AUSTRALIAN PRIMARY HEALTH CARE
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STREAM TEN TRAVELLING FELLOWSHIP: PREPARING NURSES FOR PRIMARY CARE

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BACKGROUND

Momentum is growing for a nationally driven and funded, integrated primary care service system, in Australia. The burden of chronic conditions and an ageing population, coupled with the need to mange increasing costs in health care, have focused attention on the need for primary care to develop capacity in the prevention and management of these chronic conditions. The Federal government has a clear focus on reforming the health system to strengthen prevention and facilitate care at the primary level. In the UK, nurses in primary care settings provide services focused on prevention, manage the increasing burden of chronic disease and facilitate patient self-management of their health, and provide triage functions for the new walk-in clinics. Primary and community care nurses are, as part of an integrated team, in an ideal position to play a key role in these activities as long as they are adequately prepared.

International evidence indicates that primary health care nurses provide effective care and achieve positive health outcomes for patients similar to doctors when within the scope of their practice (Keleher, Parker 2007). Nurses are good communicators and achieve good patient compliance. They are also able to undertake diverse roles including chronic disease management and health promotion activities. However, funding structures in the Australian health system limit the range and nature of care nurses can provide. Also nurse education in Australia does not prepare nurses for primary health care nor comprehensively for inter-professional care. Undergraduate programs in Australia prepare nurses well for the acute care sector but provide little opportunity for nurses to be educated about primary care, prevention, health promotion and working in a primary care team environment (Watts I et al., 2004). Postgraduate education is piecemeal, lacks consistency and mechanisms for quality assurance. No career pathways exist for nurses in general practice linking their competencies with skills, education and remuneration (Keleher H, Parker R, Francis K, Segal L, & Abdulwadud O, 2007).

Primary care nursing is not seen as a career of choice for young nurses and has limited attraction for experienced nurses who are interested in diversifying their career aspirations through working in primary care. The increasing burden of chronic conditions amongst the Australian population and the challenges of an ageing population need an inter-professional approach to care. Evidence from our Stream 6 project shows that properly trained nurses could contribute to this care and improved patient health outcomes. Stakeholder consultations for that project identified an interest among stakeholders in consolidating the role of the primary care nurse in Australia. Stakeholders were open to the development of different roles for primary care nurses. The importance of primary care and preventive health care were underlined by stakeholders. There was also concern about workforce shortages and the

significant impact these shortages would have in the primary care sector. Practice nurses were seen as one solution to helping address these challenges (Keleher H, Parker R et al., 2007) .

In establishing an effective and sustainable primary and community nurse workforce, a number of challenges are yet to be addressed. A strengthened primary care nursing workforce has the potential to drive change and improve the delivery of many aspects of primary care as well as relieving the workload pressures on GPs (Keleher H, Joyce C, Parker R, & Piterman L, 2007). Future policy development on the practice nurse role needs to be evidence based and work towards nationally consistent standards for;

- the development of the primary nursing roles in inter-professional teams
- the education framework that supports those roles and
- career pathways to enable nurses to work as part of inter-professional primary care teams.

SCOPE OF THIS STUDY

To respond to these issues, we planned a program of study across three centres in the UK. These included primary care researchers, educators, professional bodies and policy advisers. Our work was aligned with that of Professor Jill Thistlethwaite who traveled to Canada with questions pertaining to inter-professional learning in primary care.

We visited The National Primary Health Care and Development Centre at the University of Manchester (NPCRDC) and spent time with researchers from various disciplines (health services research, sociology, health economics and psychology). Our interest in this Centre was on health services research, quality and systems for primary care delivery.

At the University of Southampton, we visited the Centre for Health Innovations and the new School of Health Science. Our interest in Southampton was on their systematic approach to inter-professional learning and education in undergraduate education and in education for primary care nursing.

At Kings College London, we visited the Centre for the Advancement of Inter-professional Education (CAIPE) to glean information about the various models of IPE being implemented across the UK.

