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**Teamwork in Primary Care:
Do patients benefit?**

by

Judy Robison & Dr Rose Wiles

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SUMMARY

Teamwork within primary care has long been seen as necessary to coordinate and integrate the work of different professionals in promoting and maintaining the health of patients. This study commissioned by one FHSA sought to examine the patient benefit which may be associated with such teamwork. It did so by investigating patients' experience and awareness of aspects of interdisciplinary teamwork in primary care, identifying the potential benefits for patients and exploring the link with patients' satisfaction.

The research was divided into two phases. The first examined the nature of teamwork currently operating in 20 randomly selected practices, principally through semi-structured interviews with staff employed or attached to the practices. Data were obtained about their experiences and views of aspects of working practices, professional relationships and team-based activities. The data were analysed using strict criteria to identify evidence of teamworking in the working practices of the groups of staff being studied. Three descriptive models of teamworking were proposed to characterise practices operating with differing levels of teamwork.

The second phase of the study sought to investigate patients' awareness of elements of teamwork and differences in experience and satisfaction in practices with differing levels of teamwork. Fieldwork was conducted in two practices which were selected to provide a comparison between high and low levels of teamworking. A screening procedure was used to identify patients willing to be interviewed. A total of 36 interviews, 18 at each practice, were conducted in two phases with volunteer patients of different ages with varied and/or extensive contact with primary care health professionals.

The interviews explored:

- * patients' experience of teamwork in terms of receiving advice from professionals and their perceptions of communication between health professionals
- * the extent of patients understanding of the roles of some health professionals and their view about the most appropriate person to contact in certain situations
- * patients' perceptions of sources of information about staff and services available at the practice
- * patients views on staff attitudes and sources of patient satisfaction.

The data thus collected in the case study of two practices indicated that some potential benefits to patients can be identified through interviews with patients. There was evidence that the practice which had high levels of team work offered patients benefits through greater access to appropriate health professionals, greater awareness of health promotion and more opportunity for health education and advice, particularly from practice nurses. Greater confidence in perceived levels of communication between team members was seen to be linked to a valued sense of continuity of care. Patients at both practices expressed high overall levels of satisfaction with their practice but patients from the team oriented practice identified a broader range of sources of satisfaction suggesting that an integrated team approach can enhance the service a practice provides.

1. INTRODUCTION AND BACKGROUND

Summary

1.1 The Institute for Health Policy Studies (IHPS) at Southampton University was asked to conduct a piece of research for one Family Health Services Authority (FHSA) in the Wessex region examining the patient benefit of team work in primary care. The research was initially funded for one year, from May 1992, and two half-time researchers were employed to carry out the research. The project was subsequently completed by one of the researchers working half time for an additional four month period. The project was supported by an advisory group which met several times during the course of the project. Members of the advisory group were the general manager, assistant general manager and medical adviser of the FHSA, two GPs, a locality manager from an NHS Trust and a district nurse.

A research project to examine the patient benefit of teamwork in primary care was commissioned by one FHSA in the Wessex region.

1.2 Team work in primary care is not a new concept. The 1965 Charter for General Practice in conjunction with the move towards the attachment of community nursing staff to practices brought the issue of team work onto the primary health care agenda (Hasler, 1992). Clearly, if a number of health professionals were to be working in, or from, the same premises and caring for the same patients then a co-ordinated team approach was necessary. The issue of team work has been given a new impetus with the Government Reports 'Working for Patients', 'Caring for People' and 'Health of the Nation' which have emphasised the need for an integrated approach within primary health care to promote and maintain health.

Teamwork within primary care has long been seen as necessary to coordinate and integrate the work of different professionals in promoting and maintaining the health of patients.

1.3 There is an extensive literature, from the 1970's onwards, noting the advantages of team work in primary care (Waine, 1992; Gregson et al, 1991). Team work has been recognised as an effective way of providing primary health care for several reasons. First, a team approach leads to high levels of communication regarding patients' state of health and care and thereby avoids the duplication of services and conflicting advice to patients. Furthermore, communication should encourage early referral to the health professional most appropriate to patients' needs. Second, a team work approach provides ample scope for health promotion thus ensuring a healthier population. Third, team work has been identified by professionals as a more satisfying way of working (see Lambert, 1991).

The literature notes a number of reasons for team work being an effective means of providing primary health care for patients and a source of job satisfaction for professionals.

1.4 Although there is a consensus in the literature that team work is the most effective way of providing primary care some disadvantages or dangers of team work have been identified. It has been noted that working in teams may mean that health professionals take less responsibility for patients and assume that

Some potential disadvantages have also been identified, notably dilution of individual

patient responsibility is shared. Clearly, if all team members feel this the patient may be in some danger of 'slipping through the net' because everyone assumes someone else is taking responsibility. Other dangers of team work have been identified as stemming from the lack of control practice staff have over the selection of attached staff (and vice versa) and the possibility of personality clashes from groups of people being asked to work in close co-operation with each other (Martin et al, 1985).

1.5 While the concept of team work in primary care is not new, there has been much debate over which professionals constitute a team and what team work actually means. Members of the 'team' may vary from practice to practice. Some practices may view only core medical professionals employed or attached to a practice (i.e. GPs, health visitors, midwives, district nurses and practice nurses) as members of a team. Other practices may include administrative and clerical staff in their team while others may have a much wider definition and include such professionals as social workers, community psychiatric nurses, counsellors and chiropodists. Definitions of team work vary too with many FHSA's or practices developing their own definitions. However most would subscribe to the following definition of a primary health care team (PHCT) from the World Health Organisation:

"a group of people who share a common health goal and common objectives, determined by community needs, to the achievement of which each member of the team contributes in accordance with his or her competence and skill and in coordination with the functions of others" (WHO, 1984:13)

1.6 There have been a number of PHCT development initiatives that have taken place across the country. Some of these have been developed on a practice basis and some on a FHSA basis. Some initiatives from FHSAs have set out to examine if team work could be improved through a change in employment practices. One example of this is a joint pilot project between West Sussex FHSA and Worthing DHA in which the health visitors and district nurses in two practices are accountable to the practice rather than health authority management (Potrykus, 1991). The majority of initiatives, however, are concerned with improving team work, either in individual teams or groups of team, without changing employment practices. In most cases this has been achieved through training events organised by individual practices (Adelaide Medical Centre PHCT, 1991) representatives of interested bodies (e.g. community unit, FHSA and LMC) (Haggard, 1990) or outside management consultants (Pratt, 1990). Such events have aimed to identify the barriers to team work in particular practices and the team objectives for the future. In some cases the events

professional responsibility for patients and the possibility of personality clashes between colleagues.

Definitions of teamwork and team membership have been debated and variations may exist between FHSAs and at practice level. A widely acceptable definition of a PHCT has been provided by the World Health Organisation.

PHCT development initiatives have taken place across the country. Some FHSAs have sought to improve teamwork through changes to arrangements for the employment of community nursing staff. Many have held training events concerned with improving teamwork in individual practices. The HEA workshop manual has been widely used as a

lead to a basic statement of PHCT objectives (Haggard, 1990; Adelaide Medical Centre PHCT, 1991). In others, a programme for continuing evaluation of PHCT development is set up. The Health Education Authority's (HEA) Primary Health Care Team Workshop Manual (1991) has contributed widely to the development of the latter.

1.7 In the wake of the 1990 GP contract, the FHSA for the area being studied in this project established a commitment to strengthening primary care through developing effective team work. This commitment has been central to the strategic statements and development plans produced by the Authority. The FHSA set about engaging practitioners in thinking about team development by setting up a high profile team building workshop programme across the county. This programme has continued and complements the development work undertaken with individual practices by primary care facilitators. The intention is to have achieved 100% attendance on the workshop programme by 1993/4. The operation of the practice enhancement budget and the staff reimbursement policy has provided a financial incentive to facilitate the development of the PHCT. The FHSA thrust on business management via the management development programme may also have conveyed to GPs the importance of the team and its potential for maximising the practice income through achievement of targets and the development of health promotion activities. The FHSA is also committed to working closely with the DHA's to develop specifications for the operation of PHCTs and the integration of nursing services within the team as a basis for contracts for community nursing services.

1.8 There is a clear assumption that patients benefit from team work although there is little research evidence to substantiate this. A review of the literature on this topic found just a small number of studies indicating that teamwork had contributed to favourable outcomes of patient care. One report referred to studies which indicate that efficient team work leads to higher immunisation rates and more effective screening of the elderly (Northumberland Primary Care Forum, 1991). Studies of diabetes care have shown a favourable comparison of care in the primary care setting with care in a conventional hospital clinic where this care is provided in a structured clinic with full ancillary support. (Singh et al, 1984; Parnell et al, 1993). Evidence from various studies was quoted by Lawrence (1988) to demonstrate the effectiveness of team work on the management of hypertension and diabetes. A further study showed that a practice nurse can effectively manage asthma helping to reduce morbidity in patients and the number of GP consultations for asthma (Charlton et al, 1991). Few of these studies sought patient views; the definition of patient benefit in terms of

model for the latter.

This FHSA has been committed to strengthening primary health care through effective teamwork. A county wide team building workshop programme has complemented the work of primary care facilitators. GPs have been made aware of financial incentives to facilitate development of the PHCT. The FHSA is committed to working with DHA's towards integration of nursing services within the PHCT.

Patients are assumed to benefit from teamwork although the body of research evidence on the subject is small. Some studies have shown that teamwork can enhance the effectiveness or efficiency of care provided in the primary care setting. Such studies have not always sought the patients views.

favourable outcomes was made by professionals. With regard to patient satisfaction with the processes of teamwork some studies have found that patients were willing to be referred to practice nurses, rather than doctors (Marsh and Kaim-Caudle, 1976; Williamson, 1989; Jefferson and Martin, 1990).

1.9 The aim of this project was to examine the patient benefit of team work. Before the patient benefit aspect of the research could be undertaken it was considered to be necessary to examine the levels and models of team work operating in practices. Clearly, it is not possible to examine the benefits of team work without establishing the type of team work that exists. Thus the research was divided into two phases. The first focused on examining team work in practices in the county through interviews with people employed or attached to the practices and the second sought to examine the patient benefits (or otherwise) of that team work through interviews with patients.

The research was divided into two phases examining firstly the nature of teamwork currently operating in practices in the county, and secondly the benefit(s) or otherwise from the patients' perspective.

2. PHASE ONE - DESCRIPTIVE STUDY OF TEAMWORK

Sample Selection

2.1 The aim of the sampling process was to select a group of practices to be the focus of the first phase of the research - a descriptive study of team work in practices in the county. A random sampling method was used to select 20 from the total population of 86 GP practices. Letters were sent from the researchers to the 20 practices selected inviting them to participate in the study and giving details of what taking part in the research would involve. Letters were sent to both the senior partner and the practice manager at each of the practices. The general manager of the FHSA had already written to all practices in the county several weeks prior to this to alert them to the fact that the research would be taking place and to encourage them to cooperate, should they be asked to take part.

20 GP practices were selected randomly from the total population of 86 in the county and invited to take part in the study.

2.2 A reply slip and prepaid, addressed envelope were provided to encourage a prompt response. Where necessary, the original approach was followed by a reminder letter and personal phone call to the practice. Of the 20 practices that were first approached 12 agreed and 8 declined to participate. Not all of those who declined gave a reason for doing so but some mentioned the fact that they were already involved in other research or audit projects. Additional practices were invited to participate to substitute for those who had declined. Those approached were selected to match the originals as closely as possible with respect to size and location. In this way a sample of 20 practices was obtained.

Some practices declined to take part. Closely matched substitutes were selected and approached and a sample of 20 was obtained.

Sample Characteristics

2.3 The final sample of 20 practices selected for this study was found to be closely representative of all practices in the county in respect of size and location. The following table (Table 2.1) compares the composition of the two groups. The districts referred to in the table are the areas covered by different district health authorities. The location of practices selected for the study was judged to be a relevant consideration because the arrangements for the provision and attachment of community nursing staff, who are members of primary health care teams, may not be uniform across the county.

The final sample proved to be closely representative of all practices in the county in respect of size and location.

Table 2.1 Size and location of practices in the study sample and in the county

Size of Practice	Sample	All County	District	Study sample	Rep. sample
	No (%)	No (%)		No (%)	No (%)
Single - handed	5 (25)	19 (22.1)	District 1	7 (35)	30 (34.8)
2-4 partners	10 (50)	42 (48.9)	District 2	5 (25)	23 (26.7)
5-8 partners	5 (25)	25 (29.0)	District 3	8 (40)	33 (38.4)
Total	20 (100)	86 (100)	Total	20 (100)	86 (100)

2.4 The sample was also found to be representative of all practices in the county in respect of two further variables judged to be relevant to the subject of the study. At the time of the sample selection a total of 21 practices in the county (24.4%) had participated in FHSA sponsored team building workshops. The sample included 5 such practices (25%). At the time of the sample selection a total of 10 practices in the county (11.6%) were either already fundholding or preparing to become 3rd wave fundholders from April 1st 1993. The sample included 3 such practices (15%).

