Primary Healthcare Teams: Rhetoric versus Reality

Michael A West and Brenda C Poulton 1997

Introduction

The concept of team work as the most effective way of delivering products and services has gained increasing ascendancy within diverse organizational settings (see Guzzo & Shea, 1993). So much so, that it is now a dominant philosophy within manufacturing, service, private and public sectors within the United Kingdom, as well as internationally (Goodman, 1986; Sundstrom, DeMeuse and Fuetrell, 1990). This approach to the delivery of services and products is by no means simply a managerial fad since there is substantial empirical evidence that the introduction of team work and group goals in diverse organizational settings, and involving diverse task types, can lead to increased effectiveness in the delivery of both quantity and quality of goods or services (Weldon and Weingart 1993).

Within primary health care there have long been calls for the introduction of team work and for more effective collaboration between professional groups in the delivery of primary care. It is the thesis of this article that team work in primary health care in the United Kingdom will not develop optionally, as long as the present structural arrangements for the delivery of primary care services are maintained.

In a seminal review of research on groups at work, Guzzo and Shea (1993), have argued that five preconditions are essential for effective team work.

(1) The group must have a whole and meaningful task
(2) The individuals within the group should have unique and meaningful tasks
(3) Individual performance should be assessed and feedback on performance given
(4) There must be clear team level objectives
(5) Regular feedback on the effectiveness of the team in achieving its objectives should be given

In our research with primary health care teams, it is clear that though the first two conditions are fulfilled, we have found no examples of teams where any one of the latter three are achieved. Indeed it is almost a hallmark of primary health care teams that they fail to have clear team level objectives, beyond broad mission statements to do with improving the health and well-being of the local population. Such statements while laudable in themselves are no guarantee that the team will have clear measurable objectives on a year by year or monthly basis towards which to aim in their collaborative work. Consequently, the effectiveness of their performance at both individual and team level, cannot be judged.

In this paper we compare primary health care teams with other multidisciplinary teams on four fundamental criteria of team functioning:

(1) Clarity of and team member commitment to team objectives
(2) Levels of participation within the teams (information sharing, frequency of team member interaction, and extent of team member influence over decision-making)
(3) Task orientation or commitment to excellence
(4) Support for innovation

Method

Data were collected from 528 members of 68 primary health care teams located throughout the United Kingdom. These included 106 General Practitioners, 63 Health Visitors, 44 District Nurses, 56 Practice Nurses, 118 Receptionists, 42 Practice Managers and 99 others (e.g. midwives, counsellors, community psychiatric nurses). The teams were nominated for the most part by Local Organizing Teams involved in facilitating Health Education Authority team workshops. Data were also gathered from four other samples of multidisciplinary teams: 200 members of 24 oil company management teams; 155 members of 27 NHS hospital top management teams; 120 members of 20 community mental health teams; and 360 members of 40 social services teams. Further details of these samples and the methods of data collection can be found in Anderson and West (1994). All teams included in the sample responsed to a questionnaire survey and were included only where four members or 40 percent of members of the team responded (whichever was the larger figure).

The questionnaire was administered by post in most cases, and stamped addressed return envelopes were included in the mailing. Confidentiality was guaranteed.

The instrument

The measure used for the four elements of team functioning - Objectives, Participation, Task orientation, Support for innovation - was the Team Climate Inventory. This inventory has been validated by comparing team member responses with analyses of audio tapes of interaction processes in team meetings and shows high criterion, content and face validity (see Anderson & West, 1994). Reliability on all four scales has also been shown to be high. In addition, two measures of mutual role understanding within the teams were included in the questionnaire along with primary health care team members' perceptions of whether other members made appropriate use of their skills. We describe each of the four elements of team funding in further detail below.

Objectives

Work groups with clearly defined objectives are more likely to be effective and develop new goal-appropriate methods of working since their efforts have focus and direction.