We met with professional nursing bodies, policy advisers and a practice nurses to explore primary care nursing developments and the roles that primary care nurses play in the health system of the UK.

We also met with the Dr Angela Lennox who has pioneered a model of inter-professional learning in Leicester where students learn from the experiences of patients. She is currently an advisor to the Department of Health on primary health care.

OVERVIEW OF KEY ISSUES

Key themes	**Sub themes**
What should primary care be doing and delivering to meet the needs of the population?	• From a population health approach, what are the best systems to deliver: • Services • Quality to optimize care for the population • Meet specific population needs • Prevention/health promotion
How do we organise systematically to	• Focus on needs of the

deliver that?	population/community • The system should be designed to meet those needs • Practitioners within the system must be able to provide the right services for the right cost, at the right time in the right place – we need to make use of available labour. • Affordable access is critical • Health inequalities must be addressed • More flexible progression for nurses needs to be addressed • With the shift from hospital care to community care , the interface between health and social care needs to be developed • Shift in nursing care across the continuum. Nursing should be delivered across the care pathway whatever the setting (see Modernising Nursing Careers) (Focus not on the profession but on the patient journey)
Teams and inter-professional working	• Underpinned by inter-professional learning that is extended over time and embedded into curriculum at undergraduate level, and supported by organisational arrangements and systems in practice. • Integrated health and social care teams bridging between hospital and community • Team's roles In preventive re-admission of people to hospital who have chronic and long term conditions
Access and outcomes	• Contract the services to provide services that are outcomes driven, and

	let them decide how to do it and how to get the best skill mix. In the UK, general practice as small business has responded quickly to change and to their particular local needs when the drivers are clear and incentivised.

RESULTS OF DISCUSSIONS WITH KEY INFORMANTS

We had wide ranging discussions with a range of informants identified in Appendix 1. From these discussions we were able to:

- Understand the changes implemented in primary health care in the NHS since 2000
- Understand how funding has changed to reward quality of outcomes rather than patient throughput
- Understand how addressing health inequalities is a central tenet of the new funding agreements
- Appreciate how central nursing now is to the delivery of quality primary health care in the UK
- Recognize the changes implemented in the pre –registration nursing curriculum to reflect the change in emphasis from hospital to community care
- Understand future plans to cement community and public health education into all nursing curricula by 2010-11
- Understand the extended roles undertaken by nurses in general practice in the UK and how these roles contribute to practice income
- Understand how practices are expected to respond effectively to the particular needs of their communities, particularly in promoting prevention and comprehensive team care in the community
- Appreciate the centrality of inter-professional learning in university health and medical faculties to meet the needs of integrated team care of the health system in the UK.

DEVELOPMENTS IN THE DELIVERY OF PRIMARY CARE IN THE UNITED KINGDOM

The UK has undergone significant re-structure of its primary care system over the past decade with general practice becoming increasingly privatised. There has been a focus on quality and outcomes driven reform and on primary care systems that meet the needs of the population they serve.

Health system reforms in the UK since 2000 have been significant and it was clear from our consultations that the UK is mid way through a comprehensive reform agenda. The reform agenda for primary care and general practice has resulted in a greater emphasis on team care and quality performance measures.

The Department of Health has published a number of reports detailing the reform agenda in health and specifically in primary care (Department of Health, 1999, 2000, 2002, 2006). The development of advanced practice for nurses in primary care has been supported through these national directives. The changes in service delivery have resulted in an increasing need for skill mix and for practitioners that are appropriately trained and qualified for the work they do. The NHS developed a Knowledge and Skills Framework(Department of Health, 2004) to help define roles and scope of practice.

Over the past decade nurses have been taking on roles traditionally fulfilled by GPs in the UK. National policies indicate that this will continue to be the case. Liberating the Talents (Department of Health, 2002) underlined a need for flexibility across professional boundaries and set out a framework for framework for primary care nursing based on three core functions;

- First contact assessment, diagnosis, treatment and referral
- Continuing care, including chronic disease management
- Public health including health promotion.