The sample was also representative in respect of participation in team building workshops and 1st-3rd wave fundholding.

Data Collection

2.5 Researchers made an initial visit to the practice to meet with the practice manager in all but one case - a single handed practice without a manager. In this case the researcher telephoned the GP. The purpose of the meeting was to gain background information about the practice, answer questions the practice might have about the research and discuss arrangements for returning to interview members of staff. The type of information sought was as follows:

Researchers made an initial visit to each practice to gain background information, answer questions about the research, and to discuss arrangements for individual interviews with staff members.

- * names and contact details of practice and attached staff
- * details of practice meetings - particularly multi-disciplinary team meetings
- * any readily available data on the practice population
- * details of practice procedures for over 75's assessments, cervical smears, childhood immunisations and flu jabs
- * information about the practice premises
- * where available, a copy of the 1991 practice report
- * a copy of the practice information leaflet for patients

2.6 Only seven of the 20 practices were found to hold regular multi- disciplinary primary health care team meetings. It was possible for a researcher to attend and observe a meeting at five of these practices. In the remaining practices there was not a convenient meeting held during the 3 month period when this part of the study was undertaken. In observing a meeting the researcher sought to note and record as many as possible of the following items of information:

- * details of who was invited, attended or sent apologies
- * the content and nature of the agenda: whether it was written or verbally agreed; who compiled it; if it was available or circulated prior to the meeting
- * which member of the team chaired the meeting and observations about the style in which the meeting was conducted
- * details of any concrete decisions taken and observations about the process by which this took place
- * observations of the kind of interaction that took place between team members both before, during and after the meeting

2.7 At each of the practices, the researchers aimed to interview one of the following:

- * GP
- * Practice Manager
- * Practice Nurse
- * Receptionist
- * Health Visitor
- * Midwife
- * District Nurse

2.8 In most of the practices the practice manager offered or agreed to coordinate the arrangements for interviews with the practice employed staff - usually at one session. In allowing the practice manager to make the arrangements for the interviews the researchers lost some control over the selection of people to be interviewed. If each interview had had to be negotiated and arranged on an individual basis, however, it is highly unlikely that this phase of the study could have been completed within the time allotted. In the event, the selection of staff to be interviewed was determined largely by the need to see everyone at one session. Having found a convenient time for the GP interview the practice

Eight practices held regular multi disciplinary PHCT meetings. Researchers attended and observed a meeting at 5 practices noting and recording a variety of information.

Researchers aimed to interview a representative of seven different professions at each practice.

In most practices the arrangements for interviews with practice employed staff were coordinated by the practice manager.

manager then made arrangements with other staff who would also be working on that day.

2.9 The attached community nursing staff were, for the most part, contacted individually by the researchers after an initial letter had been sent giving details of the project. The interviews were sometimes held at the GP practice and sometimes at the individual's own workbase in a clinic or hospital. The community staff demonstrated a great willingness to cooperate with the research.

The researchers made individual arrangements, however, with the attached community nursing staff.

2.10 During this stage of the research 131 interviews were conducted in the 20 practices. There were eight members of community staff whom it did not prove possible to interview within the time allotted for a variety of reasons, principally sickness or unavoidable cancellations of appointment.

A total of 131 interviews were conducted in the 20 practices.

Interview Design

2.11 At an early meeting of the Project group, a general definition of team working, in accordance with the policy of the FHSA, was discussed and agreed. It was on the basis of this and other literature that key features of team working were identified. The research was designed to collect data which would inform judgements about the extent to which these features of team working could be identified in the working practices of the groups of people being studied.

The research sought to identify evidence of teamwork in the working practices of the groups of people being studied.

2.12 The timescale of the research did not allow for the collection of evidence of group members' behaviour or interaction over time either by systematic observation or recording. It was necessary to collect data on the basis of individual group members reported behaviour, perceptions, attitudes and opinions. The interview schedule was designed to elicit these.

Through interviews data was sought on team members' reported behaviour, perceptions, attitudes and opinions.

2.13 The interview schedules were in three parts. Part A, common to all, collected basic personal data such as details of age, sex, place of work and length of time working at or with the practice. Part B was slightly different for each category of staff member and asked questions specific to different jobs and professional relationships. Part C, again common to all, asked questions about team based activities such as meetings and about working together in general. The interview schedules were semi-structured incorporating a mix of simple questions for which there were pre-coded answer categories and some open ended questions. The responses to these questions were recorded verbatim on the questionnaire.

The semi structured interview schedule collected basic personal data, examined specific professional relationships and asked about experience and views of team based activities.

Analysis of Phase One Data

2.14 In analysing the data collected from the practices, the intention was to make a general assessment of the extent to which each practice seemed to be operating according to a team working model. For this purpose an overall measure of team working was felt to be necessary. A list of 11 key features of team working was developed from an analysis of FHSA documents and existing literature on team work in primary care. From these sources it was concluded that in practices that worked as teams, each individual working at or attached to the practices should:

- * recognise themselves as members of a PHCT
- * express a commitment to working as part of a PHCT
- * express the view that team working benefit patients
- * regularly attend PHCT meetings
- * express a common sense of purpose with the other members of the PHCT
- * subscribe to a written team goal
- * perceive that other team members understand his/her roles and responsibilities
- * perceive that he/she understands the roles and responsibilities of other team members
- * possess clear systems for communicating with team members
- * find other team members accessible
- * share the same philosophy of care with team members

2.15 The interviews yielded information on each of these features of team working for every individual interviewed. From this information it was possible to evaluate whether individuals subscribed to the features of team work outlined above. A simple scoring technique was used when an individual was judged to subscribe to each feature of team working. Strict criteria were established for deciding whether an interviewee's responses equated with a feature being present. *The specific evidence used and examples of the kinds of responses are detailed in the appendix of this report.*

An overall measure of team working comprising 11 key features was developed so that a general assessment could be made of the extent to which each practice seemed to be operating according to a team working model.

Interview data was analysed using strict criteria to establish the existence of features of team working for each individual.

2.16 A grid was used to record and collate the data for each practice. A numerical score was calculated on the basis of the presence of the features of team working for each member of the practice. The features of team working were accorded equal weighting for scoring purposes. To enable comparisons to be made between the scores of staff groups of different sizes, these scores were then expressed as a percentage of the potentially achievable score for that group.

A grid was used to record and collate the data expressed as a numerical score for each individual and practice.

2.17 The team working scores for the 20 practices ranged from 32% - 89%. These scores were grouped as follows:

The scores thus obtained ranged from 32% - 89%.

'low' team working score	32% - 56%	(5 practices)
'medium' team working score	62% - 75%	(10 practices)
'high' team working score	77% - 89%	(5 practices)

2.18 The team working scores were intended to provide only an approximate measure of team working in the practices included in the research. A detailed examination of practices within these three groups revealed that the conceptualisation of team working as a continuum ranging from low to high levels of team work did not provide an adequate picture of the different models of PHCTs operating in Wiltshire. Three main types of models of PHCT operation emerged by examining separately the groups of practices which achieved 'low', 'medium' or 'high' team working scores. These three models have been termed 'individualistic practices', 'GP-led teams' and 'democratic teams'.

These scores were regarded as providing an approximate measure of teamworking. Three descriptive models of teamworking are suggested.

Model One: individualistic practices

2.19 Practices in this category could be characterised as having low levels of team working. They tended to have poor communication, low levels of accessibility between team members and differing philosophies of patient care. Staff members often described a 'them' and 'us' philosophy between the GPs on the one hand and the practice and attached staff on the other. GPs in such practices were regarded as individualistic and many were viewed as unapproachable. High levels of dissatisfaction with the practice and an awareness that they were not really working as a team was commonly expressed. Such practices appeared to be making little progress in developing team work, with GPs being resistant to introducing PHCT meetings or participating in team-building workshops.

Individualistic practices could be characterised as having low levels of teamworking. Staff were aware that they were not working as a team and there was little movement towards team development.

2.20 Five practices in the sample were judged to come into this category. They had all been allocated low team working scores. Most of these were large practices: four of the five had at least six partners.

Five large practices seemed to be in this category.

Model Two: GP-led practices

2.21 Practices in this category could be characterised as GP-led teams. They tended to have high levels of accessibility, good communications and shared philosophies of care. However such practices rarely held PHCT meetings. Team members expressed high levels of satisfaction and a view that they were a team, albeit one led by the GP(s). No dissatisfaction with this form of team working was expressed and team members were committed to their GP(s) as leader of the team. The GP(s) in such practices similarly expressed a commitment to working in a team based way but expressed the view that the GP must always lead the team because of their legal responsibility for patients' well-being.

In GP-led practices staff worked closely together with a strong sense of being a team. The GP was recognised as the leader.

2.22 Four practices in the sample were judged to come into this category. Three of these were single handed practices. These practices had high or upper-mid team working scores.

Four small or single handed practices came into this category.

Model Three: democratic practices

2.23 Practices in this category could be characterised as having fairly high levels of team work. The practices tended to have a philosophy, to a greater or lesser degree, of working as a 'democratic' team without the assumption that the GP is, or should be, the leader. They held regular PHCT meetings which all staff attended. Communications were generally good and team members ensured that they were accessible to each other to discuss patient care. Philosophies of patient care tended to be broadly similar. However, there were occasionally personality difficulties in some of these practices so that one member of staff felt alienated from the team or one member of staff was viewed by team members as not working within the philosophy of the team. These practices were consciously trying to work towards and maintain high levels of team work.

Democratic practices could also be characterised as having fairly high levels of teamwork subscribing to a view of team members as players of equal status. There is a conscious effort to promote and maintain team development.

2.24 Six practices in the sample were viewed as coming into this category. Five of these practices had 2 - 4 partners. These practices had high or upper-mid team working scores.

Six small or medium sized practices were in this category.

2.25 Five practices in the sample could not be allocated to one of these models. These practices were viewed as being in a transitional phase between categories. In most cases these practices appeared to be moving from model one or two to model three.

Five practices were seen to be in a transitional phase between categories.

3. PHASE TWO - STUDY OF PATIENTS' EXPERIENCE OF TEAMWORK

3.1 Having established the level and types of operation of team work in the county, the next stage of the study involved examining if any patient benefit could be found to be associated with team work. It was not the intention to focus on clinical interventions and their outcomes in order to judge whether patients clinical needs were better met by one practice than another. The intention was to explore the notion of benefit from the patients' point of view.

3.2 A well functioning primary health care team has been identified as the best means of delivering a primary health care service that provides appropriate and quick treatment and prevents ill-health. The literature suggests that practices working as teams should be able to provide this through good communication and sharing of knowledge about patients, pooling of skills and knowledge of team-members roles and responsibilities, and, high morale and a good working environment. The professionals interviewed in phase one of this study were almost unanimous in the belief that teamworking benefits patients and their comments echoed views expressed in the literature. Many referred to the high morale and good motivation that teamwork creates and expressed the view that this "feel good factor" creates a good atmosphere for patients in which they find staff approachable and feel relaxed and confident. This is seen to increase compliance and aid recovery. The professionals also emphasised the value of communication and sharing of knowledge amongst themselves. They thought patients would benefit from a range of skills and perspectives provided in the context of a uniform approach with emphasis on continuity of care.

3.3 It is not clear that patients would necessarily perceive all these benefits given that much activity relating to teamwork takes place without the patient actually being aware of it. Consequently this study sought to examine if there were elements of teamwork that patients were aware of and, if so, whether there were differences in patients' experiences and levels of satisfaction relating to these elements in practices with differing levels of teamwork. The experiences of patients at a practice with a high level of team working were to be compared with those of patients at a practice with low levels of team working. The data were to be provided by patients themselves through individual interviews.

3.4 Given the exploratory nature of the research topic, the study of patients experiences of teamwork was conducted in two stages. An initial set of patient interviews was undertaken and the data examined. A judgement was made that it had been possible firstly

The aim of this stage of the study was to explore the notion of patient benefit associated with teamwork from the patients perspective.

The staff interviewed in phase one of this study echoed the views expressed in the literature about the ways in which patients benefit from aspects of teamwork.

The study sought to investigate patients' awareness of elements of teamwork and differences in experience and satisfaction in practices with differing levels of teamwork.

