Teamworking in Primary Healthcare

REALISING SHARED AIMS IN PATIENT CARE

Final Report 2000

Published by the Royal Pharmaceutical Society of Great Britain and the British Medical Association

Royal Pharmaceutical Society of Great Britain

COMMENTS TO:
Head of Practice,
Royal Pharmaceutical Society of Great Britain,
1 Lambeth High Street,
London, SE1 7JN.
Telephone/voicemail:
020 7820 3399 ext 305
Facsimilie:
020 7582 3401
e-mail:
vgreen@rpsgb.org.uk

PREFACE

The challenges of healthcare are increasingly complex and subject to frequent change. Meeting these demands requires that health professionals work in partnership with each other, with other professionals such as social services staff, and with patients and carers. The value of working as a team has already been recognised. We now need to strengthen and develop teamworking within primary healthcare to provide modern health services for the future.

The Forum on Teamworking in Primary Healthcare was convened as a result of a joint initiative between the Royal Pharmaceutical Society, the British Medical Association, the Royal College of Nursing, the National Pharmaceutical Association and the Royal College of General Practitioners. An expanded group of organisations was then brought together, under the chairmanship of Dame Deirdre Hine, to address the practical aspects of teamworking in this context. This report represents the findings of that group. It is addressed to those who lead and who work within teams in primary healthcare, and to the national organisations that represent them.

We are grateful to all who have contributed their time and effort to this important report.

Mrs Christine Glover
President
Royal Pharmaceutical Society
of Great Britain

Dr Ian Bogle
Chairman
British Medical Association

FOREWORD

'Professionalism has contributed a great deal to modern health care, but has inhibited the ability to achieve cross boundary solutions based on team work'[1].

This observation is from an Australian article on the future of hospitals in the next millennium, which was written in 1995. It is surely also true of primary healthcare in some places within the United Kingdom even now that we have reached 'the next millennium'. An ageing population with complex clinical and social needs, rapid developments in our ability to deliver more and more care outside hospitals and, not least, major new Government-led policy initiatives, make the understanding and removal of such 'inhibitions' in the field of primary healthcare an urgent priority.

That was the task which this Forum on Teamworking in Primary Healthcare accepted from its sponsoring organisations.

We approached it by: gathering and appraising evidence to support the thesis that teamworking in primary healthcare is beneficial both to patients and team members and that it can be cost effective; exploring and analysing factors which promote as well as those that inhibit teamworking, and by identifying and celebrating some of the achievements of teams that have succeeded in overcoming inhibitions and obstacles in their determination to achieve shared goals for patients.

The task was not easy. This report is a consensus arrived at only after spirited discussion by members, whose views often differed and occasionally conflicted. I would wish to pay tribute to the honesty, courtesy and constructiveness of the way in which they made their contributions. I trust that we have achieved a report which is greater than the sum of its parts and thus a good example of teamworking at its best!

The Forum owes an immense debt of gratitude to its secretariat, which was provided by Christine Gray and Barbara Stewart, without whose skill and hard work the report could not have been produced. They patiently absorbed the ideas of both Chairman and members and have distilled these into a document, whose recommendations to both primary care team members and to the organisations responsible for the individual professions will, I hope, be read and acted upon. I further hope that the progress made will be reviewed to ensure that teamworking in primary healthcare continues to evolve and advance.

Dame Deirdre Hine
Chairman
Forum on Teamworking in Primary Healthcare
October 2000

- The Forum on Teamworking in Primary Healthcare was convened as a result of a joint initiative between the Royal Pharmaceutical Society, the British Medical Association, the Royal College of Nursing, the National Pharmaceutical Association and the Royal College of General Practitioners. The Forum was also supported by the Patients Association, British Dental Association, Institute of Healthcare Management, Association of Directors of Social Services, Association of Community Health Councils for England and Wales, Doctor Patient Partnership and Community Practitioners' and Health Visitors' Association. Membership of the Forum is listed in Appendix 1. The Forum was jointly sponsored by the Royal Pharmaceutical Society and the British Medical Association.

- The remit of the Forum was: *'to examine the practical aspects of teamworking in primary healthcare and to bring forward proposals by which the national organisations representing primary healthcare professionals can support and promote this concept'*. It was hoped that when the report was produced, the national organisations would adopt its recommendations and thus demonstrate a high degree of joint ownership.

- The Forum adopted the World Health Organisation definitions of 'primary healthcare' and 'teamwork' (Appendix 2).

