- Gerrish, K.** 1999: Teamwork in primary care: an evaluation of the contribution of integrated nursing teams. *Health and Social Care in the Community* 7, 367–75.
- Godfrey, E., Rink, E.** and **Ross, F.** 1997: Measuring the workload of an integrated nursing team in general practice. *British Journal of Community Health Nursing* 2, 350–55.
- Habermas, J.** 1991: *Communication and the evolution of society.* Cambridge: Polity.
- Hudson, B., Hardy, B., Henwood, M.** and **Wistow, G.** 1999: In pursuit of interagency collaboration in the public sector. What is the contribution of theory and research? *Public Management* 1, 235–60.
- Latimer, J.** and **Ashburner, L.** 1997: Primary care nursing: how can nurses influence its development? *NT Research* 2, 258–67.
- Pearson, P.** and **Spencer, J.** 1995: Pointers to effective teamwork: exploring primary care. *Journal of Interprofessional Care* 9, 131–38.
- Pearson, P.** and **Spencer, J.** (editors) 1997: *Promoting teamwork in primary care.* London: Edward Arnold.
- Poulton, B.** and **West, R.** 1994: Primary healthcare team effectiveness: developing a constituency approach. *Health and Social Care in the Community* 2, 77–84.
- Rink, E., Ross, F., Godfrey, E.** and **Roberts, G.** 1996: The changing use of nurse skills in general practice. *British Journal of Community Health Nursing* 1, 364–39.

- Rink, E., Ross, F. and Furne, A.** 2000: *Integrated nursing teams in primary care*. Nursing Times Monograph 49. London: NT Books, Emap Healthcare.
- Rogers, E.** 1983: *Diffusion of innovations*, 3rd edn. New York: New York Free Press.
- Ross, F., Rink, E. and Furne, A.** 2000: Nursing teams in primary care: integration or pragmatic coalition? *Journal of Interprofessional Care* 14, 259–67.
- Roy, S.** (chairman) 1990: *Report of the working group: nursing in the community*. London: HMSO.
- Traynor, M.** 1994: The views and values of community nurses and their managers. *Journal of Advanced Nursing* 20, 101–9.
- Williams, A.** 2000: *Nursing, medicine and primary care*. Buckingham: Open University Press.
- Williams, A. and Sibbald, B.** 1999: Changing roles and identities in primary health care: exploring a culture of uncertainty. *Journal of Advanced Nursing* 29, 737–45.
- Wilmot, S.** 1995: Professional values and interprofessional dialogue. *Journal of Interprofessional Care* 9, 257–66.