The interviews were arranged in two phases. A second set was conducted after

to elicit patients experiences of some aspects of teamwork and secondly to identify some potential or perceived benefits that may be associated with teamwork. A second set of interviews incorporating minor additions to the schedule of questions was subsequently undertaken to consolidate the study.

examination of data from the first set indicated that the research question could be addressed.

Sample Selection of Practices and Patients

3.5 One practice was selected from the 'individualistic practices' group and one from the 'democratic practices' group. These two groups were selected as it was felt that they would provide a clear comparison between low and high levels of team working. The two practices selected were viewed as being the ones that most clearly represented the characteristics of the two types of practices. The 'individualistic' practice was one with seven partners in an urban location. The 'democratic' practice had two partners and was located in a market town.

Practices were selected to provide a comparison between high and low levels of teamworking - one each from the 'democratic' and the 'individualistic' practices group.

(The practice selected from 'individualistic practices' group will be referred to in this report as practice 'A' and the practice from the 'democratic practices' group will be referred to as practice 'B'.)

3.6 The practice managers of the two practices were contacted by letter and asked to participate in the second phase of the study. Both practices agreed to take part.

Both agreed to participate.

3.7 At each practice the intention was to select a small number of patients to be interviewed by a researcher. A screening procedure was devised by which patients attending the surgery would be asked to complete a brief questionnaire giving details of who they were seeing at the surgery that day, the number of contacts they had had with different health care professionals during the previous six months, their age, sex and how long they had been registered at the practice. Patients would also be asked if they would be prepared to take part in an interview with a researcher to express their views about the care they had received and, if so, to provide their name and address.

A screening procedure was devised to recruit a suitable sample of patients to be interviewed.

3.8 The advantages of such a screening procedure were seen to be the fact that practices were not asked to divulge the names and addresses of patients, that only patients who had already given their consent would be approached to take part in an interview and that a sample of patients for interview could be selected from those who seemed to have had the most varied or extensive recent contact with different health care professionals.

Several advantages of such a procedure were identified.

3.9 Each practice was provided with 150 screening questionnaires, each with accompanying information sheet and reply paid envelope, for distribution to patients. Receptionists handed them all out, starting on a Monday during one week in March 1993, giving one to every patient who came to keep an appointment at the surgery with GP, practice nurse or any other health care professional. Questionnaires were not given to patients who called at the surgery only to make appointments, request or collect repeat prescriptions.

Practices were asked to hand out questionnaires to 150 patients with appointments at the surgery.

3.10 Patients were asked to complete their questionnaires at the surgery and hand them back to the receptionist, sealed in the envelopes provided. They were free, however, to take the questionnaire away from the surgery for completion and post it themselves.

On completion questionnaires could be handed back to reception or posted.

Response to the Screening Questionnaire

3.11 * 79 completed questionnaires were received from patients of practice 'A', a response of 53%

A variable response was obtained.

* 144 completed questionnaires were received from patients of practice 'B', a response of 96%

3.12 It seems that the receptionists at practice 'B' may have been more active in encouraging patients to complete the questionnaire whilst still at the surgery. Very few questionnaires were received by post - the rest were held at reception for collection by a researcher. All completed questionnaires from practice 'A' were sent by post however, mailed on a daily basis by the reception staff or by patients. A patient from practice 'A' who later took part in interview reported observing that other patients attending the surgery at the same time as she did chose to take their questionnaire away from the surgery. Having done so they may then have lost interest in completing or posting it. This may have contributed to the lower response rate from practice 'A'.

Differences between the ways in which receptionists from the two practices approached this exercise may partly account for this variation in the volume of the response.

3.13 Despite this marked difference in the response rate, the percentage of those responding who said that they were willing to be interviewed was identical for the two practices - 39%. The actual numbers of volunteers were 31 patients from practice 'A' and 54 patients from practice 'B'.

The proportion of respondents from the two practices willing to be interviewed was identical.

3.14 For each practice, the group of patients who volunteered to be interviewed can be compared to the group who did not volunteer on the basis of the information provided in the screening questionnaire. It is important to check if there are marked differences between the two groups which would suggest that the

For each practice the data collected allows some comparisons to be made between the volunteers and the

volunteer group could not be acceptably representative of the whole. The following tables (3.1 - 3.8) show the age/sex distribution and the recent health care experience of the two groups at each practice.

3.15 These tables show that for both practices the over 60's were more likely than younger adults to consent to take part in interview. This is perhaps not surprising as people of this age group are likely to have more spare time and more acute concerns with their health and health care. At practice 'A' the proportion of male patients was greater in the volunteer group than in the non volunteer group. This was not the case at practice 'B'.

3.16 There appears to be very little difference between the volunteer and non volunteer group in terms of the professionals they had encountered in their recent health care experience. At each practice the non volunteer group includes a small proportion of patients who had had no contact with health care staff prior to the day they completed the screening questionnaire and these patients presumably felt that they would have little or nothing to contribute to an interview. At each practice the proportion of patients who had had recent contact with both GP and practice nurse was slightly larger in the volunteer group than the non volunteer group.

3.17 The differences that were noted in the known characteristics between the volunteer and non volunteer group at either practice were judged to be sufficiently small to permit the conclusion that the volunteer group would provide an acceptable sampling frame for this study.

non volunteers.

The over 60s were more likely than younger adults to consent to take part.

Few differences were found between the volunteer and non volunteer group in terms of recent health care experience.

The volunteer group was thought to provide an acceptable sampling frame.

Table 3.1 Practice 'A' Sex by Age of Respondents Consenting to Interview
(N.B. Where patient was under 18 the parent had completed the questionnaire)

	<18 n (%)	18-30 n (%)	31-45 n (%)	46-60 n (%)	61-75 n (%)	75+ n (%)	Total n (%)
Female	1 (3)	6 (19)	5 (16)	2 (7)	1 (3)	3 (10)	18 (58)
Male	0	0	3 (10)	4 (13)	5 (16)	1 (3)	13 (42)
Total	1 (3)	6 (19)	8 (26)	6 (20)	6 (19)	4 (13)	31 (100)

Note: The percentage figures have been rounded to the nearest integer

Table 3.2 Practice 'A' Sex by Age of Respondents not Consenting to Interview
(N.B. Where patient was under 18 the parent had completed the questionnaire)

	<18 n (%)	18-30 n (%)	31-45 n (%)	46-60 n (%)	61-75 n (%)	75+ n (%)	Total n (%)
Female	4 (8)	14 (29)	9 (19)	8 (17)	4 (8)	2 (4)	41 (85)
Male	0	2 (4)	2 (4)	0	3 (7)	0	7 (15)
Total	4 (8)	16 (33)	11 (23)	8 (17)	7 (15)	2 (4)	48 (100)

Note: The percentage figures have been rounded to the nearest integer

Table 3.3 Practice 'A' - Recent Health Care Experience of Respondents Consenting to Interview

Contact during last six months	Today see GP n (%)	Today see PN n (%)	Today see other n (%)	total n (%)
No contact	0	0	0	0
GP + PN	9 (30)	2 (6)	2 (GP+PN) (6)	13 (42)
GP only	14 (45)	0	0	14 (45)
PN only	1 (3)	0	0	1 (3)
GP+1 other	0	0	0	0
GP+2 or 3 other**	2 (6)	0	1 (GP+PN) (3)	3 (10)
column total	26 (84)	2 (6)	3 (10)	31(100)

Note: The percentage figures have been rounded to the nearest integer

** from counsellor, CPN, health visitor, midwife, PN

Table 3.4 Practice 'A' - Recent Health Care Experience of Respondents not Consenting to Interview

Contact during last six months	Today see GP n (%)	Today see PN n (%)	Today see other n (%)	total n (%)
No contact	6 (13)	0	0	6 (13)
GP + PN	8 (17)	2 (4)	3 (GP+PN) (6)	13 (27)
GP only	19 (40)	1 (2)	0	20 (42)
PN only	1 (2)	0	0	1 (2)
GP+1 other*	3 (6)	0	1 (MW) (2)	4 (8)
GP+2 or 3 other**	3 (6)	0	1 (GP+PN) (2)	4 (8)
Total	40 (84%)	3	5 (10)	48(100)

Note: The percentage figures have been rounded to the nearest integer

* midwife

** from health visitor, midwife, PN, district nurse

Table 3.5 Practice 'B' Sex by Age of Respondents Consenting to Interview
(N.B. Where patient was under 18 the parent had completed the questionnaire)

	<18 n (%)	18-30 n (%)	31-45 n (%)	46-60 n (%)	61-75 n (%)	75+ n (%)	Total n (%)
Female	4 (7)	3 (5)	12 (22)	11 (20)	11 (20)	3 (5)	44 (79)
Male	3 (5)	1 (2)	1 (2)	3 (5)	4 (7)	0	12 (21)
Total	7 (12)	4 (7)	13 (24)	14 (25)	15 (27)	3 (5)	56(100)

Note: The percentage figures have been rounded to the nearest integer

Table 3.6 Practice 'B' Sex by Age of Respondents not Consenting to Interview
(N.B. Where patient was under 18 the parent had completed the questionnaire)

	<18 n (%)	18-30 n (%)	31-45 n (%)	46-60 n (%)	61-75 n (%)	75+ n (%)	Total n (%)
Female	4 (4)	20 (23)	21 (25)	7 (8)	7 (8)	3 (3)	62 (70)
Male	4 (4)	4 (4)	7 (8)	6 (7)	2 (2)	4 (4)	27 (30)
Total	8 (8)	24 (27)	28 (33)	13 (15)	9 (10)	7 (7)	89(100)

data missing = 1 case

Note: The percentage figures have been rounded to the nearest integer

Table 3.7 Practice 'B' - Recent Health Care Experience of Respondents Consenting to Interview

Contact during last six months	Today see GP n (%)	Today see PN n (%)	Today see other n (%)	total n (%)
No contact	1 (2)	0	0	1 (2)
GP + PN	14 (25)	10 (18)	1 (GP+PN) (2)	25 (45)
GP only	10 (18)	3 (5)	1 (GP+PN) (2)	14 (25)
PN only	3 (5)	1 (2)	0	4 (7)
GP+1 other*	3 (5)	1 (2)	1 (h'path) (2)	5 (9)
GP+2 or 3 other**	3 (5)	1 (2)	2 (HV) (5) 1(GP+MW+PN)	7 (12)
column total	34 (60)	16 (29)	6 (11)	56(100)

Note: The percentage figures have been rounded to the nearest integer

* from counsellor, homeopath, CPN, district nurse, dietitian

** from counsellor, CPN, district nurse, health visitor, midwife, PN

Table 3.8 Practice 'B' - Recent Health Care Experience of Respondents not Consenting to Interview

Contact during last six months	Today see GP n (%)	Today see PN n (%)	Today see other n (%)	total n(%)
No contact	6 (7)	1 (1)	0	7 (8)
GP + PN	21 (24)	6 (7)	5 (GP+PN) (6)	32 (37)
GP only	24 (28)	4 (5)	1 (GP+PN) (1)	29 (34)
PN only	2 (2)	2 (2)	0	4 (4)
GP+1 other*	3 (3)	0	0	3 (3)
GP+2 or 3 other**	3 (3)	1 (1)	8 (9)	12 (13)
homeopath only	0	0	1 (1)	1 (1)
Total	59 (67)	14 (16)	15 (17%)	88(100)

data missing = 2 cases

Note: The percentage figures have been rounded to the nearest integer

* counsellor

** from counsellor, CPN, health visitor, midwife, PN, physiotherapist

3.18 In addition to comparing groups within practices it is interesting to make comparisons between the two practices in terms of characteristics of the patient group as a whole. The following two tables (3.9 and 3.10) show that the age and sex distribution of the patients is very similar. Female patients outnumber male patients in these groups of patients attending the surgery during a week in March 1993 by three to one at both the practices. The over 60's represented one in four patients attending the surgery during this time at both practices. The larger proportion of children under 18 appearing in the group at practice 'B' may be accounted for by the fact that the health visitor is based at the surgery and holds an open session for mothers and babies.

Comparisons made between practices of the characteristics of the patient group as a whole revealed that the age / sex distributions were very similar.