Participation

Wall and Lischeron (1977) describe participation as having these three central components. Interaction involves `.. .. two parties attempting to reach agreement through working together rather than through recourse to a balance of power based upon the exercise of sanctions' (p 37). Information sharing, they say, is also central to participation since `.. .. interaction between the two parties undertaken with the ultimate aim of reaching agreement over a decision, requires and results in an exchange of information and increased intercommunication'. Finally, they argue, participation may be said to increase ` to the extent that the influence of two or more parties in a decision-making process approaches an equal balance'.

Task orientation
A shared concern with excellence of quality of task performance in relation to shared vision or outcomes, characterized by evaluations, modifications, control systems and critical appraisals, is the third component. Within teams this is evidenced by emphasis on individual and team accountability ; control systems for evaluating and modifying performance; critical approaches to quality of task performance; intra-team advice, feedback and co-operation; mutual monitoring; appraisal of performance and ideas; clear outcome criteria; exploration of opposing opinions; and a concern to maximise quality of task performance.

Support for innovation
Finally is support for innovation or the expectation, approval and practical support for attempts to introduce new and improved ways of doing things in the work environment? At the organizational level such norms may be explicit in the socialization practices for incumbents or implicit in the culture of the organization. Within groups, new ideas may be characteristically rejected or ignored, or they find both verbal and practical support.

Within a work group characterised by support for innovation, all members of a primary health care team might be encouraged to contribute to discussions and decision-making about important aspects of the team's work. At the same time the team's characteristic interpersonal processes would be non-judgemental and supportive of the individual offering contributions and suggestions, and characterized by socio-emotional cohesiveness.

In addition to questionnaire administration, intensive case studies of primary health care team work were conducted with ten teams in order to gain a more qualitative appreciation of the challenges and difficulties faced by the different professional groups in attempting to co-ordinate their work effectively together.

Results
Analyses of the data revealed considerable variation in the size of primary health care teams, ranging from the smallest with 7 members up to the largest with 37 members. The average size of primary health care teams in the study was 18 members. Given that most organizational behaviourists view maximum effective team size as being between 8 and 12 members, it suggests that some of the difficulties of primary health care teams may derive from the assumption that groups of 20-40 individuals can be managed as work teams (see for example Guzzo & Shea, 1992). Large primary health care teams should correctly be considered as small organizations rather than as teams.

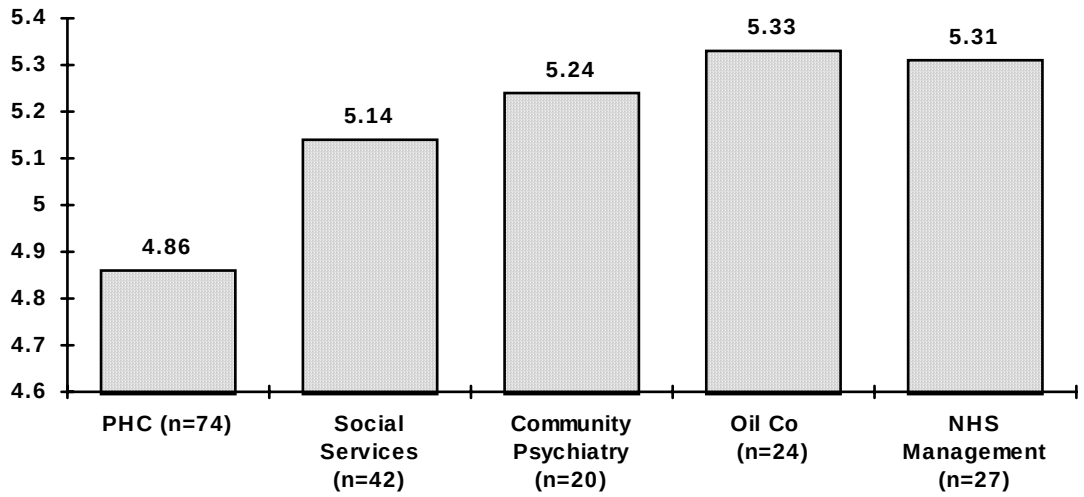
Mean scores of team members on each of the four sub-scales of the TCI were aggregated, following determination of a sufficiently high degree of within group inter rater agreement [RWGj] (James, Demaree & Wolf, 1984). The scores across the five samples of work groups (primary health care teams, NHS management teams, community mental health teams, oil company management teams and social services teams) were compared using standard analyses of variance. F ratios on all four dimensions revealed statistically significant between group differences. Figure 1 shows the mean scores of primary health care teams compared with those of the other teams on the four TCI scales and shows significant differences between primary health care teams and others on all four dimensions. On every scale but one (task orientation), primary health care teams score lowest of the five samples. Moreover, post hoc Tukey B analyses revealed that primary health care teams report significantly lower levels of participation than teams in each of the other samples; significantly lower levels of participation than is reported by NHS management teams