- The available evidence of the effects of teamworking, as applied to primary healthcare, was reviewed. The report provides a commentary on the research background and evidence base. The Forum found evidence that effective teamwork is most likely to occur where each team member's role is seen as essential, roles are rewarding and there are clear team goals. Effective communication, optimum team size, appropriate autonomy for members of the team and adequate time and resources are also important factors.

- Teamwork does not necessarily follow from professionals working alongside one another. Structural, historical and attitudinal barriers can and do contribute to difficulties which inhibit teamwork. Problems can arise from competing demands, diverse lines of management, poor communication, personality factors, plus status and gender effects.

- The Forum identified a number of contextual issues which were likely to impact on teamworking in primary healthcare in the UK. These embraced the changing health and social environment, new Government policies, and professional and technological developments. Empowerment of patients to make informed decisions about their wellbeing, health and social care will require a more sophisticated approach to teamworking to meet patients' needs and expectations.

- There has been a series of Government initiatives which could have a major impact on teamworking in primary healthcare (Appendix 3). Some policy changes might provide 'windows of opportunity' for enhancing and encouraging teamwork. The Forum has made a formal request to the Department of Health for the evaluation of new initiatives, particularly Walk-in Centres, to include their impact, if any, on professional teamworking.

- The aspirations of the professions and of individual professional members are major catalysts in the development of teamworking. Limitation of health resources has also spurred innovative approaches, eg. in the field of medicines management. There are, however, indications now that continued shortage of resources is having a detrimental effect on development, particularly in the field of information technology.

- The number of professionals available currently, especially doctors, is unlikely to meet future expectations for timely provision of high quality care, if services continue to be provided in the traditional model. Workforce availability is therefore likely to shape patterns of service delivery in a way which maximises the contribution of scarce skills. Continuing professional development is essential, as professionals working together must have mutual confidence in their fitness to practise and in their ability to keep up-to-date. Joint training opportunities will be important in this respect and in building teams.

- The Forum recognised the importance of ensuring that teamworking does not unnecessarily restrict the access of patients to the healthcare professional of their own choice.

- There are many technological developments with the potential to influence, or even revolutionise the delivery of primary healthcare. Advances in telecommunications and information technology will increase the ease of information transfer between members of the healthcare team, reducing professional isolation. In addition there are advances assisting professional development and technological developments in patient care, eg. the shift of many aspects of care from the hospital to the home has been made possible.

- A number of examples of teamworking initiatives in primary healthcare have been brought together and these illustrate the richness of opportunities which have been grasped in a variety of settings.

- The Forum has produced two sets of recommendations: one set for teams and their members currently engaged in hands-on clinical care, and another for consideration by national organisations with responsibilities for team members.

TEAMS AND TEAM MEMBERS

These recommendations are intended to represent the principles for establishing a primary healthcare team and to describe what a team member should expect as the basis for successful teamworking.
The team should:

1. Recognise and include the patient, carer, or their representative, as an essential member of the primary healthcare team at individual patient-centred team level or at practice level. *(1.11)*

2. Establish a common agreed purpose, setting out what team members understand by teamworking, what they aim to achieve as a team and how they propose to do this. *(2.18)*

3. Agree set objectives and monitor progress towards them. Build into its practice, opportunities to reflect as a team on the care provided and how it could be improved. All team members to be actively involved in the delivery of the agreed objectives and in the decision-making process. *(2.19)*

4. Agree teamworking conditions, including a process for resolving conflict. Identify predictable problems, which the team might encounter, and plan ways of managing these. *(2.24)*

5. Ensure that each team member understands and acknowledges the skills and knowledge of team colleagues and regularly reaffirm what each member contributes. *(2.24)*

6. Pay particular attention to the importance of communication between its members, including the patient and off-site or peripatetic members, and use, to the full, technological developments to assist this as they become available, where co-location is not practical. *(2.25)*

7. Take active steps to ensure that the practice population understands and accepts the way in which the team works within the community. *(1.12, 1.13)*

8. Select the leader of the team for his or her leadership skills rather than on the basis of status, hierarchy or availability and include in the membership of the team all the relevant professions serving a practice population. *(2.24)*

9. Promote teamwork across health and social care for patients who can benefit from it, using team members' joint efforts to help to reduce both ill health and social exclusion. *(3.4)*

10. Evaluate all its teamworking initiatives and as a result, develop its practice on the basis of sound evidence. *(3.7)*

11. Ensure that the sharing of patient information within the team is in accordance with current legal and professional requirements. *(2.34, 2.35)*

