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Establishing Collaborative Nursing Networks: A Clinical Screening Group's based on proof Approach

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Abstract
It is important that professional identity formation is a profound part of the nursing education and it helps students mature to good and caring practitioners. This paper dwells on Community involvement as a driver of professional identity formation in the nursing students. The importance of community-based health initiatives is manifold as, through their active engagement in them, students are not only able to develop their clinical and interpersonal skills but also learn to be responsible and show empathy and ethic commitment. Results have shown that real-world community-based experiential learning supports professional values and the growth of reflective practice and helps close the academic-professional gap. The findings bring out the transformative power of community-based engagement in equipping nursing students to overcome complexities in healthcare settings, with confidence and integrity.
Keywords: ***Community nursing, integrated care, Clinical Commissioning Group (CCG), collaborative practice, evidence-based healthcare, multidisciplinary teams, population health, primary care transformation, workforce integration, patient-centered care.***

1.Introduction
Developed healthcare systems across the globe are facing significant pressure due to a concomitant rise in the population aged, a rise in prevalence of chronic disease, and reduced resources to support them. In particular, the United Kingdom National Health Service (NHS) is passing through one of the deepest stages of transformation in history. Both financial austerity and demographic pressures have informed this reform agenda to necessitate a new model of care delivery which can be sustainable, patient centred and efficient. The convergence of health and social care services has become the guiding principle in such climate, with the aim of integrating various sectors of the system in a combined way that helps to increase continuity of care, patient experience, and utilize the limited resources in a better form(1).

FIGURE 1 The Power of Integrated Care in St Helens

Integrated care is not a new concept, but has assumed a new prominence in the current developments of NHS policy with the Health and Social Care Act and the NHS Five Year Forward View. Such frameworks have focused on the inability of effective healthcare delivery to exist alone but rather is a bridge between the primary care, community services, hospital care and social support. As membership organisations of local General Practitioner (GP) practices, Clinical Commissioning Groups (CCGs) have been charged with being at the forefront of this change to commission services that meet the needs of their local populations(2). Their mandate also involves playing a role in ensuring clinical effectiveness and financial soundness of healthcare as well as the formation of service models that incorporate the concept of integration as the philosophy behind the models.

The definition of integrated care has varied but it generally refers to an organizing principle that facilitates interactions across levels and sectors of healthcare, so as to enhance outcomes and generate less fragmented patient paths. This solution takes into account that scaling down services on a case-by-case basis tends to create inefficiencies, duplication, and unsatisfied patients. In comparison, integrated systems are designed to transcend these obstacles in order to harmonise resources, share and ensure an interdependent relationship between various professionals and agencies. Although these aspirations are described in policy documents, the real issue is how they can be realized in local settings where differences in health inequalities, resources, and capacity of workforce shape how services are delivered.

NHS St Helens Clinical Commissioning Group is one local area that has tried to respond to this challenge in a more systematic manner. The borough of St Helens having a population of almost 200,000, distributed over a fairly socio-economically heterogeneous social basis, has serious health problems with above average levels of deprivation and long-term morbidity(3). Demand had outstripped current supply and unless there was significant redesign, provision of health and social care was at risk of being unsustainable. St Helens CCG has responded to this threat through a thorough review of its community services in 2015 with the aim of redesigning them to deliver more person- centered, integrated, and resilient models of care.

The main concept that this initiative was based on was the development of the community integrated nursing teams. Such teams would unite nurses, allied health professionals and social care staff to provide services nearer to the home of the patients and at the same time make them collaborate closely with GPs and hospitals. The reconfiguration was not merely the redistribution of workloads, but also the shift of the culture of care associated with the collaboration, shared leadership, and holistic perception of the needs of the patients. The CCG aimed to harmonise professional practices with this by integrating nursing teams into primary care and linking them more closely with social services to ensure there is less duplication and a better flow of communication between them plus more timely and appropriate interventions.

The choice of this model lay in the evidence of the national and international experience. Examples of multidisciplinary collaboration have been demonstrated through health systems like the Kaiser Permanente in the United States and integrated elderly care programs in some sections of Europe, which have demonstrated that the systems may have better results, especially in the treatment of chronic disorders and frailty. Besides, local adaptation was initially given prominent consideration in pilot studies and reports in the UK: integrated care should be adapted to the particularities of the community, population health requirements, and resource limitations. In case of St Helens it involved designing of nursing teams as being wrapped around GP practices in three localities, which provided geographic alignment and face-to-face cooperation.

