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Do primary care professionals work as a team: A qualitative study

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Abstract
Teamworking is a vital element in the delivery of primary healthcare. There is evidence that well organised multidisciplinary teams are more effective in developing quality of care. Personal Medical Services (PMS) is a health reform that allows general practices more autonomy and flexibility in delivering quality based primary care. Practices in the locality where this study was conducted were offered resources to employ additional staff. Such arrangements provided the opportunity to expand and develop Primary Care Teams. In this qualitative study, semi-structured interviews were conducted with primary care professionals in 21 second wave PMS practices. Some participants felt they had used PMS to build their teams and develop quality based patient care. For other practices teamworking was limited by the absence of a common goal, recruitment difficulties, inadequate communication and hierarchical structures, and prevented practices from moving forward with clear direction. The study indicates that changing the contractual arrangements does not necessarily improve teamworking. It highlights the need for more sustained educational and quality improvement initiatives to encourage greater collaboration and understanding between healthcare professionals.

Keywords: *Primary care; healthcare teams; interprofessional relations; healthcare reform*

Introduction

Teamworking is well established as an integral part of effective primary care (Campbell et al., 2001; Horder et al., 1972; Schofield & Blakeway-Phillips, 1999; Vanclay, 1998). There is evidence (Borrill et al., 2002) that successful teamwork is associated with effective and innovative healthcare delivery. A team is usually described as a group that shares a common purpose and a common goal (Hayes, 1997). Poulton and West (1999) consider that the presence and clarity of shared objectives are essential for teams to be successful. Firth-Cozens (1998) and Molyneux (2001) described communication as one of the indicators for positive teamworking.

The Primary Health Care Team (PHCT)

The importance of developing Primary Health Care Teams (PHCT) has been recognised for over three decades (Horder et al., 1972). Historical professional boundaries in primary care may make it difficult to achieve effective teamwork (West & Field, 1995). West and

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Poulton (1997) reported a comparative weakness in teamwork in PHCTs compared with teams in other organisational settings. Wilson (2000) suggests that medical supremacy needs to be challenged to create successful teams. Riley, Harding, Meads, Underwood, & Carter (2003) reported that the hierarchical structure of general practice is an inhibiting factor to teamworking.

Bateman, Bailey, & McLellan (2003) suggested that the complex structure of the PHCT (individuals with professional responsibilities within and beyond the team) requires effective management and support in tackling the inevitable difficulties that arise. The NHS Plan (Department of Health, 2001a) lists the improvement of teamwork as an important element in the modernisation of primary care services.

Several recent initiatives address the issue of teamwork in primary care. The Practice Team Accreditation (Schofield & Blakeway-Phillips, 1999) and Teamworking in Primary Healthcare (Forum on Teamworking in Primary Healthcare, 2000) and the UK Royal College of General Practitioners have developed the RCGP Quality Team Development (QTD) programme (RCGP, 2000). The QTD programme is a partnership with the Royal College of Nursing and the Institute of Healthcare Management. QTD identifies standards and provides a comprehensive framework to enable Primary Care Teams to assess and promote primary care development with a focus on team functioning within an ethos of education, development and support.

Personal Medical Services

In recent years there has been world-wide health service reform and in England one of the reforms in general practice is a system called Personal Medical Services (PMS) (Department of Health, 2001b). PMS allows for a locally negotiated contract for primary care and has given the participating practices more autonomy and flexibility in developing services to meet local needs in comparison with the new GP contract (NHS Confederation, 2004) which is focused on the delivery of evidence based chronic disease management. PMS can enable a broader development that can go beyond the medical model and address the whole biopsychosocial needs of a community (Engel, 1977), e.g., the provision of a youth worker in an area of high teenage pregnancy. This reform planned to improve primary care and to have a positive influence on teamworking. Riley et al. (2003) confirmed that some progress had been made when they explored teamworking in first wave PMS pilots (those that joined in 1997 and included practices comprised of less traditional practice partnerships and targeting vulnerable groups, e.g., the homeless) but that its benefit was limited.

This is the first study of second wave PMS practices and their teamworking. We performed this study to see whether primary healthcare professionals in these practices felt that progress with PMS was underpinned by effective teamworking.

Method

We interviewed primary care staff in an inner-city area of southeast London. This area has a high level of social deprivation, a factor usually associated with an increased primary care workload (Carlisle, Avery, & Marsh, 2002) and high patient mobility. The local media (Mullany, 2002) had expressed concerns about the quality of primary care. Concerns about recruitment and retention of general practitioners in southeast London led the Health Authority to participate in the government's Global Recruitment Scheme (Department of Health, 2003) and included general practitioners from France (Ballard, Robinson, & Lawrence, 2004). The period of the study was one of managerial change when the Health

Authority was being divided into three Primary Care Trusts (PCT). A PCT is a National Health Service statutory body with responsibility for delivering improved community and primary healthcare services to their local population.