NATIONAL ORGANISATIONS

The recommendations of the Forum to national organisations involve aspects of support for national priorities, education, research and guidance.
They should:

SUPPORTING NATIONAL PRIORITIES

12. Promote and publicise interprofessional national initiatives designed to address health priorities. *(3.9)*

13. Impress upon Government the potential for primary healthcare teamwork in modernising the NHS and the importance that Government guidance is seen to support such teamwork whenever appropriate. *(3.3, 3.7)*

14. Seek opportunities to discuss with Government the cost-effective potential offered by the provision of appropriate resources in IT for facilitating teamworking in primary healthcare. *(3.20)*

15. Take full advantage of the opportunities offered by National Service Frameworks (NSFs) and national guidelines and give positive guidance to their members on developing teamwork to achieve the objectives of the frameworks. *(3.9)*

16. Seek to ensure that the knowledge gained from effective teamworking is incorporated into the design of future public policy and NSFs. *(3.9)*

EDUCATION

17. Take active steps to facilitate interprofessional collaboration and understanding through joint conferences, education and training initiatives. *(3.16)*

18. Establish an over-arching structure to help provide continuing support and education for teamwork amongst the primary healthcare professions. *(2.15, 3.16)*

19. Discuss with Government the resourcing of facilitation and education on teamworking to ensure the most effective use of professionals in primary healthcare. *(2.15, 2.17, 3.16)*

20. Within the responsibility of national bodies for, and their capacity to influence, undergraduate and/or postgraduate education of primary healthcare professionals, recognise that teamwork is a skill, which needs to be taught and learnt, and build opportunities to develop this into relevant basic curricula and post-basic training. *(2.28, 2.33)*

21. Highlight in their educational and service development initiatives the importance of organisational factors to the effectiveness of teamworking, including the provision of protected time and resources. *(2.15, 2.24)*

RESEARCH

22. Take positive steps to secure investment in research on teamworking and its impact on primary healthcare. *(2.2)*

23. Promote the evaluation of all new initiatives in teamworking by having an evaluation component built into their design. Track these initiatives, collate and publicise evaluation results, and disseminate information on good practice to their members. *(2.2)*

24. Give some priority to evaluating teamworking initiatives which include health and social care staff. *(2.2)*

GUIDANCE

25. When defining primary healthcare teams, include patients and, where appropriate, carers, as full team members. *(1.11, 1.12)*

26. Promote the development of information for the public on the skills and knowledge of different health and social care professions, what they do and the links which exist between them. Also explore ways of empowering people to care for themselves, when that is appropriate, to access primary healthcare services at the most appropriate point, and to make effective and responsible use of services. *(3.2, 3.4)*

27. Publicise the value of teamwork and the factors that facilitate good practice in teamworking in their communications to their members. *(2.22, 2.24)*

28. Acknowledge and promote the existence and value of various team compositions in primary healthcare, while accepting the importance of the general practice-based primary healthcare team. *(1.12, 3.14)*

29. Promote primary healthcare teamworking in partnership with social care, when appropriate for the benefit of patients. *(3.4)*

30. Take necessary steps to explore with the NHS Executive, NHS Wales and the Scottish Executive NHSiS, the issues of confidentiality and sharing of information as they relate to teams in primary healthcare, so enabling the provision of clear guidance to their members on these important and sensitive issues. *(2.34, 2.35)*

31. Provide guidance to primary healthcare professionals on legal and ethical aspects of sharing patient information between team members. *(2.34, 2.35)*

1. INTRODUCTION

1.1 The Forum on Teamworking in Primary Healthcare was established in 1999 by the Royal Pharmaceutical Society of Great Britain (RPSGB) and the British Medical Association (BMA). The Forum was convened as a result of a joint initiative between the BMA, RPSGB, the National Pharmaceutical Association (NPA), the Royal College of Nursing (RCN) and the Royal College of General Practitioners (RCGP)[2]. An expanded group of organisations was then brought together including: the Patients Association (PA), British Dental Association (BDA), Institute of Healthcare Management (IHM), Association of Directors of Social Services (ADSS), Association of Community Health Councils for England and Wales (ACHCEW), Doctor Patient Partnership, and Community Practitioners' and Health Visitors' Association (CP&HVA). The membership of the Forum is detailed in Appendix 1. The Forum held five meetings between October 1999 and June 2000.