Table 3.9 Practice 'A' Sex by Age of all Respondents

(N.B. Where patient was under 18 the parent had completed the questionnaire)

	< 18 n (%)	18-30 n (%)	31-45 n (%)	46-60 n (%)	61-75 n (%)	75+ n (%)	Total n (%)
Female	5 (6)	20 (26)	14 (18)	10 (13)	5 (6)	5 (6)	59 (75)
Male	0	2 (3)	5 (6)	4 (5)	8 (10)	1 (1)	20 (25)
Total	5 (6)	22 (29)	19 (24)	14 (18)	13 (16)	6 (7)	79(100)

Table 3.10 Practice 'B' Sex by Age of all respondents

(N.B. Where patient was under 18 the parent had completed the questionnaire)

	< 18 n (%)	18-30 n (%)	31-45 n (%)	46-60 n (%)	61-75 n (%)	75+ n (%)	Total n (%)
Female	8 (6)	23 (16)	33 (23)	18 (12)	18 (12)	6 (4)	106 (73)
Male	7 (5)	5 (3)	8 (6)	9 (6)	6 (4)	4 (4)	39 (27)
Total	15 (11)	28 (19)	41 (29)	27 (18)	24 (16)	10 (7)	144(100)

data missing = 1 case

Note: The percentage figures have been rounded to the nearest integer

3.19 The following tables (3.11 and 3.12) show the recent health care experience of patients at the two practices and suggest some interesting differences. At both practices the majority of respondents had an appointment with the doctor on the day they completed the screening questionnaire but the proportion was greater at practice 'A' (84%) than at practice 'B' (65%). Similarly the proportion of patients whose only contact with health care professionals during the previous six months had been with the GP was greater at practice 'A' (43%) than at practice 'B' (30%). The proportion of patients seeing the practice nurse was larger at

Differences were found between the practices in terms of the recent health care experience of the groups of patients.

practice 'B' (22%) than at practice 'A' (6%). The proportion of patients who had had past contact with professionals other than the GP or practice nurse was slightly larger for practice 'B' (20%) than practice 'A' (14%). This data would seem to suggest that the patients from practice 'B', where high levels of team working had been found, were likely to experience health care more widely shared among a range of professionals than those patients at practice 'A'. The health care of patients at practice 'A' seemed to be characterised by more contact with the GP.

Table 3.11 - Practice 'A' - Recent Health Care Experience of All Respondents

Contact during last six months	Today see GP n (%)	Today see PN n (%)	Today see other n (%)	total n (%)
No contact	6 (7)	0	0	6 (7)
GP + PN	17 (22)	4 (5)	5(GP+PN) (6)	26 (33)
GP only	33 (42)	1 (1)	0	34 (43)
PN only	2 (3)	0	0	2 (3)
GP+1 other	3 (4)	0	1 (MW) (1)	4 (5)
GP+2 or 3 other**	5 (6)	0	2 (GP+PN) (3)	7 (9)
column total	66 (84)	5 (6)	8 (10)	79 (100)

Note: The percentage figures have been rounded to the nearest integer

* midwife

** from counsellor, CPN, health visitor, midwife, PN, district nurse

Table 3.12 - Practice 'B' - Recent Health Care Experience of all Respondents

Contact during last six months	Today see GP n (%)	Today see PN n (%)	Today see other n (%)	total n (%)
No contact	7 (5)	1 (1)	0	8 (6)
GP + PN	35 (24)	16 (11)	6(GP+PN) (4)	57 (39)
GP only	34 (23)	7 (5)	2(GP+PN) (1)	43 (29)
PN only	5 (4)	3 (2)	0	8 (6)
GP+1 other*	6 (4)	1 (1)	1(h'path) (1)	8 (6)
GP+2 or 3 other**	6 (4)	2 (1)	2 (HV) (8) 1(GP+MW+PN) 8 other	19 (13)
homeopath only	0	0	1 (1)	1 (1)
column total	93 (64)	30 (21)	21 (15)	144(100)

data missing = 2 cases

Note: The percentage figures have been rounded to the nearest integer

* from counsellor, homeopath, CPN, district nurse, dietitian

** from counsellor, CPN, district nurse, health visitor, midwife, PN, physiotherapist

Selection of patients interviewed

3.20 At each of the practices 10 patients were selected from the volunteer group to be interviewed in the first exploratory phase. The sample was selected to include patients of different ages who seemed to have had the most varied and/or extensive contact with different health care professionals. These patients were contacted initially by telephone where possible and then a letter was sent confirming the agreed date and time for the interview. In cases where no telephone number was provided details of an appointment for interview were sent in a letter with a request to contact the researchers, using a reply paid envelope, if the time suggested was inconvenient. At each practice nine of the interviews were conducted successfully but in one instance the volunteer was not at home when the researcher called. At practice 'B' it was possible to substitute for the missed interview by arranging an interview with another patient at short notice, but unfortunately at practice 'A' this was not possible within the time available. For the second set of interviews contact was made in the same way with other "volunteer" patients. Twenty interviews were arranged but only 17 completed as three patients were not at home when the researcher called. The total number of interviews conducted was 36, 18 from each practice.

Interviews were arranged with selected volunteer patients of different ages with varied and/or extensive contact with health professionals. A total of 36 interviews, 18 at each practice, were conducted in two phases.

3.21 The patients interviewed were as follows:

PRACTICE 'A'

1. **Female under 18** (interview with mother)
Appointment for child with GP (to obtain treatment for athletes foot).
In last six months mother has also seen GP for other child (medication for asthma) and PN for self (treatment for verruca)
2. **Male aged 46-60**
Appointment with GP (for sick note and result of hospital test).
In last six months has seen PN twice (vitamin injections) and GP five times (industrial accident + heart and lung condition)
3. **Female aged 46-60**
Appointment with PN for blood tests (rheumatoid arthritis).
In last six months has seen PN eight times and GP five times (sick notes and blood tests)
4. **Male aged 61-75**
Appointment with GP (haemorrhoids)
In last six months has seen GP three times and PN once (back problems, breathing problems, recent suspected heart attack).
5. **Female aged 18-30**
Appointment with GP (sick note).
In last six months has seen GP four times and MW twice (for antenatal care) PN twice (for blood tests) and HV once (for toddlers developmental check).
6. **Female aged 18-30**
Appointment with GP (to obtain prescription and discuss problems).
In last six months has seen GP seven times (ongoing but unspecified problem) and PN twice (blood pressure and weight check).
7. **Female aged 18-30**
Appointment with PN (for smear test).
In last six months has seen PN once (tetanus jab) and GP once (skin problem).
8. **Female aged 31-45**
Appointment with GP
In last six months has seen GP 15 times, PN twice and has had eight home visits from CPN (for ongoing but unspecified problem).
9. **Female aged 61-75**
Appointment with GP (monitor progress with medication).
In last six months has seen GP six times (ongoing blood pressure and stomach problem) and PN twice (blood tests).

10. **Female aged 31-45**
Appointment with GP (bladder infection)
In last six months has seen GP eight times (recurring bladder infections and irritable bowel syndrome)
11. **Female over 75**
Appointment with GP (bleeding from ulcer)
In last six months has seen GP six times (monitoring blood pressure and ulcer) and PN twice (blood test and blood pressure check)
12. **Female over 75**
Appointment with GP (problem with blocked colostomy)
In last six months has seen PN 10 times (has known PN since childhood - seems to drop in for "general chat")
13. **Female aged 18-30**
Appointment with GP (confirmation of pregnancy and repeat prescription for son)
In last six months has seen GP twice (re son's eczema and "other childhood bugs")
14. **Female over 75 years**
Appointment with GP (kidney infection)
In last six months has seen GP "many times" (monitoring high blood pressure, artificial knee joints and chronic diverticulitis) and practice nurse once (blood pressure check)
15. **Male aged 61-75**
Appointment with GP (gout)
In last six months has seen GP six times (medication for asthma and "nerves")
16. **Male aged 46-60**
Appointment with GP (check up and medication for angina)
In last six months has seen GP once (same reason)
17. **Male aged 61-75**
Appointment with GP (check up following surgery for ingrown toenail)
In last six months has seen GP once (ingrown toenail)
18. **Male aged 46-60**
Appointment with GP (skin problem and repeat prescription for son)
In last six months has seen GP twice (persistent skin problem)

PRACTICE 'B'

1. **Female under 18** (interview with mother).
Appointment for baby with HV at clinic session (weighing and advice about weaning).
In last six months mother has also seen GP, PN, MW and HV for antenatal and postnatal care + attends HV clinic every fortnight.
2. **Female aged 75+**
Appointment with PN (for 75+ check).
In last six months has seen GP once (repeat prescription - arthritis) and PN once (jabs for holiday abroad).
3. **Female aged 61-75**
Appointment with GP (eye infection).
In last six months has seen GP once (eye infection) and counsellor several times.
4. **Female aged 31-45**
Appointment with GP (for medication following blood test)
In last six months has seen PN four times (blood tests and flu jab) and GP five times (results of blood tests and medication)
5. **Female aged 46-60**
Appointment with PN (blood test).
In last six months has seen PN 10 times (blood tests) and GP three times (cancer, shingles, chest infections, monitoring warfarin medication).
6. **Male aged 61-75**
Appointment with PN (for blood test)
In last six months has seen PN 12 times (blood tests), GP twice + 12 phone contacts (to discuss warfarin medication) and has had two home visits from DN (removal of stitches and catheterisation)
7. **Female under 18** (interview with mother)
Appointment with GP (baby had cold)
In last six months mother has seen GP three times, MW twice and HV four times (antenatal and post natal care)
8. **Female under 18** (interview with mother)
Appointment with HV at clinic session (baby weighing)
In last six months mother has seen GP 12 times, MW six times and HV seven times for antenatal and postnatal care (additional treatment and support for mother following isolated epileptic fit)
9. **Female under 18** (interview with mother)
Appointment with homeopath (child's asthma)
In last six months has seen GP three times (asthma and ear medication).

10. **Female aged 31-45**
Appointment with GP and PN (ante natal check)
In last six months has seen GP three times, MW once and PN three times (antenatal care + asthma).
11. **Female over 75**
Appointment with GP (persistent cough)
In last six months has seen GP six times (for same cough and "other minor complaints"
12. **Male aged 61-75**
Appointment with practice nurse (blood pressure and weight check)
In last six months has seen PN once (monitoring BP and weight)
13. **Female aged 61-75**
Appointment with GP (annual check up re heart condition)
In last six months has seen GP twice (muscle and hip pains) and PN once (flu injection, bp check, blood and urine tests)
14. **Female aged 61-75**
Appointment with PN (flu injection)
In last six months has seen GP twice (eye problem) and PN twice (removal of stitches and follow up to minor surgery)
15. **Female aged 46-60**
Appointment with GP (well woman clinic - PN also involved)
In last six months has seen GP twice (did not give reason)
16. **Female aged 31-45**
Appointment with GP (sinus infection)
In last six months has seen GP once (regular urine check for diabetes + flu jab)
17. **Male aged 61-75**
Appointment with GP (bladder cancer)
In last six months has seen GP four times (suffers from under active thyroid, polymyalgia, asthma and bladder cancer) and PN twice (blood tests, urine tests and management of asthma attacks)
18. **Female aged 31-45**
Appointment with GP (monitoring high blood pressure)
In last six months has seen GP three times (control of BP) and PN once (6 monthly check up for oral contraceptive)

The Patient Interviews

3.22 In the interviews data were collected on four main areas as follows:

*** PATIENTS' EXPERIENCE OF TEAMWORK:**

Patients were asked to recall visits to health professionals at their surgery during the six months prior to the interview. If patients had had consultations with different health professionals for related conditions, they were asked if they had received any **conflicting advice** from staff employed or attached to the surgery. Patients interviewed in the second phase were asked more specifically about the nature of the advice they had received. Patients were also asked about their perceptions of **communication** between health professionals and their views on having their case discussed by various health professionals.

The interview explored patients' experience of teamwork in terms of receiving advice from professionals and their perceptions of communication between health professionals.

It was anticipated that this information would indicate whether communication between health professionals was perceived as being higher in the practice with a high level of team work than the practice with a low level of team work.

*** PATIENTS' KNOWLEDGE OF THE ROLES OF HEALTH PROFESSIONALS:**

Patients were asked if they had had any contact with the practice nurse, district nurse and health visitor employed or attached to the practice and **what they felt each professional's job entailed**. Patients were also given a list of situations and asked **which health professionals they would contact initially for advice or treatment**. These conditions were: ear syringing; flu jabs; advice on giving up smoking; advice on diet; family planning; problems with a pre-school age child; problems with a school-age child; and, inoculations for a holiday abroad.

The interview explored the extent of patients' understanding of the roles of some health professionals and their view about the most appropriate person to contact in certain situations.

As a result of good communication, practices with a high level of team work are assumed to possess knowledge of each others roles and to communicate this information to patients. It was anticipated that data regarding patients' understanding of the jobs of health professionals would indicate whether patients from the practice with a high level of team work had greater knowledge about the roles of health professionals and which professional to see for particular conditions than those from the practice with a low level of team work.