The new GMS contract with GPs in the UK aims, amongst other things, to provide:

- A greater emphasis on a team approach to meeting patient needs
- More opportunities for nurses to take on new clinical roles
- The chance for nurses to become equal members of the practice team holding the contract
- A greater skill mix so that practitioners can be freed up to take on advanced and specialist roles (Department of Health, 2002:7)

The focus of the new contract is delivering to patients, the right care in the right place at the right time (Department of Health, 2002:3)

THE QUALITY OUTCOMES FRAMEWORK

One of the key elements of this reform is aggressive performance management where funding was targeted at outcomes rather than throughput. In response, general practices in the UK have evolved into businesses that are remunerated to deliver care to their specific populations and against set targets. Since 2000 the quality of care delivered has been measured through a Quality and Outcomes Framework (QOF). Initially, individual GPs were rewarded through this mechanism, and according to set measures. Since 2004 this remuneration has gone to the practice as a whole. The QOF has been described as:

...an evidence based financially incentivised quality framework within the new contract for General Medical Services (nGMS) introduced in the United Kingdom (UK) in April 2004. It consists of a series of indicators that represent quality primary care, in clinical and organizational areas, and also in additional services such as contraception and maternity services and patient experience. QOF is largely resourced from new monies within the Department of Health budget. During the first two years of operation, it represented a 2.5 billion pounds investment by the Government in primary care. Although QOF is a voluntary system, it was taken up by over 99 per cent of practices in the UK.
(HTTP://WWW.PCPOH.BHAM.AC.UK/PRIMARYCARE/QOF/QOF_OVERVIEW.SHTML)

General practices responded very quickly to the changing funding mechanisms and tended to employ more nurses. Nursing teams were expanded to achieve outcomes through the QOF. In fact, it was reported that nurses now do most of the work to achieve QOF targets and GPs were able to see fewer patients and spend more time with patients when necessary. The ethos behind QOF was payment by quality and not volume. However, a recent study found that nurses reported a substantial increase in workload, related to QOF domains and spent more time on data entry and less time with patients (McGregor W, Jabareen H, O'Donnell CA, Mercer SW, & Watt GC, 2008) This study also found that whilst nurses were given increased responsibility, there was discontent about how the financial gains from the QOF were distributed in practices and this impacted on nurse motivation and morale.

The QOF was initially criticized for focusing more on treatment than on prevention. However, the changes that have been implemented are expected to address this with some move towards intermediate outcomes.

The NPCRDC assessed the available evidence on the QOF (National Primary Care Research and Development Centre, 2007) and found that;

- There was rapid improvements for some conditions (asthma and diabetes) after the QOF

- Practices employed more nurses and administrative staff and there has been an increase in the care provided by nurses with nurses taking more responsibility for the management of chronic disease in general practice
- QOF should be seen as part of a wide range of quality improvement initiatives, including electronic records the development of national guidelines and the introduction of audit into general practice
- QOF provides publicly available information on the quality of care provided by general practices and this has stimulated general practices to improve their performance in certain areas
- The financial investment in the QOF was significant and in the short term may appear to be poor value for money. However, the mechanism for continued quality improvement has been established in the health system and the UK is now regarded as leading the developed world in quality improvement initiatives in health.

ADDRESSING HEALTH INEQUALITIES

General practices and hospitals were driven to respond to regional and population needs as their targets related to the health profile of their specific demographic. In Health Inequalities: Progress and Next Steps (Department of Health, 2008) the Department of Health sets out the challenges for addressing health inequalities to 2010 and beyond. This document clearly acknowledges that, whilst strategies to date have help improve the health of the general population, there remain significant disparities across some population groups. Providing the workforce to address these disparities means:

…understanding what needs to be done locally, by who, and the resources needed, taking into account the necessary scale of activity and balancing skill mix to obtain cost-effectiveness and sustainability of systems (p22)

Local Primary Health Care Trusts are commissioned to provide programs that fit with their local context. Over the past 5 years there has been a shift from hospital based care to community care and a strengthening of the links between health and social care. Supporting this move, are a larger number of integrated care teams who work with patients to put together a package that supports the individual's needs.