2.The Argument for Reform

Changing health and social care services is not an easy choice as some other alternatives exist; the need to change prevails because of acute realities that support change as not only a desirable option but a necessity. With NHS St Helens Clinical Commissioning Group (CCG) the drivers to change were a mixed combination of growth in demand, entrenched geographical inequalities, and inefficiencies emerging in the system, which were threatening the long term sustainability of the current arrangements. The population of St Helens, as in many other areas of England, is a mixed one in terms of have and have-nots, heavily deprived and much more burdened with chronic disease relative to the national picture. Such context placed immense pressures on the community services, primary care and hospitals which made visible the necessity of a highly integrated and effective strategy(4).

The CCG acknowledges that do-nothing alternative would translate to a further increased gap between resources and demand with the utilization of current models of service delivery. Demographic dynamics pointed to the reality that services would be unsustainable in terms of finance within a few years in the absence of structural change. Further, there was the increased demands of long-term conditions including diabetes, cardiovascular disease and respiratory illness, that were straining stretched services to an extent never seen before. Adding to these realities was the increasing demands and expectations of patients: citizens were becoming more demanding in the way they wanted care to be accessible to them, patient-centered, and focused on their specific needs. Elaborating such requirements in conventional, siloed environments was becoming harder and harder.

These issues aside, in 2015 St Helens CCG embarked upon a significant piece of work to review its overall community health provision. It was not a top-down audit, and instead this review required close partnership with major stakeholders such as the community nursing teams, therapy services, hospital providers, social care

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professionals, patients, and carers. The CCG endeavored to acquire an all inclusive and proof based way of undertaking the initiative to achieve clear understanding of how existing services focused their care, what gap existed and what was the potential that could be exploited to achieve better convergences. The very important sessions were the two engagements with frontline staff and service users who offered lived experiences of life on the frontline with the reality of disjointed care, lack of communication between the various services, and replicated services that both the professionals and patients were fed up with.

Among the most salient conclusions of the review was that the current services offered at the community level existed in isolation with each other as well as with other areas of the system. Though limited areas of collaboration existed, the overall situation was described as being disconnected: nurses, therapists, GPs and hospital employees generally worked on their own and thus opportunities to provide coordinated care were missed. This fragmentation was experienced as confusion, duplication of assessment and unnecessary admissions to hospital by patients with complex needs, especially those with several long-term conditions. In terms of staff, it was inefficiency, duplication and frustrations by the staff in the profession. It was found that a more integrated model was needed in an extreme sense, to incorporate a combination of community nursing with social care, and to make the support pathways within the system seamless(5).

Importantly, St Helens CCG understood that a redesign that could lead to any sort of meaningful impact would have to be evidence-based, rather than being based on intuitions or policy hopes. This implied being able to learn both national and international examples of integrated care. The experiences with managed-care systems like Kaiser Permanente and Geisinger in the United States served to show that through integrated, multi-disciplinary practice, improved patient outcomes could be obtained with patients having chronic conditions as well as unnecessary hospital utilization. Likewise, the importance of tighter integration of health and social care in addressing the needs of older people and vulnerable groups had been mentioned in European plans. Based on these observations, the CCG focused on the idea that no single blueprint on integration could be implemented instead, the lessons that were learned should be adapted to a local context, and models should be specifically related to problems of St Helens.

The focus and core of the change case centered on the fact that integration should go beyond structures into culture, relations, and common values. Already a Nuffield Trust report by S. Fuller and S. Blunden had contended that integrated healthcare entailed a multi-layered view of the nature of governance, leadership, professional cultures, and customer-centered values. This was the perspective taken up by St Helens, where service redesign could not be effective without the development of collaboration and trust among its care agents. So moves towards integration were not a matter of some technical process of aligning the organizational charts but of building a climate in which doctors, nurses, administrators, and others operating within a given field of endeavour moved towards a sense of belonging in the same system with common goals(6).

The process of consultation also emphasized the need to tailor services to the experiences and expectation of patients. Frustration over needing to navigate bureaucratic systems, and retell their story to each professional that they saw, as well as dealing with the inability of the various providers to coordinate their efforts together, was present in the reports of the patients and carers alike. Through these narratives, it also became clear that integration was not a mere theoretical policy objective but a practical approach to the solutions to day-to-day issues experienced by individuals struggling to get care. Adding these voices in the redesign process gave the initiative legitimacy, so that the new model would be sensitive to actual needs.