*** PATIENTS' KNOWLEDGE OF THE PRACTICE AND THE STAFF:**

Patients were asked if they knew the **names of the staff** who worked at their practice and whether any of the staff wore **name badges**. In addition, patients were asked if they had seen any **information about the services that the practice offered** to patients and if so, if they had taken notice of such information.

The interview sought to identify sources of information for patients about staff and services offered.

Again, it was anticipated that this data would identify whether patients from the practice with high levels of team work were better informed than patients from the practice with low levels of team work. Discovering whether patients knew the names of staff was felt to be useful in indicating whether the practice with high levels of team work had a more friendly and informal attitude to patients than the practice with low levels of teamwork.

*** PATIENTS' VIEWS OF THE SURGERY**

Patients were asked for their views on the **attitudes of receptionists and the medical staff** at the practice. They were also asked what they felt was the **best and poorest aspect of the practice**.

The interview sought patients' views on staff attitudes and sources of patient satisfaction.

High levels of team work are thought to result in high morale among team members which may translate into greater patient satisfaction. It was felt that discovering patients' views of the practice would reveal whether patients in the practice with high levels of team work were more satisfied with their practice than patients in the practice with low levels of team work.

FINDINGS

EXPERIENCE OF TEAMWORK

Conflicting Advice

3.33 No patients in the **first set** of interviews reported receiving any conflicting advice from different health care professionals. Examination of the data revealed that there were some differences, however, between the experiences of patients in the two practices. Patients in practice 'A' seemed to be less likely to actually receive advice from more than one health professional than patients in

In the first set of interviews no patients reported receiving conflicting advice. The data suggests, however, that the

practice 'B': only three out of seven patients in practice 'A' who were in contact with more than one health professional for a condition received advice compared with six out of nine patients in practice 'B'. In addition, patients from practice 'B' reported receiving advice from a wider range of professionals than those in practice 'A'. In practice 'A' two of the three patients who received advice from more than one professional received this from the GP and practice nurse about giving up smoking in one case and reducing weight in the other. The third patient reported receiving non conflicting advice from GP and CPN but was not specific about the nature of the advice. Patients from practice 'B' reported receiving non-conflicting advice from GP and practice nurse; health visitor and midwife; health visitor, practice nurse and GP; and, GP and homeopath.

3.34 It was felt that it would have been interesting to have asked patients more about the nature of the advice received, distinguishing between advice about coping directly with a particular health problem or illness and advice about keeping in good health. Consequently in the second set of interviews patients were asked if they had received advice of those particular sorts in the context of their recent contact with GPs and practice nurses, those being the only professionals involved.

3.35 More patients from practice 'B' (7/8) than from practice 'A' (5/9) reported receiving advice in the course of recent contact with health professionals. There was a particularly marked difference in the number receiving advice about keeping in good health (5/8 patients from practice 'B' compared to 1/9 from practice 'A'). Patients from practice 'B' were also more likely to have received a range of advice. Three had received advice both about coping with a health problem and about keeping in good health. Two patients also mentioned having received advice and support in the role as carer of a spouse and both felt that this had contributed to their own health.

3.36 The principal advice givers at both practices were the GPs. It could be suggested then that the offering of a broader range of advice to patients from practice 'B' could be attributed in part to a more holistic approach to patients on the part of the GPs with a greater emphasis on health education. Patients from practice 'B', however, were also more likely to have received advice from a practice nurse. Only one patient from practice 'A' had received advice from a practice nurse who had repeated and reminded her of the GPs instructions about medication. In contrast four patients from practice 'B' had received advice from a nurse. Two patients had received advice about coping with a respiratory illness which was complementary to other advice given by the GP and two

patients from practice 'B' were more likely than those from practice 'A' to receive advice from more than one of a wider range of health professionals.

Patients interviewed subsequently, (whose contacts were limited to GP and/or PN) were asked more about the nature of advice received.

Patients from practice 'B' were found to be more likely than those from practice 'A' to have received a range of advice and in particular to have received advice about keeping in good health.

Principal advice givers at both practices were the GPs. Patients from practice 'B' were more likely, however, to have received advice from a practice nurse with a clearly defined role in this respect. Teamwork implies a recognition

patients had received advice from the nurse about diet and exercise. Both these patients had also had contact with the GP but had received advice specifically from the nurse. This would seem to suggest that the role of the practice nurse in relation to advice giving was more clearly defined at practice 'B' - a suggestion which is supported by comments made by the professionals themselves in individual interviews. The important issue in relation to teamwork, then, is perhaps not just that there should be avoidance of conflicting advice but also that there should be an understanding of who may be the most appropriate person to offer advice in a given set of circumstances. Whilst it may be helpful for some patients if advice offered by one professional is echoed and reinforced by another such duplication of advice may otherwise be unnecessary.

3.37 The assumption being made here is that patients benefit from receiving advice. With one exception, patients who had received advice also seemed to regard it as appropriate and potentially beneficial to them.

3.38 It is interesting to consider the views of patients who had not received advice during their recent contact with the health professionals. In most cases they were satisfied that no advice had been warranted in their circumstances. For example, three patients at practice 'A' and one at practice 'B' had long term health problems, said they were following advice given in the past and had not expected to receive further advice. Some other patients believed that they were already following a healthy lifestyle and needed no further advice about keeping in good health. Three patients, however, all from practice 'A', identified a need for advice which had not been met. That is to say advice had not been offered and they had for various reasons not felt able to ask for it. It is open to speculation as to whether the lack of advice made available to these patients can be linked to the individualistic style of working of health professionals at practice 'A'.

3.39 Patients in both practices expressed very positive views about practice nurses, finding them friendly and caring and feeling comfortable in discussion with them:

" We talk over my asthma attacks - when I have them and how I deal with them." (practice 'B', interviewee 17)

It would seem that there is great potential for the practice nurse to contribute to the care and education of patients in the advice giving role and that this may have been maximised more effectively through teamworking at practice 'B' than at practice 'A'.

of who may best offer advice in given circumstances. Teamwork may, therefore, result in less unwarranted duplication of advice as well as less conflicting advice.

Most patients appreciated receiving advice.

Most of those who had not received advice during recent contact with health professionals were satisfied that none had been warranted. Three patients from practice 'A', however, identified a need for advice which had not been met.

The data suggests that the potential for practice nurses to contribute to the care and education of patients in the role of advice giver may be realised more effectively through teamwork.

Communication

3.40 Good communication between professionals to allow pooling and exchange of information about patients where appropriate has been seen as an important element of well developed teamworking. For some of the patients interviewed, rather more at practice 'A' (7/18) than at practice 'B' (3/18), no data was forthcoming about communication between professionals involved in their care. This was either because their recent health care experience had been confined to contact with just one professional or because the contacts they had had with different professionals were not seen to be sufficiently linked to warrant any such communication.

3.41 More patients from practice 'A' (10/18) than from practice 'B' (8/18) said they were **aware** that the health professionals they came into contact with had communicated regarding their condition. A closer look at what had taken place revealed that in practice 'A' the communications referred to were, in all but one case, between the GP and practice nurse. Only three patients were aware that the professionals concerned had actually spoken together about their case - they otherwise perceived the communication to involve the sharing of information via a common set of patient notes.

"She (PN) has always got my notes there. I don't get the feeling that she's talked to the doctor about me but there's no need." (practice 'A', interviewee 2)

"I don't think they do talk - they don't have the time. They have to rely on notes." (practice 'A', interviewee 14)

In practice 'B' the communications were between a wider number of professionals: GP and practice nurse; midwife and health visitor; GP and health visitor; GP and midwife; and, GP and homeopath. These contacts may be more time consuming necessitating phone calls, messages or face to face discussion.

"It was obvious that the GP and the homeopath had discussed the case. He knew all the background including details of exactly what medication she was taking." (practice 'B', interviewee 9)

3.42 No patients from practice 'A' reported a breakdown of communication between health professionals regarding their condition but two patients from practice 'B' mentioned an occasion when important information had not been passed on. This lack of communication concerned a GP and health visitor in one case and a health visitor and midwife in the other. The additional effort

Good communication is seen as fundamental to teamwork. Data was forthcoming only from those patients who had had linked contacts with more than one professional.

The instances of communication reported by patients from practice 'A' were almost exclusively between GP and practice nurse and most involved sharing information via a common set of notes. The instances reported by patients from practice 'B' were between a wider range of professionals involving phone calls messages or face to face discussion.

Instances of lack of communication between professionals reported by two patients from practice 'B' suggest that the

required to keep in contact for professionals who are not working daily in close proximity to each other may account for the failure of communication in two cases in practice 'B'. The potential for patients receiving conflicting advice or for a breakdown in communication is greater when all members of the PHCT are involved in caring for individual patients rather than where involvement centres around the GP and practice nurse. It is likely that the fact that GP and practice nurse share patient notes and are on site are important factors in aiding communication between these two professionals.

3.43 All interviewees stated that they had no objections to being discussed by health professionals. Indeed, on the contrary they positively welcomed being discussed. Typical comments from interviewees regarding this were:

"The only way to get help is if professionals discuss you. I don't mind at all" (practice 'A', interviewee 8)

"I have no concerns about health care staff discussing me. It can only be to the patient's benefit. I'm confident they are discreet" (practice 'B', interviewee 6)

3.44 Five patients at Practice 'B' compared to only one at Practice 'A' had not been recently aware of professionals communicating about their condition. Four of those five patients from Practice 'B' were, however, quite confident that the professionals **would** do so if the need arose. Their confidence seemed to result from past experience and seemed to be linked to satisfaction with their care:

"I am confident that she (the practice nurse) would talk to the doctor. They talked together at the start about the arrangements for monitoring my blood pressure and once again as soon as a problem arose because I put on weight. They work very well together." (practice 'B', interviewee 12)

"They are not talking behind your back for gossip reasons but to be totally genned up about what's going on. I feel more inclined to take advice from these doctors than any I've ever known because they regularly look back through the notes and consider the antecedents". (practice 'B', interviewee 18)

3.45 The latter of those two patients' comments reveals that communication between the different GPs at a practice may be as important to them as communication between different professionals - a point which is sometimes overlooked in discussion

potential for such breakdown in communication is greater when care is shared between professionals who do not share a common work base or use the same patient notes.

All interviewees said they had no objections to being discussed by health professionals; in fact they positively welcomed it.

There were several patients from practice 'B' who had not been recently aware of professionals communicating about their condition but most were confident, on the basis of past experience, that such communication would take place if the need arose.

Discussions about teamwork tend to focus on interactions between members of

of team working which focuses on interactions between the disciplines. In the first set of interviews, patients were not asked directly if they had a preference for seeing one doctor in particular. This emerged as an issue of importance, however, for patients at the large group practice 'A'. It emerged that patients at practice 'A' perceived their GPs to have very individualistic styles. Every one of the nine patients interviewed expressed clear ideas about which of the partners they would prefer to see. Six had a strong preference for one (not the same) GP only and said they would not see another except in an emergency whilst two said they liked and would see any of just two or three doctors. Only one patient, whilst identifying one GP in particular as her "own", did not in practice mind who she saw. In contrast, only one of the 10 patients from practice 'B' who took part in the first set of interviews made any comment at all directly relating to this subject and this was to say that she did not mind which doctor she saw.

3.46 When the second group of patients was interviewed it was decided to ask each patient if they habitually asked to see one GP in particular. The patients from Practice 'A' responded similarly to the first group. Five patients expressed a strong preference for one GP they saw as their "own"; one liked and saw either of two GP's and two identified their own GP but did not mind seeing another. In contrast, with only one exception, the patients at practice 'B' said they had no personal preference for seeing one GP in particular.

3.47 It was clear that patients from both practices valued a warm personal relationship with their doctor. Patients from practice 'A' were more likely than those from Practice 'B' to look for and find this in an exclusive relationship with one GP:

"I always see the same doctor. He knows me and my family well." (practice 'A', interviewee 6)

"I would see either doctor because they are both very nice to patients" (practice 'B' interviewee 15)

Beyond that, the patients obviously also valued continuity of care. The data would seem to suggest that patients from Practice 'A' may have found that this was best achieved by keeping where possible to one GP:

"Each does their best but you get to know one better. I don't think they talk to each other. They don't have the time. They have to rely on notes. So its much better to rely on one who knows your case history. I was in bed for three weeks and didn't always get the same doctor on call.

different disciplines. Patients comments reveal, however, that they perceive communication between different GPs at a practice to be of critical importance. It became clear that patients at practice 'A' perceived their GPs to have very individualistic styles.

Most patients from practice 'A' were found, moreover, to have clear preferences regarding their GPs whilst those from practice 'B' did not.

Patients from both practices valued a warm relationship with their GP and a sense of continuity of care. Many patients from practice 'A' sought and found this through keeping, where possible, to one GP but patients from practice 'B', who seemed to experience greater confidence in levels of communication between GPs, were not so concerned to have an exclusive relationship with one GP.