1.2 The terms of reference of the Forum were **'to examine the practical aspects of teamworking in primary healthcare and to bring forward proposals by which the national organisations representing primary healthcare professionals can support and promote this concept'.** It was hoped that when the report was produced, the national organisations would adopt its recommendations and thus demonstrate a high degree of joint ownership.

1.3 The importance of teamworking in achieving the aims of organisations was established at least seventy years ago[3]. However, only in the past twenty years has that idea been acted on widely by large organisations, including the National Health Service. Teams are important because they allow those working in them to use their diverse knowledge, skills and experience to contribute to collective decision-making and achieving desired outcomes. This has obvious relevance to the provision of high quality health and social care to both individuals and populations.

1.4 Over the past twenty years, professional staff in both primary and secondary healthcare have attempted to develop and practise teamworking in the care of patients. In the primary healthcare context much valuable work has been done in promoting and practising teamwork. This is especially so within the groups of staff belonging to or associated with Group Practices, in some of which the concept has been fully developed and is working well to the benefit of patients. Teamwork has more recently been extended in some instances to include social care staff.

1.5 However, teamworking within healthcare settings is more complex and difficult to achieve than is commonly understood. Both the structure and processes of primary healthcare have features that constitute barriers to interprofessional co-operation and collaboration and that impede effective team decision-making.

1.6 The members of the Forum had the task of identifying the factors that promote or alternatively impede the full development of teamworking in the care of patients in a primary healthcare context. One of the first tasks was to agree a set of definitions from among the plethora of those available in the literature (see Appendix 2).

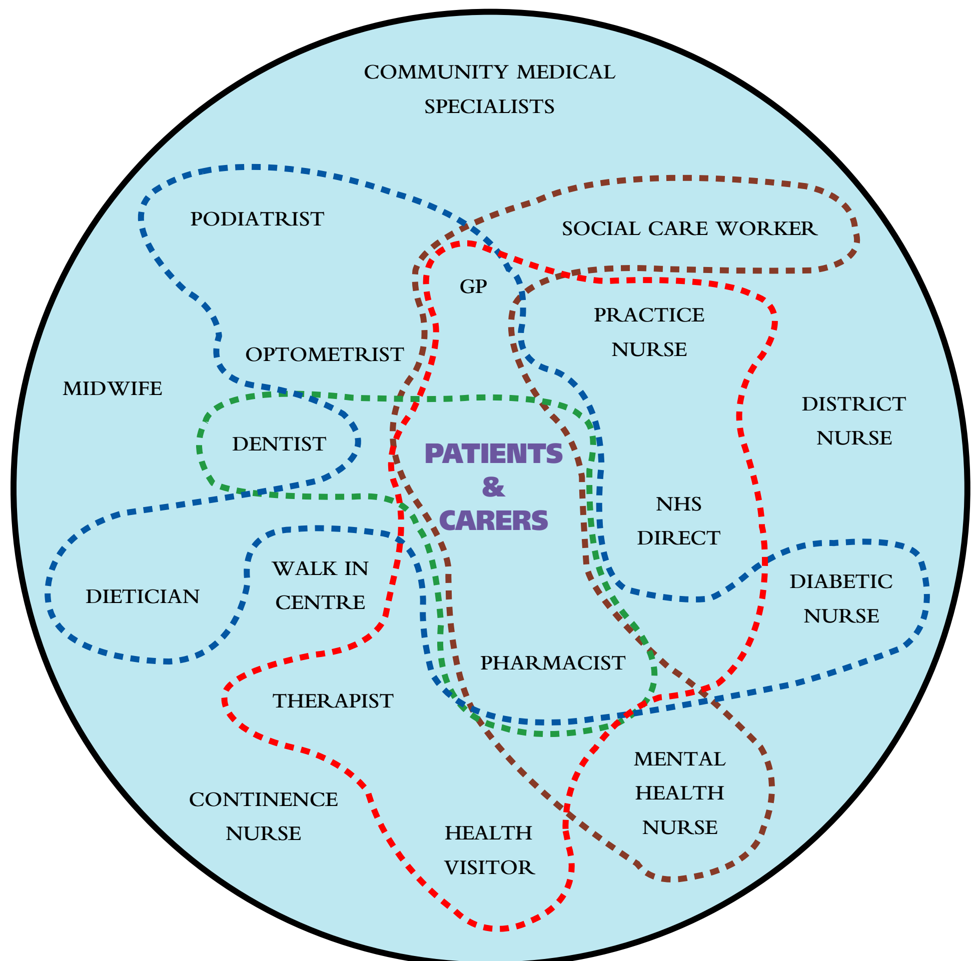
1.7 The Forum used as its working definition of primary healthcare **'the first level contact of individuals, the family and the community with the national health system which brings healthcare as close as possible to where people live and work, and constitutes the first element of a continuing health process'** (WHO declaration of Alma-Ata, 1990)[4].