The possibility of sustainable change would also be realized through strong local partnerships with providers, which was admitted to by the CCG. It was not possible to mandate integration on the basis of the commissioners view; rather, integration needed to be co-produced by people with delivery responsibilities. This identification influenced the realization of new community nursing models, which were developed in conjunction with the providers, and creation patterns were made in such a way that necessary considerations were made on the consideration of the ground realities. As an example, GPs complained of a lack of coordination between community nurses and them, and that particular piece of feedback was directly used to decide to organize the nursing teams by GP practice, in order to enable a frequent dialogue and joint resolution.

Finally, the change argument in St Helens was set up on a mixture of resounding reality and promising opportunities. Services would not be able to meet demand without this change, which would further increase inequalities and population at risk. The change, though, had the potential of creating of a more sustainable, integrated, and patient-centered system that would be offering more effective outcomes and more efficiency. This

two-sided story of crisis and open door lent its energy to the CCG to move forward with its radical redesign programme.

3. Facilitators of Achievement

The design and development of integrated healthcare systems is a complex task with the outcome of success depending on a combination of structures and policies and a set of enablers that will determine the probability of success. In the case of NHS St Helens Clinical Commissioning Group (CCG), national and international evidence helped them to form their idea of integration. The overview of the literature dealing with such points and available case studies helped to realize that sustainable transformation cannot exist without paying attention to organizational culture, leadership, co-location of teams, governance, and the involvement of the community. These enablers were the scaffold on which new care models could be planned, making it not only possible to achieve integration, but rather likely.

1. International learning and local adaptation

Integrated healthcare is by no means a recent idea but various forms of integration have been attempted all over the world since decades ago. As the experience of organizations like Kaiser Permanente and Geisinger in the United States showed to St Helens, multidisciplinary and coordinated care can lead to a greater improvement of outcomes of people with long-term conditions and a reduced level of duplication of services. Leading edge European projects focussed on the need to integrate healthcare with social care in older populations. But St Helens saw that it would not be possible to directly replicate. Adaptation was the key: evidence pointed to the fact that integration would most effectively occur when modified to correspond to the demographic, socio-economic, and cultural reality of the local population. In the case of St Helens, this implied recognition of the prevalence of deprivation and taking special efforts to address the needs of people who experience more than one issue at a time(7).

2. The Co-location and Shared Spaces Role

The worth of physical proximity in establishing collaboration was revealed as one of the recurring themes in the literature. By ensuring that the different disciplines are co-located, there is improved communication, better understanding of the roles played and trust becomes established. Mackie and Darvill (2016) and Ling (2012), on the one hand, have shown that co-location boosts the process of relationship-building and enhances teamwork. This fact was incorporated by St Helens in creation of new community nursing teams which would be wrapped around GP practices therefore prompting them to interact with the primary care staff daily. Such a switch was not purely logistical, it was cultural It is an indication of a shift towards concerted thinking where teamwork is the rule and not an exception.

3. Leadership as the foundation block of change

Leadership has been a common denominator in evidence-based success in integrating healthcare well-being. Leadership is the process that converts vision into practice, overcomes resistance and maintains momentum. Coupe (2013) and Zakaria (2015) point out that integrated systems are successful when a clinical leader supports the initiative and the management systems are overwhelmed by transition stability. In St Helens, the significant role was played by the Chief Nurse who defined leadership, informed the strategy, connected the professionals, and maintained continuity. Purposeful integration of senior clinical nurses into the community teams further strengthened leadership at various levels, which embedded authority and accountability into the workforce.

4. How to Maintain Motivation and How to get around the Resistance

Reform in the healthcare industry could start with enthusiasm but can easily fail due to obstacles that come up the way. The evidence indicates that integrated teams may require 3-5 years to mature and in the interim poor performance may be accompanied by resistance and frustration. Greenhalgh et al (2004) and Bardsley et al (2013) studies show that in order to maintain motivation strong leadership is also needed but collective values and purpose must also be instilled. In St Helens the deliberate design of engagement activities was to allow professionals to have some say in the development of reforms. Such participation allowed minimising resistance as all the staff becomes co-owners of the vision instead of being the recipients of the top-down directions.

5. Governance and Resilience of the Systems

Bringing integration about must involve governance structures that propagate both Accountability and agility. Experience of pilot schemes like Whole Systems Integrated Care (WSIC) indicated that any change of leadership, or changes in the management structure, could disrupt the process and undermine credibility. In the case of St

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Helens, governance was integrated with agreements made up of the CCG, local authority and providers in a collaborative manner. This made it responsive as it brought about collective responsibility and resilience to reorganizational changes. Embedding governance also facilitated a sense of clarity of purpose: everybody knew their jobs in making integrated care work, and duplication and overlap were reduced.

