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# Rethinking workforce boundaries: roles, responsibilities and skill mix and readiness for change in general practice

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#### BACKGROUND

Over the last decade across primary and secondary care traditional territorial divisions between posts, grades and occupations has undergone major revisions. Driven by economics, skill shortages, policy reform, European and domestic legislation, quality improvement, multidisciplinary team (MDT) working and shift of care delivery particularly for long term conditions to primary care<sup>1</sup>.

Locally commisioned advanced nurse practitioner (ANP) postgraduate training has produced a steady stream of ANPs into the workforce. Most were easily assimilated but a few experienced resistance <sup>2</sup>. Organisational readiness<sup>3</sup> to change and/or team climate<sup>4</sup> were identified as possible contributing factors to barriers.

## AIM

To explore team climate and readiness as features of general practices that successfully accommodate new roles, re-define professional boundaries and reallocate tasks.

#### DESIGN

Realistic evaluation case study design <sup>5,6</sup>

A survey using Team Climate Inventory Short Form (TCI-14) <sup>7,8</sup> a 14 item instrument with four sub-scales (Vision, Participative Safety, Task orientation, and Support for Innovation). Exploratory statistical analysis using SPSS v18.0 followed by hierarchical regression analysis using MwiN.

Semi-structured interviews, recorded and transcribed and analysed using thematic analysis 9

### SAMPLE

"Cases" were five West Yorkshire general practices serving different populations, locations (urban or rural) and size.

TCI-14 administered to all staff clinical and non clinical (n=218). Response rate 122/128 (56%, range 41.5%-65.7%)

A GP, ANP, practice nurse (PN), health care assistant (HCA) and practice manager were invited to participate in the interviews. 22 completed.

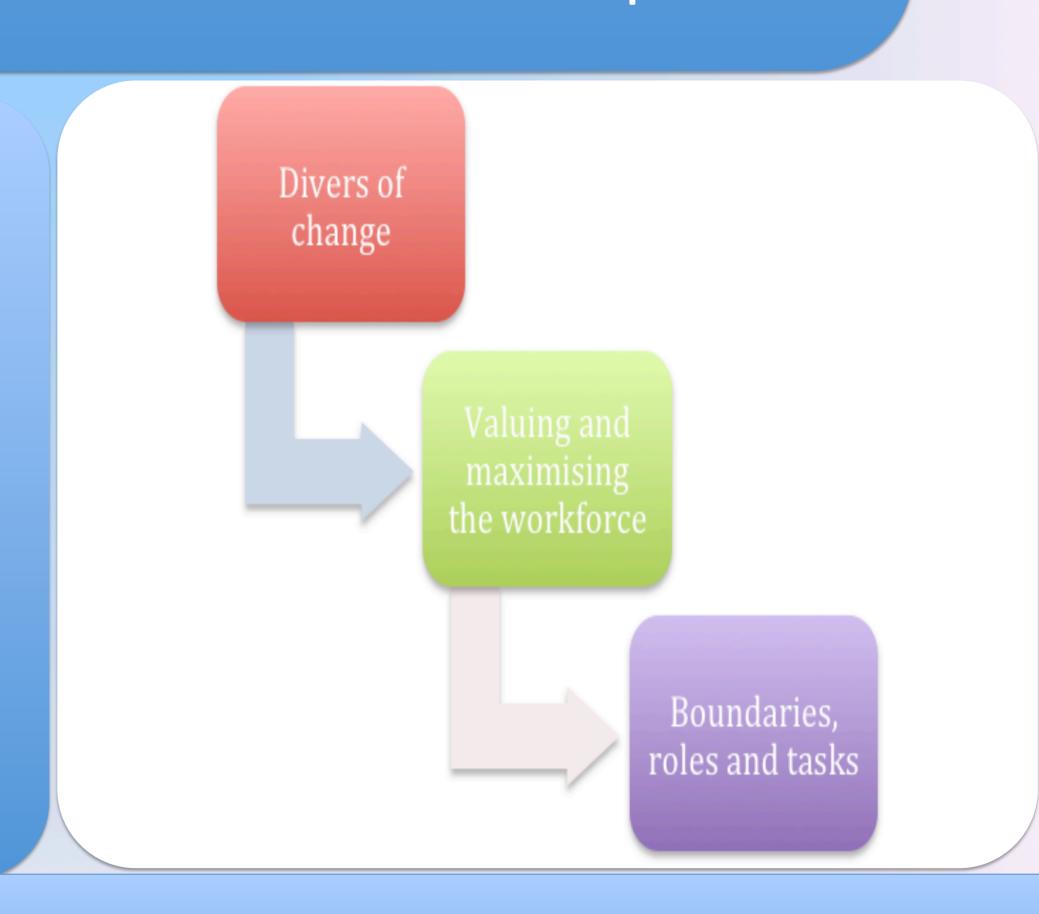
## RESULTS

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respondent- and practice-level characteristics					
Location	1	1	2	2	3
Туре	Rural	Urban	Rural	Urban	Urban
Total staff	24	24	35	100	45
Proportion of clinicians	54.2%	41.7%	51.4%	47.0%	57.7%
Practice list size	11,000	7,534	9,881	25,300	17,000
Response rate	58.3%	41.7%	65.7%	47.0%	62.2%
Respondent gender					
Males	1	1	3	5	5
Females	13	9	20	42	23
Years at practice (Mean (SD))	6.00 (2.38)	12.3 (7.17)	7.65 (7.05)	6.76 (5.04)	9.65 (7.65)
Hours per week worked (Mean (SD))	26.6 (7.56)	31.2 (5.04)	27.0 (6.79)	29.9 (7.35)	29.9 (6.55)
Vision score (Mean (SD))	16.0 (1.65)	17.2 (2.40)	15.4 (2.34)	15.9 (2.11)	14.5 (3.49)
Participative Safety score (Mean (SD))	16.3 (2.05)	16.5 (2.06)	15.9 (2.22)	14.9 (2.50)	14.3 (2.62)
Task Orientation score (Mean (SD))	11.9 (1.03)	12.5 (1.28)	11.3 (1.88)	11.7 (1.38)	10.9 (1.68)
Support for Innovation score (Mean (SD))	11.9 (1.67)	12.8 (1.94)	10.9 (1.89)	11.7 (1.86)	11.1 (1.77)
Total score (Mean (SD))	56.1 (4.45)	59.0 (5.31)	53.5 (7.37)	54.2 (6.60)	50.8 (8.10)

TCI-14 scores consistently high for all practices - range 50.8-59.0 (70 max score). Higher mean scores associated with higher number of non-clinical to clinical staff (p=0.026), longer employment (p=0.007) and male (p=0.007).

QOF Patient experience only differentiating value between practices and no significant association between TCI-14 and QOF



KEY FINDINGS The 'architecture of roles and tasks' seem permeable and flexible. Sustained employment relationships, investment in multi and "up" skilling staff coupled with local intelligence seemed to foster readiness to innovate and implement change.

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