1.8 There was more difficulty with the definition of the primary healthcare *team*, since it seemed to us that various levels of team could be described: from networks which included both health and social care staff, through the more formally structured teams based around general medical practices, to small individual patient-centred teams, often task-based and time-limited. The different types of team were characterised by their differing intensity of communication between the members - intermittent in the networks; tighter, though broad, communication in the practice-based teams and frequent, full, but narrower and more specific communication in the patient-centred team.

1.9 We concluded that the concept of the team in primary healthcare was a dynamic rather than a static one, changing to meet the changing needs of patients and groups of patients in different situations and reflecting to some extent the changing nature of health care delivery. Individuals could therefore be contributing as members of different teams at different times, or even simultaneously.

Teamworking in primary healthcare

Teamwork in primary healthcare is flexible and dynamic, centred on the needs of patients and carers. This diagram illustrates how teams might form around a particular patient, for example to provide services to:



- a person with diabetes
- a parent with young children
- a person needing dental treatment
- a person with mental health problems

1.10 The Forum adopted as its definition of teamwork that of the World Health Organisation: **'Co-ordinated action carried out by two or more individuals jointly, concurrently or sequentially. It implies common agreed goals, clear awareness of and respect for others' roles and functions'.** A fuller description can be found in Appendix 2.

1.11 One important point emerging from this discussion was that few, if any, definitions of the primary healthcare team included the patient as a member. It was clear that using patient needs and preferences as a starting point could change the perception of team composition. For example, many patients with short term or acute conditions might interact primarily with a very small team consisting of receptionist, doctor and possibly, pharmacist. However, patients with longer term or chronic illnesses might need a wider team including the practice nurse, district nurse, physiotherapist or other profession allied to medicine, pharmacist and social care worker, with more intermittent involvement of the doctor. In still other cases, the team, even though delivering care to a patient in his or her own home, might include a carer as well as members based in secondary care, eg. community psychiatric nurse, or in a voluntary organisation eg. a palliative care nurse.

1.12 Developing further the theme of the patient as a team member, other scenarios for involvement include: membership of a service team eg. patient participation groups at a GP practice; and/or membership of a policy-making and monitoring organisation within a Primary Care Group/Trust (PCG/PCT) in England, Local Health Group (LHG) in Wales or Local Healthcare Co-operative (LHCC) in Scotland. The vital role of carers and the contribution they can make to complex packages of care should not be overlooked. Patients (and carers) should be the centre of attention for all primary healthcare service provision.

1.13 The Forum concluded that the concept of the primary healthcare team could be applied to a spectrum of groups in primary healthcare with members being drawn from different organisations, while recognising that for most members of the public the most easily recognised and understood team is that based around the general practice. Our discussions embraced all these levels from networks to task-related, patient-focused teams.

2.1 Having agreed our definitions, we thought it important that our discussions should begin with a review of the available evidence of the effects of teamworking as applied to primary healthcare.

2.2 The Forum recognised that much of the research data on teamworking was 'soft' compared with published clinical data: qualitative rather than quantitative and with few, if any, randomised controlled trials. This section of the report, therefore, provides a commentary on the research background and evidence base rather than a comprehensive critical appraisal. On behalf of the Forum, the Health Policy and Economic Research Unit of the BMA reviewed the published research literature on the value of teamwork in primary healthcare. Individual members also drew our attention to published work. As stated in the Introduction (1.10), the definition of teamwork was taken as that given by the World Health Organisation (Appendix 2).

Benefits of teamwork in primary healthcare

2.3 The review of the research evidence showed that *benefits* of teamwork could be classified as:

- a more responsive and patient-sensitive service
- a more clinically effective and/or cost effective service, and
- more satisfying roles and career paths for primary healthcare professionals.

The most frequently cited advantages of team care over traditional care were:

- aspects of improved organisation and planning
- avoiding duplication and fragmentation
- developing more comprehensive databases leading to better identification of health problems, leading to
- developing better and more comprehensive healthcare plans.

More responsive and patient-sensitive services

2.4 A team approach to primary healthcare can improve accessibility for patients. Much of the research evidence centres on reducing the general practitioner's workload and thereby increasing the number of patients who can be seen[5] and reducing the length of time patients need to wait for an appointment, or enabling a more 'patient-centred' consultation[6].