and oil company management teams; significantly less clarity of the commitment to objectives than any of the other few samples; and significantly lower levels of task orientation than community mental health teams and social services teams.

Table 1

Team scores and cross-sample analyses of variance for your team climate sub-scales

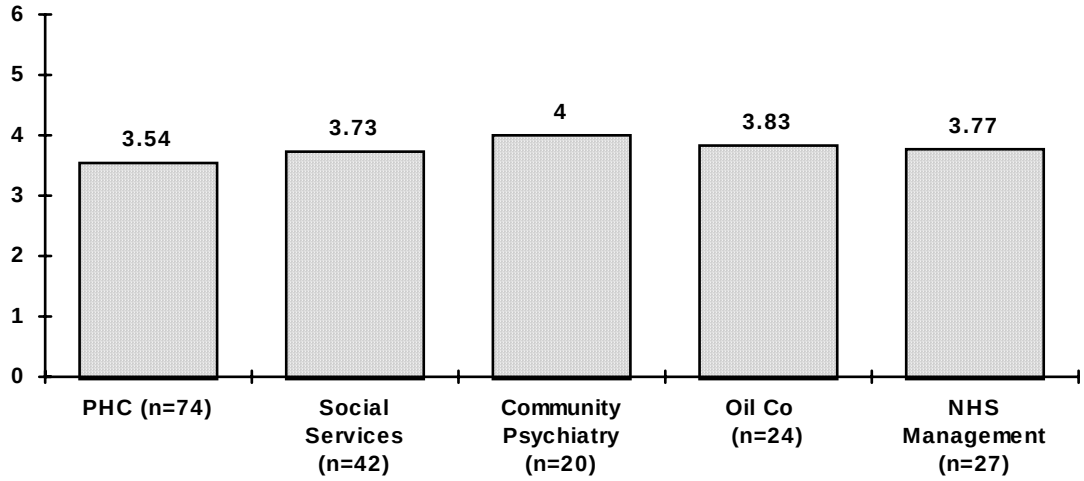
Team Scores: Clarity of objectives



F = 14.20; df = 4,1551; p = < 0.001

Table 2

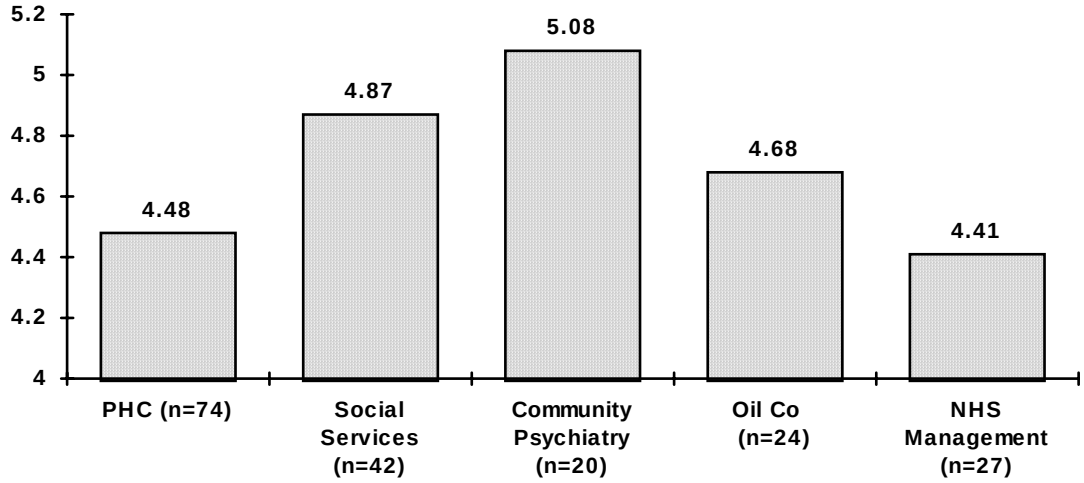
Team Scores: Participation



F = 20.69; df = 4,1557; p = < 0.001

Table 3

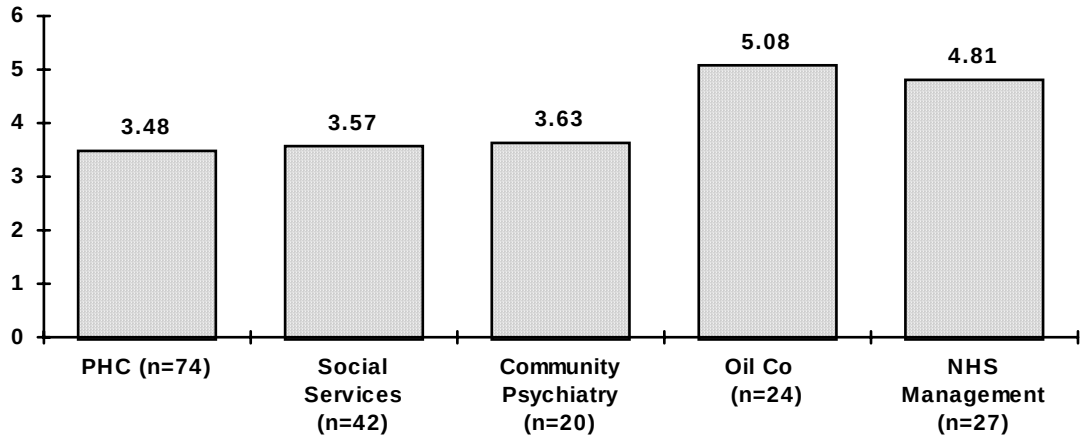
Team Scores: Task Orientation



F = 10.67; df = 4,1564; p = < 0.001

Table 4

Team Scores: Support for Innovation



F = 265.64; df = 4,1560; p = <0.001

Discussion

The results of this research suggest less effective team functioning amongst primary health care teams than amongst other comparable multidisciplinary professional teams in a variety of organizational settings.

It might be argued that the sample of primary care teams included in this study is unrepresentative. However, our view is that these teams are more likely to be aware of and making an effort towards working effectively as teams, as a result of their agreement to participate in the HEA team building workshops. It is probable that more organizationally aware and enlightened teams would volunteer for such events and so would be better examples of effective team work in primary care than those which did not volunteer.

Qualitative analysis of the functioning of ten teams (West, Poulton & Hardy, 1994) revealed what, from an organizational perspective, is an understandable obstacle to team work. Many researchers point to the importance of organizational context for effective team work, arguing that simply bringing groups of people together and calling them teams is an inadequate way of promoting co-operative working and interdependence (see e.g. Hackman,1990 and Guzzo and Shea, 1993). The structure and functioning of the organization should support rather than undermine team work. In our work with primary health care teams (Poulton & West, 1994; West, Poulton & Hardy, 1994) we repeatedly discovered conflicts between and within professional groupings (see also Field and West: West and Field, in press).