This analysis was based on 48 interviews from 21 practices conducted by AS. The study participants (as defined by the funding body) were a general practitioner (GP), a practice manager (PM), a practice nurse (PN) or a nurse practitioner (NP) from each of the practices. Some of the practice nurses were training to be nurse practitioners with funding through PMS.

The practices in the sample had all opted to join the second wave PMS pilots. PMS was established as part of the modernisation agenda of the NHS allowing practices to opt into a locally agreed quality orientated contract. The emphasis was on giving practices more autonomy to develop services to meet local needs and to deliver a higher standard of quality in primary care. As part of the scheme practices were offered more resources to employ additional doctors and nurses. Unlike many of the first wave PMS pilots, some of which were nurse led, the second wave pilots comprised more traditional practice partnerships.

This study was commissioned as a qualitative evaluation of PMS (Patton, 1987). A sampling frame representing the size of practice, locality, type of premises and whether they felt they had achieved their goal was used to select the first interviews for detailed analysis. The development of effective Primary Care Teams was part of the plan to raise standards and efficiency in primary care (Department of Health, 1996). One of the critical success factors identified in this evaluation, for the achievement of a practice's quality improvement targets, was the presence of a cohesive Primary Health Care Team that was able to communicate effectively. This further analysis explored ideas about teamworking in more depth.

The Local Research Ethical Committee decided that as there was no patient, or patient data involvement, ethics committee approval was not needed. Participants were assured of confidentiality by the study team.

Practices were contacted to arrange the interviews with participants. The interviews were conducted by AS and taped and transcribed and the transcripts checked and annotated. The interviews were loosely structured around a topic guide and included the reasons for, and expectations of entering PMS, the effect on patient care, staffing and teamwork and reflections of the PMS experience. A qualitative software computer package called QSR N'VIVO (QSR, 2000), was used to carry out both the original and further analysis. Thematic analysis continued until saturation point was reached.

Results

The interviews were made up of 19 general practitioners (GP), 2 nurse practitioners (NP), 10 practice nurses (PN), including 2 nurses training to be nurse practitioners and 17 practice managers (PM). In three practices team members declined to be interviewed individually. This included two practices with a general practitioner and a practice manager and one practice with a doctor, a nurse and a manager. This was felt by the interviewer to inhibit frank dialogue, particularly in relation to interprofessional issues. There was a relatively small number of practice nurses in the sample; either the nurse had left the practice, or was on sick or maternity leave. One practice nurse declined to be taped, although consented to a brief interview and notes were kept.

The ownership of shared objectives is what differentiates a team from a group (Poulton & West, 1999). The importance of shared aims and goals in ensuring effective teamwork in primary care is highlighted by Pearson and Spencer (1997). Field and West (1995)

described the lack of clear group goals as an indication of a fundamental failure of teamworking. We found some participants were still unclear about their team's direction and lacked clarity in their objectives. This lack of a common purpose made it more difficult for the team to develop and for participants to feel involved as team players.

> I think people have different expectations. I think, you know, we haven't got a common aim of where we want to go, you want to get to a certain goal but when people don't have the same ambitions in mind . . . you don't really feel like part of a team. (PM 5)

> Yes, older (the GPs) they have been in the practice for a long time and they are afraid of changes they don't want to change and I think we all have to change to go forward, unfortunately life isn't static and that is partly my reason for leaving. (PN 12)

> Dr A is stuck in his ways I feel and it is going to be done his way or not at all . . . I'm not saying that he is not pleasant but it is his way and that is how you are going to do it. (PM 19)

In some practices participants felt they had used PMS to discuss and develop aims and objectives for the future and saw it as a tool for developing more cohesiveness as a team.

> I saw it as a real spur to the development of the practice and because we had to proactively think about where we were going and what our priorities, set objectives in a way that we had never had to do before it was a real drive . . . we developed a plan with every body in the practice. (GP 2)

> I see it from the other side from what is happening to do with morale . . . to do with working as a coherent team that I didn't see before and I know that this will, it has got to impact on patient care . . . we are doing a lot more things as a team so it is very rarely just somebody just going off on their own and learning one thing like CHD there will be the nurse involved, the doctor involved, the staff, a particular admin person will be involved. (PM 3)

The opportunity to employ new staff attracted many practices to join the PMS pilots and raised expectations of extra manpower without which they could not have developed their teams and widened areas of service development. Many practices suggested that the recruitment of staff, particularly general practitioners and nurses, was difficult, but for some practices it had proved an impossible task and they had been unable to recruit new staff despite the availability of funding. The high level of deprivation and the resulting increase in workload were thought by some to deter interest in working in the inner city. Some participants expressed feelings of frustration, stress and low morale.