The Darzi Review (Lord Darzi, 2008)states that the vision for the UK National Health Service of the future should be that it is:

- **Fair** – equally available to all, taking full account of personal circumstances and diversity

- **Personalised** – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- **Effective** – focused on delivering outcomes for patients that are among the best in the world
- **Safe** – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

This Review sets out the challenges faced by the NHS in the UK as;

….rising expectations, demand driven by demographics, the continuing development of our 'information society'; advances in treatment; the changing nature of disease; and changing expectations of the health workplace (Lord Darzi, 2008:8)

Similar challenges face the health system in Australia and the outcomes of the Darzi Review have resonance for the Australia's health system.

MODELS OF PRIMARY HEALTH CARE DELIVERY

Ham and others (Ham C, 2008) (Ellins J, Ham C, & Parker H, 2008) identify different models of primary health care delivery and identify choice and competition as most effective. This model provides incentives to service deliverers to respond to the needs of service users and to use resources efficiently and effectively. The delivery of health care services are being seen as increasingly based on the 'choice and competition model' and that integration of care and a team approach to health care delivery and the integration of care are seen as crucial to the delivery of effective and efficient care.

As noted above, GPs in the UK are paid to deliver a new range of services and achieve specific performance targets. One of the attributes of GPs meeting these targets was having a nurse in the practice. Discussions with nurses working in general practice elicited information about the different ways nurses were being utilized. In larger corporate practices there were examples of nurses being clinical leaders and working closely with GPs to meet the needs of very specific populations and from a population health approach. This was driven in many ways by the QOF and the expectations for practices under that framework. Nurses needed to be trained to work from the population health paradigm.

PREPARING NURSES FOR THE NEEDS OF THE COMMUNITY

Like Australia, nurses in the UK during the early 1990's were recruited from hospitals and lacked formal preparation and training for their new role. Nurses were voicing concern that they were working beyond their skills and training. In response to this, accredited education and training

programs were developed and the government moved to modernize nursing careers across the four countries of the UK (Beyond 2000). The outcome was that nurses now begin their training with a common foundation and then chose from four possible option: first contact and urgent care, family, child and public health, mental health and psycho social care and emergency and critical care. As a result of this young nurses are being prepared for work in primary care with general practice competing well with hospitals in recruitment. Nurses in general practice were not paid less than their hospital counterparts and practice nursing now has a much greater stature than it had previously.

In addition, the Nursing and Midwifery Council (NMC) are developing a new framework where community and public health outcomes must be achieved in the curricula of all undergraduate nursing programs by 2010-11

Over the past 5 years there has been a shift from an emphasis on hospital based care to community based care. This has resulted in nurses being intimately involved in integrated care and operating as part of social care teams. A key component of such care is that care packages are tailored to the needs of patients. In order that nursing can respond to the changing health landscape, there will be specific community and public health outcomes that nurses must achieve during their training from 2010-11. Trainee nurses will also be linked with a preceptor to mentor them during their community/public health training.

Nurse education at Southampton University requires that public health is integrated into the pre-registration curriculum. Students are required to work with families and communities through placements in the community and in general practice. Every student has to undertake at least one community placement. Although it is difficult to sustain placements in general practice, it has been agreed that practice nurse time will be paid for when supervising students. All students also have to be involved with other health students in the IPL program outlined later in this document.