Thus, general practitioners were sometimes in conflict with community nurses practice nurses were sometimes in conflict with their community counterparts. An examination of the organizational structure of primary health care reveals an important cause of this conflict.

Health visitors, district nurses, practice nurses and midwives typically have separate lines of management. General practitioners are independent contractors and are paid on different basis from their counterparts. Such diverse management lines are

likely to lead to diverse objectives and therefore conflicts (see generally Daft, 1992; Robey, 1986). This is all the more so where there is no single cross-functional managerial grouping responsible for ensuring effective collaboration and co-operation, as one would find in most organizational settings. The reasons that, for example manufacturing organizations have boards of Senior Managers drawn from production, marketing, sales, quality etc. is simply to ensure that there is adequate cross-functional integration, collaboration and communication to manage destructive conflict and ensure that all are working toward clear shared objectives. In primary health care the opposite appears to apply, i.e. separate lines of management prevent teams from developing clear shared objectives in their work and instead can cause interprofessional conflict.

A further potential difficulty is that general practitioners are rewarded in different way to their professional counterparts in primary health care. The latter are salaried by their respective employing organizations. General practitioners' reward arrangements are a curious concatenation of balk payments salary, performance related pay and piece rate system. Research on organizational behaviour suggests that the application of individual bonus or performance related pay systems are often ineffective (Markham, 1988; Marsden & Richardson, 1992) and may militate against team working. Incentives have proved rather more successful where they are used to reward groups for group performance. These schemes lead to small but significant improvements in group performance. Such a model would require members of primary care organizations to be rewarded proportionately for their organizations' achievements.

Here it is proposed that all primary health care teams be responsible to a primary health care organization. This authority would provide organizational support in the form of education (for example training), information (locality health care needs) and resources (including pay) to enable the team to function effectively. The individual primary care organization would then have a single management structure with a local board determining its annual objectives and evaluating the performance of the organization against those objectives. This board would be cross-functional, ensuring that all professional views were adequately represented and integrated in the development of the strategy of each "team". It could comprise a representative each of general practitioners, community nurses, practice nurses and practice administrators. It could also include patient representatives and a non-executive Chair. One person from the organization could be nominated as an Executive Director on a rotating basis to ensure that no single professional grouping maintained political dominance.

Within the primary health care organization the sub-structure of teams would then depend upon local circumstances. Three models suggest themselves as examples:

Locality based teams. - Here one or more representatives would be drawn from each professional group to provide services for different geographical areas of the primary care catchment area e.g. North West, North East.

Functionally based teams. - In this model General Practitioners would work as a separate team, as would Community Nurses and Practice Administrators.

Service based teams. - One or more representatives would be drawn from each professional group to provide specific services to, for example, the elderly; another multidisciplinary team for mothers and toddlers; another for adolescents and so on.

In addition to this structure we also suggest a tier of locality management incorporating representatives from all the primary care teams charged with developing a locality strategy, and implementing national and regional policies where necessary and appropriate. The primary care purchasing authority would have an Executive Officer representative on this locality management team, whose function would be to liaise with the authority and other agencies involved in promoting the health and well-being of the local community (such as Social Services, housing etc.), to carry out the team's policy in practice.

Our quantitative and qualitative research suggests that the main problem of primary health care teams is their failure to develop clear shared objectives amongst the different professionals involved. Consequently, the required conditions for effective team work specified by Guzzo and Shea (1993), cannot be achieved, since without clear objectives at the team level, appropriate individual objectives cannot be determined and team performance cannot be measured. As long as the structure of primary care militates against the development of clear, shared objectives then attempts to encourage effective team work require primary health care team members to swim against a powerful tide. Nevertheless, it is very clear from a wealth of previous research that team work is precisely the means by which the effective delivery of primary care to local populations, can best achieved (West, 1994; West, in press).

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