They gave me different medication and sometimes it was a bit confusing." (practice 'A', interviewee 14)

Patients from Practice 'B', whilst expressing no personal preference for a particular GP, were also mindful of the fact that for any one episode of illness it might be better to follow through with one doctor. The difference seems perhaps to be found in a greater confidence that, should this not be possible, continuity of care would still be preserved:

" If I've already been about something then I try to see the same doctor but there isn't a problem if you can't. They read all the notes and know why you're there." (Practice 'B', Patient 16)

Once again confidence in levels of communication would seem to be a key factor. The issues raised here in relation to continuity of care between members of the same profession would seem to have equal relevance to other professions within the primary health care team.

3.48 The data collected on patients' experiences of team work illustrate the different ways practices with high and low levels of team work operate. As would be expected in practices with high levels of team work, patients from practice 'B' experienced more contact with a range of health professionals than patients from practice 'A'. In addition, to the patients, communication between these professionals seemed to be relatively high. In practice 'A', where professionals worked more individualistically, communication between GP and practice nurse was reliable but there seemed to be little communication for other members of the PHCT. While some patients from practice 'B' experienced a failure of communication - a risk where more people are involved - other patients appeared to benefit in the areas of advice and communication when team work was working well. These data suggest patients in practices with high levels of team work are likely to experience more advice, notably about keeping in good health, from a range of health professionals and, as a result of good communication between professionals, experience quick referral to the most appropriate health professional and a sense of continuity of care.

The data on patients' experiences of team work illustrate how practices with high and low levels of teamwork operate. It suggests that patients in practices with high levels of teamwork may receive more advice, notably about lifestyle, from a range of people, and due to good communication, experience quick appropriate referrals and a sense of continuity of care.

KNOWLEDGE OF ROLES OF HEALTH PROFESSIONALS

Roles

3.49 Most patients (13/18) in both practices had an understanding of the role of district nurses as providers of nursing care at home for the elderly, infirm or convalescent. Only two patients at practice 'A' and five patients at practice 'B' had either received care from a district nurse themselves or had contact with a district nurse who was caring for a close family relative. This understanding seems not, therefore, to originate largely from personal experience. Fewer patients, (8/18 from practice 'A' and 11/18 from practice 'B') had a general understanding of the role of health visitors in providing advice and support to mothers and monitoring the development of babies and children. More patients (8 at each practice) recalled personal contact with a health visitor at some stage in their life, albeit many years ago for some, and few of those who had not had personal contact could say what a health visitor's job might entail. In this case, therefore, it seems that understanding was more likely to have been informed by personal experience. It may seem unsurprising that the majority (12/17) of those who were ignorant of the health visitor's role were either men or women over 60 who might reasonably judge such knowledge to be irrelevant to them. It is interesting then that the district nurse is a more familiar figure, even to those in the younger age groups and without personal experience.

3.50 Every patient interviewed had, at some time, seen a practice nurse and had some understanding of what her job might entail. Interviewees were asked to state the activities that they felt practice nurses undertook and most mentioned several at least, based largely on their own experience or that of family members. All patients but one in both practices clearly understood the "treatment room" role of practice nurses mentioning tasks such as dressings, removal of stitches, injections and taking blood. There was a difference, however, between the practices regarding patients' perception of practice nurses' health promotion role. For the purposes of analysing these data, the activities defined as constituting health promotion were: advice relating to lifestyle (diet, smoking, weight); weight checks; blood pressure checks; over 75's assessments and, well person clinics. In practice 'A' fewer than one third of the patients interviewed (5/18) identified any health promotion activities but in practice 'B' two thirds of patients (12/18) did. Only one of these patients from Practice 'A', moreover, identified the giving of advice as part of her role - the testing of blood pressure was the activity most frequently mentioned (by 4/5). The patients from Practice 'B' mentioned a wider range of health promotion activities and most included the

Most patients had an understanding of the role of district nurses which did not seem to be wholly dependent on having had personal contact. Fewer patients had a general understanding of the role of health visitors and where knowledge existed this seemed to be related to personal experience.

Every patient had seen a practice nurse and had some knowledge of what her job entails. The 'treatment room' role of practice nurses was widely understood. There was a marked difference, however, between the practices in terms of patients' perceptions of the nurse's health promotion role. More patients from practice 'B' cited health promotion activities and most mentioned giving advice.

giving of advice in their list.

Consultations

3.51 A difference was found between patients from practice 'A' and practice 'B' regarding the health professional they would contact for a list of situations. The eight situations that were presented to patients were ones that it would not be **necessary** to consult a GP about. In responding to this question patients from practice 'A' were more likely to say they didn't know who they would contact or to discount the question, regarding it as inapplicable to their situation. Where answers were given, patients from practice 'A' were overall much more likely to report that they would consult a GP for advice or treatment for these conditions than practice 'B' who were more likely to consult the practice nurse. This is consistent with the data provided on the screening questionnaire by patients from the two practices which showed that the recent health care of patients from practice 'A' had been characterised by more contact with a GP than that of patients from practice 'B' who were more likely to have been in touch with other professionals, particularly the practice nurse.

3.52 Some specific examples illustrate this point. Interviewees were asked who they would contact if they thought that their ears needed to be syringed. Twice as many patients from practice 'A' (12/18) as from practice 'B' (6/18) reported that they would consult a GP first. In contrast a much greater proportion from practice 'B' (11/18) than from practice 'A' (4/18) said they would consult a practice nurse first. Most patients were aware that the practice nurse was the person who would actually syringe the ears. The difference seemed to be that patients from practice 'A' were more likely to believe that the practice nurse **could or should** do so **only** at the GP's direction, whilst patients from practice 'B' were more likely to judge the nurse as competent to decide when she should proceed and when she should refer to the GP. For another example, interviewees were asked who they would consult for advice about a slimming diet. In this case a similar number of patients from both practices said that they would consult a GP (10/18 patients from practice 'A' and 8/18 patients at practice 'B'). It is interesting, however, that whilst the remaining eight patients at practice 'A' either said that they didn't know who to consult or said that they would not consult a health professional at all, nine of the remaining ten patients from practice 'B' said that they would consult a practice nurse.

3.53 Few patients mentioned any other health professionals in response to these questions. The health visitor was mentioned by fewer than one in three patients at either practice as a source of

There was a difference between the practices regarding patients' perceptions of the appropriate health professional to consult in some situations. Patients from practice 'A' were, overall, more likely to say that they would consult a GP first than patients from practice 'B' who were more likely to consult a practice nurse.

The patients response to two of the given situations is described in order to illustrate that general finding. Patients from practice 'B' were more likely to consult a practice nurse first in both situations revealing a different perception of her role and status in relation to the GP.

Few patients mentioned any other professionals in

advice for problems with babies or toddlers which would seem to be consistent with the earlier finding that the role of the health visitor is not generally well known to patients at either practice.

3.54 These data indicate that patients in the practice with a high level of team work had a greater awareness of the health promotion activities of their practice and of the role of the practice nurse in this area. The fact that a greater proportion also reported having received advice about keeping in good health suggests that this awareness is linked to take up of these services. Data collected during phase one of this study reveals an expressed commitment from both practices to health education as a worthwhile activity to meet the needs of patients. The practice with the high level of teamwork, however, would seem to have been able to carry out more health promotion activities and to create a greater awareness of health education issues. Important factors would seem to be the clear definition of the role of practice nurses and good communication and accessibility between GPs and practice nurses.

3.55 There is also some evidence that patients in team oriented practices may have better knowledge about the most appropriate health professional to see for various conditions. This knowledge may be largely confined to the role of the practice nurse but nevertheless if this is the case, this may enable patients in practices with high levels of team work to receive better and quicker care as well as saving GPs' time.

KNOWLEDGE OF THE PRACTICE AND THE STAFF

3.56 Patients were asked if they knew whether their surgery provided any information in leaflets or on notices about the people who worked at the surgery or the services offered at their practice.

Staff names

3.57 Similar numbers of patients at both practices (7/18 at practice 'A' and 9/18 at practice 'B') reported seeing photos and job titles of members of staff displayed on the wall in the surgery waiting room. Most patients thought that this was a good idea although some pointed out that a job title doesn't tell you what a person actually does:

" The photos are up in the surgery. One thing mystifies me though - what does the Practice Manager do?" (practice 'B' interviewee 1.)

response to this question.

This data suggests that the practice with the high level of team work has been able to carry out more health promotion activities and create greater awareness of health education issues.

Patients in team oriented practices may be better informed about the appropriate professional to consult for some conditions.

Patients were asked if information is provided.

Patients from both practices had seen a 'portrait gallery' in their surgery waiting room. Patients from practice 'B', however, mentioned a greater variety of additional sources of information about staff names than patients from practice 'A' with particular

For the patients from practice 'A' the portrait gallery seemed to be the principal source of information about staff names. Only five patients thought they had seen any members of staff - mainly the practice nurses - wearing name badges and none mentioned having received a practice information leaflet. In contrast the majority of patients from practice 'B' (14/18) recalled receiving a practice brochure and nine referred to this specifically as a source of information about the names of staff. Half the patients from practice 'B' (9/18) reported seeing practice staff wearing name badges and in addition several mentioned that a notice is always displayed on the reception counter giving the names of the receptionists and the practice manager on duty.

recognition of the practice leaflet.

3.58 More patients from practice 'B' (11/18) than from practice 'A' (8/18) said they knew the names of one or both of the practice nurses. The difference between the two practices was more marked in respect of patients' familiarity with the names of receptionists. Only one of the eighteen patients interviewed from practice 'A' knew the names of more than one of the receptionists compared with twelve of the eighteen patients from practice 'B'. The fact that more patients from practice 'B' knew the names of staff members may indicate that the practice with strong team work may be more informal and friendly than the practice with lower levels of team work and that this may occur as a result of team work. However, team work may not be the only factor that explains this. A number of other factors, such as personalities of the GPs and other staff, could account for this apparent difference.

More patients from practice 'B' than practice 'A' knew the names of practice staff. This may indicate that the team oriented practice is more informal and friendly due to teamwork. Staff personalities may also account for this apparent difference.

Services offered by the practices

3.59 The majority of patients at both practices were aware of a source of information about activities carried out in their surgery. The source of information about services which was most often mentioned by patients at practice 'B' was once again the practice leaflet although some also referred to a surgery notice board. Patients at practice 'A' referred most frequently to an abundance of posters, notices and leaflets displayed in their surgery. These were said to be concerned with a wide range of subject matter beyond surgery based activities such as self help groups, voluntary organisations and DSS benefits.

There were differences between the practices regarding the source of information about services most commonly mentioned by patients.

3.60 It seems that patients may not always pay much attention to the information being provided. Patients from both practices said that unless they were seeking information on a particular activity they tended not to read notices in the waiting room. One interviewee, for example, said:

Patients may not always pay much attention to information which is provided.

"They have a big blackboard in reception telling people what's going on but I don't really take much notice of it. I'm very selective in what I take notice of. I expect it's all there but I don't take any notice of it" (practice 'B', interviewee 4)

Another said:

"There's a range of leaflets and posters on the wall but I haven't taken much notice of them really." (practice 'A', interviewee 7)

It is equally possible that patients from practice 'B' may not have read and gleaned information from their practice leaflet although only two admitted to having little or no idea of what it contained.

3.61 It is hard to draw definite conclusions from this data but the high level of awareness about the practice leaflet may indicate that practice 'B' had made more effort to convey information about staff and services effectively to their patients.

3.62 This question focused on written or other visual information. Patients also receive information by word of mouth to which they may pay more attention. Receptionists are an obvious source but consensus on the view that they should not routinely quiz patients about their reasons for wanting an appointment means that they can only provide information if patients are prepared to ask for it. In a practice where patients' health care is centred on contact with a GP, then he or she would seem to have a major role to play in telling patients about the services other professionals may offer.

Practice 'B' may have made conveyed information more effectively.

Information may be communicated more effectively to patients by word of mouth. Staff should take every appropriate opportunity to educate patients about services of other professionals.

VIEWS OF THE SURGERY

Receptionists

3.63 Patients from practices 'A' and 'B' rated the attitudes of receptionists highly. All patients from practice 'B' (18) and all but three patients from practice 'A' (16/18) rated receptionists as friendly when greeting them at the surgery or on the telephone. Typical comments were:

"When you go in the surgery they are pretty friendly. They ask you to take a seat and they call you by your name. They take an interest in a young family and know who you are. That's quite an achievement with that many patients" (practice 'A', interviewee 1)

Patients rated the attitudes of receptionists highly. Most rated receptionists as friendly when greeting them at the surgery or on the telephone.