6. Culture, Relationships and Common Values

Integration works well beyond structures and policies in an environment where there is alignment of culture and values. As evidence, effective integration can occur when relations of trust and mutual respect together with congruent objectives develop. According to the social movement approach to healthcare reform (Bibby et al., 2009), personnel should not only be willing to do what the change entails but also uphold the reason behind the change. St Helens integrated this understanding and focused on communication, common learning sessions and multidisciplinary working. It was honed that the establishment of a communal identity between teams was very crucial in the transition of thinking patterns from individualism to collectivism.

7. Partnerships outside of Healthcare

One more experience gained under the evidence was the importance of going beyond the health boundaries. There is a need to have integrated care, which should include more than doctors and nurses and extend to wider partners in areas of housing, voluntary organizations, and community groups. In St Helens, liaising with the housing associations, the police, the fire brigade and the third sector was to be an in-built part of the long-term strategy. The reason behind these partnerships is that health outcomes are influenced by social determinants, which have made it necessary to integrate services at this broad scale in order to enhance the capacity of providing comprehensive services.

8. Using Metrics and Occupational accountability

Evidence also pointed out that success has to be quantifiable. It is unlikely, however, that the traditional measures of impact like emergency hospital admissions will always show the full effect of integrated care. Rather, a multiplier of clinical outcomes/patient-reported experience and process measures is necessary. At St Helens, the monitoring of outcomes was built into the contracting arrangements with rewards designed to be paid in relation to reductions in admissions and increases in patient experiences. By linking the outcomes to accountability the CCG meant that the new models did not become bureaucratic but were both impact oriented.

9. Long Term Vision and Resiliance

Rest lastly, integration is not a long term undertaking but an on-going process. Some research indicates that big changes in health care take time to settle in before any results can be realised. St Helens understood this and adopted a program of integration as a strategic long-term change process as opposed to one that is focussed in the short term. The CCG placed the redesign in the context of borough-wide health and social care plans therefore incorporating integration that cannot be influenced by short-term political or financial decisions. The long-term vision was a source of stability and continuity that was appreciated by staff members as well as patients.

4.Assessing Impact and Outcomes

Healthcare transformational change that cannot be measured and maintained is meaningless. In the case of NHS St Helens Clinical Commissioning Group (CCG), the idea of introducing integrated community nursing teams required not just the change of the organization, but also an effective mechanism of monitoring its efficiency. The CCG did not focus on the single measure of traditional hospital indicators, i.e. emergency admission rates, and instead, became aware that in order to measure impacts, a many-dimensional collection of measures, including process, patient experience, workforce outcomes, and sustainability, had to be calculated.

1. Efficiency and Process Gains

The results of pilot programmes in England have indicated that process-level improvement is commonly achieved through integrated care and may concern improved role clarity among the staff, facilitated transitions of care, and minimised redundancy. At St Helens, initial assessments indicated that co-located teams were able to communicate more effectively and this has led to the subsequent minimization of delays in providing referrals and enhancing continuity of care. These process gains can be small but it is on such gains that system change can be built and the stepping stones that eventually result in greater outcomes over time are constructed.

2. Success Beyond Hospital Admissions: Rethinking Success

Conventional success indicators, including the fewer unplanned hospital admissions, have frequently disappointed in terms of their performance when used to assess integrated care interventions. Evidence reviewed by studies like

that comparable to Lewis et al. (2011) and Ling et al. (2010), showed that even though emergency admissions can be of insignificant change, planned and elective admissions usually fall, indicating a more effective preventative and community-based treatment. In the case of St Helens, this brought in the significance of widening the definitions of success. Greater scheduled care, fewer outpatient visits, and decreased duplicated assessments were considered to be clear proxies of improvement, although headline emergency figures were not expected to change immediately in the short-term(8).

3. Putting Incentives in Commissioning

In order to focus on results, St Helens linked its new community nursing model to contractual arrangements, in which recommended improvements were tied to financial incentives. This approach synchronized that element of provider activity with that of the CCG priorities and made the system accountable. The incentive to embed outcomes made the CCG communicate that integration was not an abstract effort but a performance-based initiative with actual benefit in an effective delivery.

4. Quality of life and Patient-Centered Outcomes

The success of an integrated care cannot be assessed by system-level success. Better quality of life, better relationship continuity with professionals and gaining confidence in controlling conditions are the real effects of improvement in the case of patients. St Helens used patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) as important outcomes. Hearing the voices of the patients told me whether integration was actually making a positive difference to their day to day experiences or simply remodeling organizational charts.