As mentioned above a major principle of reforms in the UK is for shared multi-disciplinary pre-registration nurse education: a common entry pathway that allows students to decide post entry on their chosen career pathway. This aims for a flexible health care workforce engaged in:

- teamwork as the medium for health care delivery
- partnerships and joint working between patients, agencies and professions
- flexible working without rigid professional boundaries
- career progression that provides opportunities to alter training pathways.
- the development of flexible health care delivery by various health care professions.

TEAMWORK AND INTER-PROFESSIONAL PRACTICE

Explicit in the reform agenda in the UK is the centrality of multi-disciplinary teams and inter-professional collaboration in patient care. We consulted with three groups that are involved with inter-professional education and practice; the University of Southampton, the Centre for the Advancement of Inter-professional Education and a member of the IPL team from Leicester.

THE SOUTHAMPTON MODEL

We were able to visit the University of Southampton, which has a distinctive and well integrated inter-professional learning (IPL) model for health professionals, the Centre for the Advancement of Inter-professional Education (CAIPE)and meet with Dr Angela Lennox a GP champion of IPL in Leicestershire and a primary care advisor to the UK Department of Health.

In the Southampton model medical, nursing and allied health students begin IPL in the first weeks of University. Through the New Generation Project (Humphris D & Macleod Clark J, 2007) curriculum was developed where common learning across courses contributed to student progression and their award, took place across the first 3 years of their degree and included campus and practice based learning.

Under this program there are three inter-professional learning units.

Unit 1 - Collaborative Learning: This unit introduces students to the concept and practice of collaborative learning and team working and develops their knowledge management and IT skills needed to participate in collaborative learning supported by on-line methods.

Unit 2 - Inter-professional Team Working: This unit provides students with an opportunity to apply their team working and negotiation skills in an inter-professional context.

Unit 3 - Inter-professional Development in Practice: This unit enables students to examine inter-professional working in modern health and social care services from a personal, professional and organisational perspective.

(see http://www.commonlearning.net/project/index.asp)

The underpinning philosophy of the program is that practice environments are interdisciplinary and Universities should be training people for such an environment and not in professional silos. To meet the challenges of the future in health, resources should be used efficiently to provide safe, high-quality, integrated and well-managed care.

THE LEICESTER MODEL

A slightly different model has been adopted in Leicester with students being much more involved as teams with patients. This model is in three strands. The aims of these three strands are:

Strand 1: to learn about self and other professionals identified in relation to promoting person-centred care

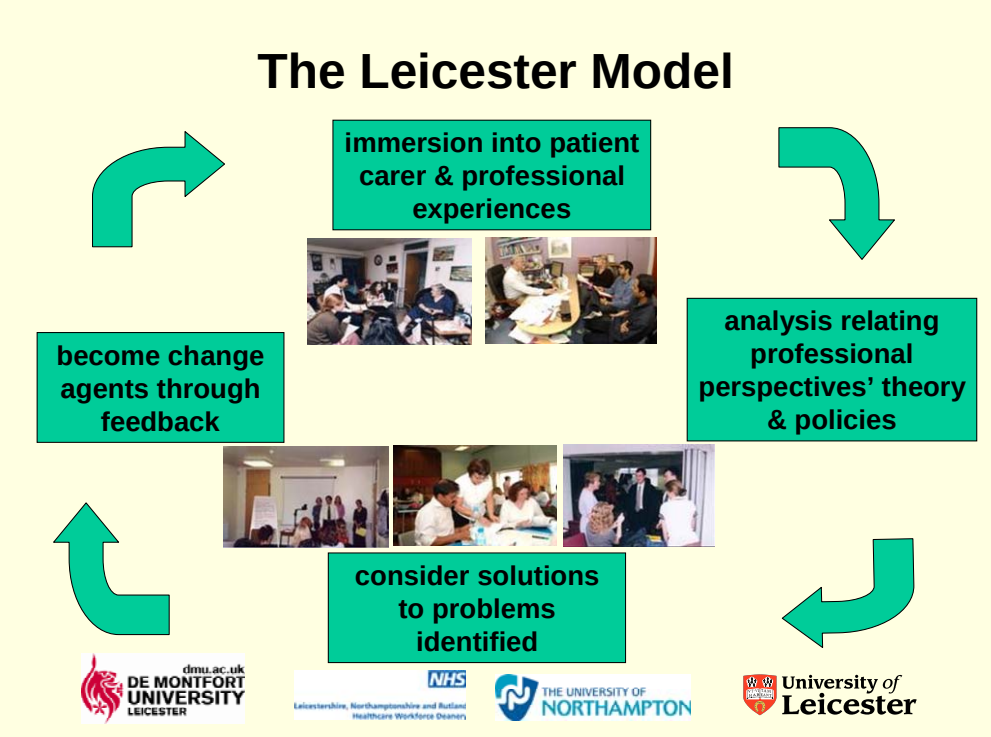
Strand 2: to become familiar with the theoretical basis of team working and effective collaborative team practice and consider their future roles within teams.