"They are very good - open and friendly and call me by my name." (practice 'B', interviewee 12)

3.64 Patients were also asked about making appointments and how helpful receptionists were. All patients but two from practice 'A' (16/18) and all but one from practice 'B' (17/18) rated receptionists as helpful. Typical comments made were:

"They are very good, I've never had any problems. There's no problem getting an appointment and they always fit in the children. Also I've never had any problem getting home visits." (practice 'A', interviewee 1)

" You can get appointments easily. My husband has poor health and they always treat him as urgent - its very reassuring." (practice 'B', interviewee 15)

3.65 Those patients from practice 'A' who found the receptionists unfriendly felt that they had not been acknowledged as an individual. For example:

" When you go into the surgery you are a bit like a number - just another person....they just look up and ask you to take a seat." (practice 'A', interviewee 6)

In most patients experience, for non urgent matters, appointments were often not available as soon as they would have liked. Most patients seemed to recognise, however, that receptionists are not to blame personally if they cannot offer an immediate appointment with the doctor of their choice. The two patients from practice 'A' who criticised receptionists were exceptional in this respect. One said:

"They can be bullying, dismissive and off hand - they tend to treat you as though you are a time waster. They ask you whether it's urgent and they try to put you off. Eventually they will grudgingly fit you in. (practice 'A' interviewee 7)

The one patient from practice 'B' who described the receptionists as unhelpful was less specific:

" They don't have a lot of initiative. It depends on the person but generally they are not very helpful." (practice 'B', interviewee 8)

Most patients also found receptionists to be helpful when making appointments.

The few patients who found receptionists unfriendly or unhelpful felt that they had been treated impersonally or not taken seriously.

Medical Staff

3.66 Patients were asked to think about the doctors and nurses who worked at their surgery and to describe their attitude to patients. It was hoped that their comments would reveal the patients' perspective of what is important about the way in which professionals approach their interaction with patients. The intention was also to look for evidence to suggest that the way in which professionals work together affects their approach to patients.

3.67 In their responses patients referred to a number of aspects of the way in which the medical staff at their surgery behaved towards them. It was clear that the most pertinent criteria from the patients' perspective are, firstly, how friendly and approachable the staff are to patients and, secondly, how willing they are to listen, give them time and make them feel valued.

3.68 Every patient from both practices made a positive evaluation of the attitudes of some or all of the medical staff at their surgery. Some expressed this positive view in very general terms but most of the specific comments evaluated the attitudes of the medical staff on the basis of the two criteria referred to above.

Some patients referred to the staff in general:

"I have no adverse criticism. No one is brusque to patients that I've ever seen. They are always friendly, will listen and give you time." (practice 'A', interviewee 17)

whilst others mentioned doctors and nurses separately:

"The doctors are exceptionally kind, always give you their time, and truly and above all listen carefully to what you have to say. There is no sense of hurry - it's a pleasure to see them. The practice nurses are always welcoming and friendly and always helpful." (practice 'B', interviewee 13)

3.69 Without exception patients who commented specifically about nurses - in most cases the practice nurses only but in two cases midwives and health visitors were included - rated their attitude very highly. The comments in relation to doctors however were not exclusively positive:

"Some doctors have an attitude problem, especially towards new mothers. They are not very understanding but seem to think you are making a fuss and wasting their time. The health visitor, midwives and nurses are very friendly and

Patients descriptions of the attitudes of medical staff were sought in order to reveal patients' priorities and possible influence of team work.

The most pertinent criteria for patients are friendliness and willingness to listen.

All patients were positive in their evaluation of some or all of the medical staff at their surgery. Most specific comments rated staff according to the two criteria referred to above.

Every patient who referred specifically to nurses rated their attitude to patients very highly. Specific comments in relation to doctors were not exclusively positive.

helpful. " (practice 'A', interviewee 13)

3.70 In patients' descriptions of the attitude of their GPs there would seem to be further evidence that patients from practice 'A' perceived the GPs at their surgery to have markedly differing attitudes and styles and that most had strong views about the GP(s) they got on best with. One patient's favourite was another's last choice so it would seem that this may be largely a matter of personality. Seven patients, whilst speaking positively about the attitude of their preferred GP(s), pointed out that the doctors were "not all the same". For example:

" Some GP's can be rather abrupt - act as though you are bothering them - but generally they are pretty good." (practice 'A', interviewee 10)

Patients from practice 'B', with fewer GP's, whilst describing differences between the personalities of the GPs, did not express likes and dislikes in the same way.

3.71 Clearly patients like both reception and medical staff to be friendly and approachable and they hate to be made to feel that they are wasting someone's time. It appears that overall levels of satisfaction with the attitude of staff in these respects were high in both practices, although some patients at practice 'A' had reservations about some doctors. It is not clear then how teamworking relates to these issues. It was suggested by the staff interviewed in phase one of this study that the high morale associated with more developed teamworking would somehow be conveyed to patients in the way they behave towards them. If this were to be the case one might expect patients from practice 'B' to be consistently more positive in their description of staff attitudes. In fact this was not the case at all with respect to nursing staff and it seems that perceptions of GPs' attitudes may relate to personality differences.

3.72 Of some relevance to teamwork, however, it is perhaps worthy of note that three patients from practice 'B', in answering this question, felt moved to refer to the attitude of staff, not only to patients but to other professionals. For example:

"I have a good relationship with the practice nurse and so I feel it must be this way between all the surgery staff." (practice 'B', interviewee 12)

"All the staff are approachable and they all work wonderfully well together" (practice 'B', interviewee 17)

This data provided further evidence that patients from practice 'A' perceived their GPs to be markedly different individuals and had strong views about who they could get on with.

It is unclear how team work relates to issues raised by the data on staff attitudes. The hypothesis that staff experiencing high morale associated with teamwork convey this in their attitude to patients is not supported by the finding that levels of satisfaction with staff attitudes were high in both practices.

Interestingly, a number of patients from practice 'B' commented positively on the way in which practice staff work together.

Best and poorest aspects

3.73 In both practices patients were more willing to praise than to criticise their surgery. Some expressed an overall satisfaction in general terms and were unable to single out for special mention any aspect of the care they had received. Some were quite detailed in their comments mentioning a range of inter-related aspects of care.

Patients were more willing to praise than to criticise their surgery.

3.74 In making positive comments about the surgery patients from practice 'A' tended to focus on what they liked about their GP. Eight of the thirteen patients who identified a "best aspect" mentioned the GP's attitude towards them. The following are typical of such comments made by patients from practice 'A':

Patients from practice 'A' tended to focus on what they liked about their GP. Some also mentioned the efficiency of the appointment system.

"Most people realise that doctors are pressed for time these days, yet you don't feel that you are on a clock, they don't ever hurry you" (Practice 'A', interviewee 6)

"It's the fact that the GPs treat you personally despite their large bank of patients" (Practice 'A', interviewee 8)

Three patients mentioned the efficiency of the appointment system indicating that delays are infrequent.

3.75 In practice 'B' patients clearly thought highly of their GPs but also made more extensive positive comments referring to the practice staff in general, the comprehensiveness of services and the emphasis the practice had on patient education and health promotion. Typical comments from practice 'B' patients were:

Patients from practice 'B' tended to comment more widely referring to the practice staff in general, the range of services and the emphasis on patient education and health promotion.

"This surgery comes out very highly compared to most I've known in my time. They are prompt, supportive and seem to understand. This goes for all the staff - they don't mind you contacting them, they are very flexible" (practice 'B', interviewee 6)

"It's a very happy surgery which is reflected in the way you are greeted and seen. All this gives you confidence. It's lovely to go down there. The new surgery has room for all the visiting staff they have. This has added to the breadth of services offered on the spot and adds to convenience for the patients. (practice 'B', interviewee 12)

"It's the excellence of the doctors. They are so clued up with the latest knowledge. I'm particularly impressed with the emphasis they place on preventative medicine and

raising awareness that lifestyle may be detrimental to health" (practice 'B', interviewee 9)

3.76 In practice 'A', less than half the patients (7/18) made a comment about the 'poorest' aspect of care provided by the practice and there was no agreement on the negative comments that were made. Two patients mentioned the dismissive attitude of some GPs to patients and there were isolated references to various problems connected with accessibility of services such as inconvenience of surgery times, parking problems at the surgery and difficulty getting through to the surgery on the phone. In practice 'B', half the patients (9/18) made a comment about the poorest aspect of the care provided at the surgery. Five patients from this practice noted that waiting to see the doctors because surgeries ran late was a problem although they were aware that this problem arose because the GPs were willing to give time to patients.

3.77 The fact that the patients from the two practices made broadly different kinds of comments regarding 'good' and 'poorest' aspects of the practices suggest that they do have an awareness of their practice style and that there are indeed some differences between the two practices. Patients from practice 'A' focused on the GPs in assessing the practice, thus illustrating the traditional way that this practice worked with GPs at the centre. Patients from practice 'B' focused more on health education and the medical staff in general, suggesting a response to the team approach at this practice. This would seem to suggest that the service to patients is enhanced by high levels of teamwork. However, patients from both practices expressed high levels of satisfaction with the services being offered. This may be because patients were reluctant to express dissatisfaction or because their expectations are shaped by the kind of service they are accustomed to receiving. Whatever the case, patient satisfaction is probably not a straightforward measure of the patient benefit associated with team work. The fact that some patients noted long waiting times as an inevitable consequence of a thorough, holistic and educating approach to patients, moreover, highlights the fact that where there are benefits to patients there may also be disadvantages.

A minority of patients from practice 'A' identified a 'poorest' aspect and no common theme emerged. There was evidence of some consensus in the comments made by patients from practice 'B' that waiting times at the surgery can be long.

The data suggests that patients do have an awareness of practice style and that there are differences between these two practices. There are indications that the service to patients is enhanced by high levels of teamwork but that teamwork may not be without its disadvantages. Patient satisfaction is probably not a straightforward measure of the patient benefit associated with teamwork.

4. CONCLUSIONS

4.1 Managers and practitioners regularly make judgements on the basis of their professional expertise about the benefit for patients which may be associated with aspects of clinical practice or management and delivery of care. This study sought to investigate patients' experience and awareness of aspects of interdisciplinary teamwork in primary care, to identify the potential benefits and explore the link with patients' satisfaction.

4.2 As a preliminary step data were gathered about the current levels of teamwork in primary care in the county. There was widespread evidence that practices had been influenced by the prevailing ideas about teamwork. There were few objections to the idea in principle, but the level of commitment to making changes and the progress being made was variable. Whilst some practices were found to be characterised by individualistic working practices, others were achieving greater levels of integration and coordination of their activities. Some achieved this through consensus about the definitive role of the GP as leader whilst others were working to a democratic model which recognised the status of all members of the team.

4.3 The data collected subsequently in the case study of two practices indicated that some potential benefits to patients can be identified through interviews with patients. There was evidence that the practice which had high levels of team work offered patients benefits through greater access to appropriate health professionals, greater awareness of health promotion and more opportunity for health education and advice, particularly from practice nurses. Greater confidence in perceived levels of communication between team members was seen to be linked to a valued sense of continuity of care.

4.4 Patients' satisfaction represents a complex mixture of perceived need, expectations of care and the experience of care (Wilkin et al, 1992) and it does not seem to be a wholly straightforward measure of patient benefit. While the practice with high levels of teamwork offered more benefits to patients than the individualistic practice, patients at both practices expressed high overall levels of satisfaction with their practice. The areas patients focused on in reporting their satisfaction, however, reflected the extent to which each practice operated as team. While patients from the individualistic practice focused on the approachability and friendliness of the individual health professionals with whom they came into contact, patients from the team oriented practice focused on the practice staff as a group and the emphasis given to patient education and health promotion. This would suggest that patients from the individualistic practice might well be more broadly satisfied if their practice adopted a more integrated team approach.

4.5 This study has provided evidence of the important contribution that the practice nurse can make in the area of health education. Since the data were collected for this study there have been changes to the organisation and funding of primary care health promotion programmes. (British Medical Journal, 1992). Practice nurses have a key role to play in working towards achieving the targets outlined in the government white paper "Health of the Nation" (DOH, 1991). The continuing extension of the practice nurse role has implications for the roles of other members of the primary health care team. There is evidence that health visitors, for example, perceive an erosion of their own role which has traditionally had a strong health promotion element. GP fundholding, which is proving a powerful force for

change has led some health visitors to fear that GPs might prefer to employ further practice nurses in place of health visitors (Exworthy, 1993). The processes of teamwork would seem to be essential to appropriately differentiate and integrate the activities of these different health professionals in recognition of the skills they have to offer and the contribution they can make. The potential for practice reorganisation which GP fundholding offers may provide the stimulus for more effective teamwork.