5. The use of Emotional and Psychological Wellbeing as Indicators

New evidence emphasises the relevance of considering emotional and psychological outcomes especially in cases where the patient has a long illness, which is often accompanied by anxiety or depression or isolation. A similar view was captured by St Helens which trained the teams in the community to evaluate the psychosocial needs besides clinical indicators. This integrative viewpoint echoed the understanding that in the true integration all the aspects of a natural person are integrated and not merely a disease.

6. Workforce Experience: a Sustainability Metric

The implementation of integrated care can be maintained in the case where the professionals feel encouraged, recognized, and rewarded. In St Helens the staff surveys and focus groupings provided vital information in determining whether integration was enhancing morale, making available professional development, and eliminating burnout. There was evidence that staff satisfaction has a direct influence on patient outcomes so workforce experience is valid as an outcome measurement in its own right(9).

7. Constant learning and adaptive monitoring

Evaluation is something that is not periodical but is constant. St Helens has followed an adaptive monitoring process that has had the strength to provide some form of relaxed “light-touch” formative assessments in the initial stages that would move towards the more systematic assessments as a model meets its maturity. This was an iterative approach that would give feedback loops that could be used as a source of continuous improvement so that the integrated model could be sensitive to the challenges and opportunities.

5.Conclusion

NHS St Helens Clinical Commissioning Group (CCG) example of achieving community integration nursing teams development is not just a story about a reorganization within the organization; it is also a story of how evidence-based planning, engagement, and the perspectives of the long-term vision can be the basis of sustainable change in terms of healthcare reform. Although integration is frequently referred to in policy documents as a structural aspiration, it is mathematically a cultural construct and hence demands leadership, dedication and tenacity at several levels within the system. This case study may end with the findings that integration can happen, rather than with the conclusion that integration is needed to be a possibility, and that its effectiveness is predicated by the incorporation or entrenchment of some enabling conditions in practice.

Integration as a Reply to Urgent Realities

In the example of St Helens, it is clear that integration was not an attractive luxury or optional addition, but a reaction to highly urgent forces of demographic change, escalating prevalence of long-term illness and financial constraint. In the absence of reform, the borough faced a situation that can result in an unsustainable system

incapable of satisfying the population needs. This traction toward reality is an echo of a broader truth: integrated care is not a passing fad, but a strategic fact of health systems around the world.

Evidence as the Bearing Star

The lesson about evidence in decision-making and its strength might have perhaps been the strongest about St Helens. Rather than wholesale imitation of models, the CCG engaged in critical learning of what has been done in other countries, and learning international and national experience, with lessons being distilled that may be applied locally. It was an evidence-based adaptive approach that guaranteed reform on the reality and not ideology. It provided validity to the initiative as well because staff and stakeholders could observe that the changes they were being asked to employ were predicated upon what had previously worked and faultless analysis.

The Human Composition of Change

Policies, structures, and incentives are important, but integration ultimately works or does not work on the basis of human relationships. St Helens proved that the importance of leadership, staff engagement, and culture alignment could not be degraded relative to contractual arrangements or governance systems. By engaging nurses, GPs, patients and carers in co-design, we not only helped to minimize resistance, but also developed a feeling of shared ownership. This underlines a key tenet to guide future reform, namely that integration does not happen to staff and patients, but with them.

The dilemma of Success Measurement

Integration is one of the most complicated elements of reform to be evaluated. The experience of St Helens, starting with the linkage of incentives to outputs, the expansion of outcomes beyond hospital admissions, and the preparation of a long-run assessment, shows how a balance between accountability and the levels of realism should be established. The real world of integration is not likely to show any immediate result of reducing admissions in the emergency care sectors, but it can deliver the positive result of improving care co-ordination, patient satisfaction, and planned care efficiencies. Without being aware of this one could make hasty conclusions of failure which becomes an encouragement to persistence.

B beyond the NHS

The other lesson is the realization that other factors besides healthcare services determine health. Integration within the wider determinants of health was expanded by St Helens through their collaboration with housing, police, fire services and the third sector. It is indicative of a shift in thinking: that integrated care is not just about systematically coordinating clinical services, it is about ensuring healthier communities by means of cross-sector working together. If future integrated care systems are to be able to tackle the causes of ill health, then they cannot do so without also continuing to embrace these broader partnerships.

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Conflicts of interest

The authors have no conflicts of interest to declare

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