Strand 3: to further develop knowledge and team working skills as applied to the modern health and social care services, identifying solutions to effective team working

Strand 1 is implemented within the first 6 month of the student's course.

The IPL model operates across three universities and across local government boundaries.

The diagram below explains the Leicester model (Inter-professional Education in Leicestershire, Northamptonshire and Rutland, Healthcare DeaneryLiz Anderson)



CENTRE FOR THE ADVANCEMENT OF INTER-PROFESSIONAL EDUCATION (CAIPE)

CAIPE was established over 20 years ago and aims to foster collaboration in inter-professional learning across organizations in the UK and elsewhere. Since the Kennedy Report (Kennedy I, 2001) inter-professional education has received significant attention in the UK. The Department of Health has invested in inter-professional education to improve quality of care. In 2007 CAIPE and the Department of Health published a framework for education and training providers (Department of Health & Centre for the Advancement of Interprofessional Education, 2007). The framework has twelve recommendations for effective inter-professional education and training in health. These recommendations are underpinned by the need for education providers, professional bodies and employers to work together in embedding quality inter-professional education and practice in the delivery of health care.

As noted above, institutions such as the University of Southampton and universities in Leicestershire have made significant investment in integrating IPE across their health and medical curricula.

INTER-PROFESSIONAL TEAMWORK AND AUSTRALIAN PRIMARY CARE

In Australia the discussion paper 'Towards a National Primary Health Care Strategy' (Department of Health and Ageing, 2008) notes that primary health care is increasingly becoming team-based care. It also notes that we need to ensure that;

'The current and future primary health care workforce is provided with high quality education (undergraduate, postgraduate and vocational) and clinical training opportunities that support interdisciplinary learning.' (Department of Health and Ageing, 2008:40)

Future challenges for the delivery of primary care in Australia are well documented and include workforce pressures and increasingly complex conditions. A greater emphasis on teamwork will be required to meet these challenges and this will need to be supported by comprehensive inter-professional undergraduate and postgraduate education.

CONCLUSIONS

- Significant changes have occurred to the delivery of primary care in the UK since 2000
- Funding is increasingly used to reward outcomes rather than throughput
- Extended nursing roles in primary care have been developed within an overarching national framework
- Nurses are central to the achievement of quality outcomes in primary care and are particularly important in the management of chronic conditions
- General practices in the UK have employed more nurses since the introduction of the Quality and Outcomes Framework and these nurses do the bulk of the work in achieving QOF targets
- There is some concern amongst nurses that too much time is spent on data entry for QOF and too little with patients. Nurses also report being dissatisfied with how QAF financial incentives are distributed in practices
- Nurses education in the UK is evolving to reflect policy changes towards community care and away from hospital care
- Significant investment has been made in the UK to support the development of inter-professional learning in university medical and health disciplines with inter-professional care being seen as central to the development and delivery of quality health care
- UK health policy is increasingly focused on addressing health inequalities and in providing the right care in the right place at the right time and funding agreements reflect this.

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