> Recruitment is a nightmare, it's a nightmare . . . the part of PMS which I still feel let personally let down is the salaried GP. I would have loved a salaried GP. (GP 8)

> It's the last stop if they (doctors) can't find a job anywhere else then they'll take it, the quality of patients is 'bad' (in such a) highly deprived area. (GP15)

> Even recruiting reception staff is a problem. It doesn't matter where you advertise the quality of staff you get is, well, laughable to say the least. (PM 13)

> The nurse I was working with has been off sick for the last 6 months and I have really stretched myself . . . I have found it very stressful and expected to do what is required of two nurses. (PN 12)

In contrast one respondent, whose practice was well staffed and flourishing, expressed concern that they may be unable to sustain the situation.

> (PMS) has certainly rejuvenated the practice I think and I think the best way to describe it is that I think we work in a bubble at the moment, that here things are positive, we have doctors, we have nurses, we have reception staff, the building is good, we meet, we talk about it and I hope we aren't but it feels fragile. (GP 13)

Team members have different skills and expertise and to function effectively communication is vital in achieving positive teamworking (Firth-Cozens, 1998; Molyneux, 2001). When communication is limited it is difficult to gain team cohesiveness and sustain motivation.

> When the morale is low you can't communicate very well, our practice meetings used to buzz with excitement, we used to meet with the receptionists, with the nurses, we used to have constantly challenging meetings with new ideas and new input but that sort of enthusiasm is not there. (GP19)

> I guess what would have been an exciting place to work in just did not work out and it was just routine and my dissatisfaction with all the problems not being able to share all the time, not that I shout at people, I just become a little bit more, I close down. (GP 5)

With the need to address the staff shortages, the NHS and the PMS scheme has encouraged more flexibility in employment and has led to an increase in part-time working. Some participants expressed concern and an awareness of the impact of greater numbers of part-time staff on communication within the team.

> The only problem I guess as far as teamwork is concerned is that the flexibility that we now have has its own problems in that we now employ a lot more part-time people, doctors, nurses, which in itself is quite difficult because they then have much more limited time because they have other commitments . . . where you get many more people you can disenfranchise some as well. (PM 6)

There was evidence that some practices still operated traditional hierarchical structures (Riley et al., 2003) with many GPs referring to 'my' nurses or 'our' nurses in a larger practice. With many practices there was evidence to suggest that medical dominance was at the forefront of decision making. Some practice nurses and managers expressed feelings of disappointment and regret that their involvement in decision making had been limited.

> I teach the students, I teach my nurses. (GP 12)

> The senior partner makes most of the decisions . . . the senior partner isn't a great communicator and it all stems from there (laughs). (PM 21)

> We are puppets on a string at the end of the day. (PN 12)

> I really wasn't consulted it was just a GP decision. (PM 13)

> I was quite disappointed that we hadn't been involved in the initial discussions . . . I felt maybe some of the emphasis could have been different if it wasn't just purely from a medical opinion. (PN 7)

We felt that some participants may have felt inhibited or disloyal in being more vocal about the hierarchical structure, and in practices where participants declined to be interviewed individually the opportunity to explore teamworking in a more open way was limited. Voices were lowered on more than one occasion and comments made after the tape recorder was switched off.

> There are two partners but only one dealing (with decisions) you know, it's a good job this is confidential he would wring my neck . . . it causes a certain degree of ill feeling because he keeps a lot of things to himself and nobody else knows, he makes life a bit difficult at times. (PM 13)

Change and innovation were important parts of the PMS scheme. Successful teamwork is associated with innovative and effective healthcare delivery (Borrill et al., 2002). Some practices involved their teams in new ways of working.

> . . . (we) looked at how, you know, people coming in for emergency contraception, how that is dealt with from the receptionist upwards, and, you know, saying the appropriate things giving them information. (GP 6)

> . . . that very much encourages input from everybody trying to get everybody's ideas rather than it just being the GPs that are feeding all the ideas and leading and moving the way forward . . . it has been a big plus in terms of teamwork and morale and people working well together that has made a big difference. (PN 7)

> A lot of time has been put into the nursing team . . . developing their role within chronic disease management and using healthcare assistants to do things like bloods and that has actually come back as quite a large piece of work that has now come to fruition. (PM 2)

Participants reflected on how some roles within the team had changed.

> Well the practice manager's role has changed and in quite subtle ways really it has become much more focused on the future rather than the past. (GP 6)

> When I look back to years ago, I mean I just used to come in and I just used to see the patients for their particular problem . . . now you are very aware that there are a lot of other issues which you pick up on and, you know, they might come in for a smear and you end up talking to them about sexual health. (PN 2)

> The other is actually quite difficult to describe, it is more about people sort of feeling its their responsibility so if there is a problem about something people feel that they have a role in tackling it and dealing with it and they can't just say, well the doctor can do that, there is much more of that sort of sense of empowerment. (GP6)

Despite this, in some practices there was still a lack of understanding and conflict about the role of others which appeared to inhibit teamworking.