4.6 It is a regional objective to make primary care the principal focus of responsibility for health (Meads, 1993). Implicit is an extension of practice based care with transfer of some interventions from secondary to primary care and the development of primary care led purchasing models. The general practice-based team is looked to as the standard future unit of primary care. In this area, as elsewhere across the country, the coming together of the DHAs and FHSA as a Health Commission with responsibility for purchasing primary health care services for non fundholders has strengthened the commitment to integrate nursing services effectively within the primary health care team. Achievement of these objectives in order to enhance patient care will both promote and depend upon a continuing process of team development.

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APPENDIX

Checklist of Indicators - Measure of Teamworking

Criteria for judging each item.

1 - the individual recognises him/herself to be a member of a PHCT

The individual should answer "yes" to the question:

"Do you consider yourself to be part of a team at this practice?"

and mention at least the seven categories of staff defined as comprising the core PHCT in response to the question:

" Can you tell me which other people you see as members of this team - their job titles rather than their names?"

In cases where the individual failed to identify the full PHCT the following question served as an additional prompt:

" Do you have any sense of belonging to and working as what is sometimes referred to as a Primary Health care Team which includes all the members of staff employed at or attached to a practice?"

Examples of additional comments supporting a positive identification are

" Yes, I feel it more so since our team meetings started. Also the doctors are not aloof at this practice - they show respect to others." (2 PN)

" I feel it especially now that I have an office at the surgery and have been away on the team building workshop and understand other peoples' roles." (2 DN)

Examples of additional comments supporting a negative identification are

" I just don't have enough contact with the other members -I'm much more detached here than at the other surgery I work with. Its not that I like this practice any less but I just feel less of a team member. Our (midwifery) managers certainly don't see us as part of the PHCT" (20 MW)

" I don't feel part of a PHCT here compared to other places I've worked in. I don't think the practice nurses are trying to put the health visitors out intentionally but I feel very much an outsider. I don't go daily to the new building because its very off putting. " (18 HV)

" Everybody works very individually here, no one's got any idea how each other works. Its very poor, very individualistic." (16 PM)

2 - the individual expresses a commitment to working as part of a PHCT

The individual should answer "yes" to the question:

"Do you personally feel committed to working as a member of a primary health care team?"

Examples of comments supporting a positive answer are

" Yes, the multi disciplinary approach is basic to my philosophy." (9 PN)

"Yes, you have got to have the inter relationships." (19 PM)

"We just couldn't offer such a good service to patients otherwise - we depend on the skill of the others. Team working also gives more job satisfaction." (11 GP)

Examples of comments supporting a negative answer are

" Its difficult because I'm not based only in the community- I'm also based in the hospital with different goals." (9 MW)

" I think it could get too large and impersonal." (4 Rec)

" Our women are our priority. I don't concentrate on being part of the whole team - just a team with midwife and GP." (18 MW)

3 - the individual expresses the view that team working benefits patients

The individual should answer "yes" to the question:

" Do you think that patients benefit from teamworking?"

Examples of comments supporting a positive answer are

" It can only help because a range of skills are needed for good patient care." (20 DN)

" Team working would be much better - at the moment patients get conflicting advice from the HV and the GP re feeding problems." (4 HV)

" When the team works well patients benefit. When you know what other team members are best at and get them to do that, patients benefit." (13 GP)

" I'm convinced that they do (benefit). It helps to bring continuity, uniformity of approach, saves duplication and encourages confidence which aids the recovery of patients." (1 GP)

Examples of comments supporting what was judged to be negative answer are

" I can't really see how it would affect patients. I mean its things like clinics and caring receptionists that patients really appreciate. " (20 PM)

" I'm not sure. We have to be very aware of each other. We mustn't undermine each others role or give conflicting advice. " (20 PN)

" I think its better for midwives now we are (based) in the hospital. I feel strong and supported. Its better for patients. They can by pass the doctor and call us. " (4 MW)

4 - the individual regularly attends PHCT meetings

The individual should report regular attendance in response to the question:

" How often do you attend the meetings?"

An example of comments supporting such a positive answer is

" I always attend and I ask my SEN to deputise if I can't make it. I'm very much in favour of getting together and suggested having PHCT meetings some time before they actually started being held. " (20 DN)

Clearly this was only an option for staff working in practices where such meetings are held.

Examples of comments of those who reported only infrequent attendance are

" I only work in the afternoons - its difficult to get here for lunchtime " (8 PN)

" Its not my normal day and also admin things are not often brought up - we use our practice meeting for that. " (2 Rec)

5 - the individual believes that the member of the team share a common sense of purpose

The individual should answer "yes" to the question:

" Do you have a feeling that you have an overall goal here that all the members of the PHCT work towards? "

Examples of comments accompanying a positive response are

"Providing care for the patient of good quality and a good environment for the staff to work in. " (8 GP)

"Ideally we are all working for patient's well being and satisfaction. " (8 HV)

"Providing better care and access to care." (9 MW)

Examples of comments accompanying a negative response are

"In the long term we may be thinking along the lines of Health of the Nation. In the short term it's to get to the end of the day. Maybe when we move to new premises we can all sit down and discuss this. I believe its more likely that people have individual goals. (19 GP)

" It's a gap, we haven't got a goal. I don't know how to set one. It's just day to day stuff, getting by. There's not enough time to plan." (6 GP)

6 - the individual subscribes to a written goal

This was only judged to be the case where the individual was aware that the matter had been discussed as a team activity, the outcome of which was recorded.

Examples of what was judged to be a positive response are

" It has been discussed as a topic at the PHCT meeting and recorded." (9 MW)

" We looked at the areas of professional practice we wanted to improve and develop. Our goal was discussed and put into words." (9 HV)

Examples of what was judged to be a negative response are

" We've never discussed it - it's just a feeling" (8 Rec)

" It's something I've discussed with individuals but not as a group." (8 HV)

" We touched on this lightly at the one meeting we had but it needs to be gone into more deeply." (19 PM)

" Once we get our PHCT meetings going then we can discuss this." (19 DN)

" It's probably somewhere in the report, but I don't know," (5 PN)

7 - the individual thinks that other team members understand what his/ her job entails

Allowing for some minor reservations, the individual should give a positive response to the question:

" Generally speaking do you feel that other people working at or attached to the practice understand what your job entails?"

Examples of comments accompanying what was judged to be a positive response are

" This was the first aim of our PHCT - everyone defined their roles and this was written down" (9 GP)

" I get appropriate referrals and I don't get asked things that don't concern me so I'm sure everyone does understand my role." (14 DN)

" Since the workshop we've got a much better understanding of each others roles." (16 PM)

Examples of comments accompanying what was judged to be a negative response are

" The nurses and doctors don't understand my job." (7 Rec)

" I don't think the GPs or the reception staff understand my role." (7 DN)

" Work in that area is needed. Our roles are changing, we should know more about each others roles" (10 PM)

" The GPs don't understand or value our role." (18 HV)

8 - the individual thinks that he/she understands the jobs of other team members

Allowing for some minor reservations, the individual should give a positive response to the question:

" Generally speaking do you feel that you understand the jobs of other members of staff at the practice ?"

Examples of comments accompanying what was judged to be a positive response are

" Much more so since we've had PHCT meetings and people have given their job description in full." (11 PN)

" Yes, but at the other practice I work with its much less clear." (11 DN)

" Yes I know exactly where they all fit in - without necessarily having detailed knowledge of all their tasks." (4 PM)

Examples of comments accompanying what was judged to be a negative response are

" I don't understand the job of the practice nurses or the admin staff. They are all living in cubicles and the right hand doesn't know what the left hand is doing. (8 DN)

" I'm only just starting to learn about the jobs of the attached staff as they share this information with us a PHCT meetings." (20 PM)

9 - The individual rates highly the system for communicating with other staff at the practice.

The individual should give a very positive response to the question:

" Overall how do you rate the systems for communicating with other staff in this practice ?"

Examples of comments accompanying what was judged to be a positive response are

"Communication is definitely better since we've been having (PHCT) meetings. We are more aware of team members and the fact that the fringe members are just as important" (2 PN)

" Having been to Bournemouth and talked to other practices I realise how good we are compared to most. Everyone is on first name terms, everybody is approachable and there's no fear attached to talking to anybody." (2 GP)

Examples of comments accompanying what was judged to be a negative response are

" In urgent cases, about a specific patient, its not a completely shut door but the more general stuff just isn't properly covered." (4 HV)

" When there's a problem we're fine at communicating but we're poor at allowing time to discuss patients routinely. It's okay when there are problems but we don't communicate as a matter of course." (12 PM)

" Communication with the receptionists is fine but with others it's poor. The practice manager acts as gatekeeper to the GPs and there's lots of 'holy' information - things we're not 'allowed' to know. Things could be a lot better." (7 HV)

10 - the individual finds other members of staff to be accessible to him/her

During the interview, a series of questions were asked, specific to each discipline, about aspects of communication such as the nature of arrangements for making inter disciplinary referrals or for discussing the ongoing care of specific patients. Individuals were asked for their view on how well these arrangements work in practice. Administrative staff were asked about the nature of their day to day contact with the health care staff in relation to passing on messages, raising queries etc. On the basis of answers to these questions a judgement was made about whether, on balance, the individual perceived other members of staff to be accessible. If a serious problem was noted with any one member of the team then the overall response was counted as negative.

Examples of responses which contributed to the overall response being judged to be positive are

" The GPs are very approachable. I always try to see them in person - I pop my head round the door - but otherwise I leave a written memo on the desk. We value sharing

information and I feel I'm treated as professionally equal. (20 HV)

" I call into the surgery regularly - I have no problems getting to see a GP. " (20 DN)

" Everyone is very helpful - there are no barriers. " (4 DN)

" We could have daily contact (with district nurses). They're in daily. We've always had a great relationship. " (17 PN)

Examples of responses which contributed to the overall response being judged to be negative are

" The GPs are available every day between 11 and 12 but its not really protected time. They aren't really sufficiently accessible because you feel like you are interrupting their conversations. " (4 HV)

" Its very difficult to see the GPs. You have to leave notes. They are always busy - their computers are more important to them. " (18 HV)

" Contact with the health visitors is the poorest of all the attached groups. We don't see them often. We're aiming to improve contacts but at the moment it hasn't happened" (12 GP)

" She (health visitor) works in isolation. We don't meet and she rarely rings me. I could easily go for six months and not see her. " (17 MW)

" The GPs are very inaccessible and unresponsive. They're very hard to approach so we feel we shouldn't bother them. They just don't want to know. " (12 PN)

11 - the individual believes that other health care professionals within the team share the same overall approach to patients / philosophy of care

(This was not included in the case of non clinical staff.)

The interview focused on specific inter professional relationships and where relevant, the individual was asked:

" Do you feel that you share the same overall approach to patients; the same philosophy of care?"

On the basis of the several answers given, a judgement was made about whether, on balance, fellow professionals were perceived to share a common philosophy

If serious difference was noted in any one relationship the overall response was judged to be negative.

The response to this question was judged to be positive where alternative, but complimentary approaches were seen to be offering choice to the patient

Examples of responses which contributed to the overall response being judged to be positive are

" We (self and midwife) talk a lot. We want to ensure we give the same advice to patients. We liaise to ensure we give consistent advice." (5 HV)

"I feel it more so with the younger partners. GPs are coming over to the health visitors approach, leaning towards health promotion and building the patients self esteem. Unfortunately the GPs have less time and tend to be prescribers." (2 HV)

" Yes, the doctors and nurses work at different levels complimenting each other. We have the same aim in life and concern for patients welfare." (19 PN)

" Yes, for example with regard to terminal care, we (GP and DN) agree that keeping people at home is very important." (20 GP)

" Yes we share a holistic approach to patients." (11 DN)

Examples of responses which contributed to the overall response being judged to be negative are

" They (district nurses) have their own methods of working and ways of doing things. They're bound by their own rules and regulations of what they can do or mostly what they can't do. They won't do the things that we want them to do." (7 GP)

"Its partly a reflection of the different approaches of doctors and midwives in general and partly because of this GP's personality. He is inclined to treat pregnancy as an illness." (9 MW)

" No we are different. (MW & HV) The midwife wears a uniform and is recognisable and seen as helpful. Mums don't understand the health visitors role." (4 MW)

" No we (HV and GPs) have different opinions about the management of child health issues and conflicting advice is given. GP's just don't look at the whole picture. There are differences of opinion between us and the midwives on how we should run the antenatal classes and about what should be promoted, like breast feeding. We really need meetings." (4 HV)

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