> We wanted the nurses to change the way they worked, district nurses and health visitors and they were firmly against it and it wasn't possible ... nurses are firmly entrenched in what they do now and have no intention of changing. (PM 21)

> Doctors don't seem to want to use the computers and they actually do the notes, write the notes, but, you know, if you look on the computer and say the blood pressure wasn't done for a year and it is in the notes twice, you know, its not consistent it is not, you know, improving the system. They know what to do but unless everybody is consistent we are not going further ... its frustrating. (PN 12)

> Expectations now are very high, the nurses are different, I know nurses are given a hell of a lot more, you know, importance because its all very well, sometimes it's a hindrance because they have started to see themselves equally or more important than doctors. (PM 12)

Some participants were trying to tackle the issues of possible conflict and lack of understanding about the role of others.

> I have also been able to feedback to my colleagues, you know, give them some tips and some things I have learned and my other colleagues, my GP colleagues and receptionists, you know, explain what a nurse practitioner does as most people don't know. (PN 3)

> ... the doctors did do that, they came and ran the surgery, you know, two of them just dropped out and became receptionist and filing person, but I think they completely ballsed it up and I think it killed them (laughs) but they did do that. (PM 3)

Discussion

Principal findings

Some of the teams were clearly effective in delivering innovative programmes, however, teamworking was poor for many in the study. A lack of shared objectives, the inability to recruit, poor communication and hierarchical structures were all barriers to the development of effective teamworking. Many practices had no common purpose and lacked identifiable shared goals. Poor communication made it more difficult to share and relate. Problems with recruitment heightened the difficulties with communication and led to feelings of low morale and loss of motivation. In hierarchical practices, general practitioners were usually dominant and often limited the level of staff participation in planning and decision making, therefore reducing feelings of shared ownership in the future development of the team.

Implications for practice

The implications for practice are that despite working within a framework which offers more autonomy and flexibility, many practices operated from an authoritarian, often medically dominant management structure that prevented the creative interaction of the entire team.

West and Poulton (1997) stated that the views of a senior GP partner at a meeting were likely to have considerable influence on the outcome. This can be a barrier to developing a broader health agenda which crosses the health and social care divide and uses the skills and expertise of primary care professionals in a creative and challenging way. Although a structure like PMS can be a catalyst for good practices to improve teams and teamworking, for struggling practices it may take more than a structure like PMS to change the way in which people work. The use of a team coach (Arthur, Wall, & Halligan, 2003) may be a way of facilitating change for those poorly performing teams. The participation in a programme such as the RCGP QTD offers a framework to develop and support Primary Health Care Teams in assessing and improving the quality of care.

Limitations of the study

A limitation of this study is that the interview sample included only a narrow range of primary care professionals at a time when teamworking is being developed with many more professionals, such as pharmacists and psychologists. The specification of the study was defined by the funding body and included the decision to interview general practitioners, practice managers and nurses. The nurses were under-represented (14 interviews out of 21 practices). Fourteen nurses were interviewed, including one who refused to be taped and one as part of a joint interview.

Comparison with the literature

Wiles and Robison (1994) looked at the experiences of practice nurses, district nurses, midwives and health visitors in a primary care setting and found differences between these groups. They also reported a lack of understanding of each other's roles and responsibilities. An evaluation of first wave PMS pilots, some of which were nurse-led, found the introduction of PMS had changed cultural values and led to new interprofessional partnerships and a shift away from medical dominance (Riley et al., 2003).

An evaluation of the RCGP QTD programme (Macfarlane, Greenhaigh, Schofield, & Desombre, 2004) showed that the participating teams had found the experience, with its focus on team development, a positive one. Elston and Holloway (2001) reported on the impact of primary care reform on interprofessional working and suggested it might take a new generation of health professionals to bring about an interprofessional culture in the NHS.

Further research

Further research is needed to look at the role of other members of Primary Health Care Teams. Many of those may have less rigid boundaries in their philosophy of care. Educational interventions such as those described by Kendrick and Hilton (1997) may help to improve opportunities for more effective teamwork. Multidisciplinary educational initiatives, such as those by supported by nursing and general practice professional bodies (CAIPE, 1996), are likely to increase greater understanding between professions.

Conclusions

Teamwork in primary care is effective in some practices where the introduction of PMS has enabled them to innovate and develop. For many other practices, however, teamworking is

limited by a lack of shared objectives, problems with recruitment, poor communication and hierarchical structures. Greater collaboration and understanding, including targeted team development support for struggling practices, is required if primary healthcare is to have the genuine teamworking required to give the best care to patients and primary care is to make the best use of new and innovative ways of working.

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