2.5 GPs sharing home visits with other team members may make it possible to increase the average number of contacts patients have with a health worker, thereby improving patient satisfaction. Teamwork can enable the expansion of the range of services available to patients. This offers more integrated care, reduces duplication and can be more convenient for the patient[5]. Teamwork can also enable doctors to manage larger list sizes and, through sharing home visits, increase intensive home care to patients who are seriously ill, potentially reducing referral rates to hospital[5].

2.6 Many Community Health Councils (CHCs) have made a positive contribution to GP services in their area[7]. For example, a model of partnership for Primary Care Groups and CHCs in West Sussex has been developed, which includes looking at potential difficulties and mutual gains, while making proposals for effective joint working[8].

More clinically effective and/or cost effective services

2.7 The advantages to patients of a team approach are said to accrue through a group process of 'co-operation', 'co-ordination' or 'collaboration'[9]. When care outcomes of teamwork were measured, the benefit to the patient of professionals working together was greater than would have been achieved had they worked in isolation. The best patient outcomes were achieved after contact with the least hierarchical team model[9]. Effective team care for chronic illness often involves professionals outside the group of individuals working in a single practice[10].

2.8 Secondary care examples may provide useful models for primary healthcare. Some randomised controlled trials[11,12] have shown that patients treated by a multidisciplinary team in a geriatric unit had a lower mortality rate than controls, while team-care of stroke patients resulted in significantly higher scores for motor performance and functional ability than traditional care patients.

2.9 Organisational advantages of multidisciplinary teamwork have impacted favourably on: health surveillance, management of chronic disease, terminal care and the psychosocial impact of illness[13]; in Holland a general practice diabetic clinic[14]; a practice-based cervical cancer screening call system[15] and preventive care of patients in a severely deprived area of England[16].

2.10 Some studies have identified improved efficacy through deployment of the skills and expertise of primary care professionals, for example, evaluation of nurse-run asthma and hypertension clinics[17,18,19].

2.11 As well as medical practitioners, other team members can and do contribute directly to making primary care services more cost-effective. A recent audit of the introduction of a home-based counselling service found that it had reduced patients' use of other practice services[20]. Practice pharmacists can promote rational prescribing, manage the drugs budget, and develop and implement repeat prescribing policies[21]. A pharmacist-managed, practice-based anticoagulant clinic has reduced waiting times and travelling costs for patients, while improved communication between the GPs and pharmacist reduced the risk of toxicity and treatment failure[22]. Aside from their role with patients on prescribed medicines, community pharmacists are readily accessible to the public for consultation about self-limiting conditions and some chronic conditions, a quicker option than seeing a doctor[23].

Enhanced job satisfaction

2.12 Teamwork can reduce work-related stress among general practitioners by reducing workload. Being able to spend more time with patients may also reduce stress for the GP[24]. A large research study on teamworking in the healthcare setting, where the team was defined as *'a group of people with shared objectives and a unique contribution from each other'*, showed that clear benefits of teamworking were improved staff wellbeing and with it, increased performance[25].

2.13 Nurses' involvement in teamwork should increase job satisfaction by reducing perceived alienation, although the extent to which nurses and other members of the team participate in decision-making currently varies between teams[26]. A research project, which explored the role of shared learning involving clinical team case studies, showed that, in those teams where there was more collaborative working, there were clear benefits for patients, carers and the team itself[27].

Barriers to teamwork in primary healthcare

2.14 Teamwork does not necessarily follow from professionals working alongside one another and some researchers have observed that the path to achieving teamwork may be a long and difficult one[28]. Structural, historical and attitudinal barriers contribute to the difficulties. In some circumstances teams may perform less effectively than individuals working alone[29]. The published literature[30] provides evidence of the problems of:

- competing demands
- diverse lines of management
- poor communication
- personality factors, plus
- status and gender effects.

Organisational structure

2.15 Potential organisational obstacles include different lines of management into primary healthcare teams, which can undermine attempts at teamworking[29,30,31]. Added to this are different payment systems associated with the independent contractor status of some team members. A further barrier in primary healthcare is the lack of any over-arching structure, which could provide continuing support and education for teamwork. As with so many areas of work in healthcare, inadequate staff and resources may also constitute a barrier.

Size and location of teams

2.16 Team size can be a critical factor; the increasing size of some extended teams can be disadvantageous[32]. Experience suggests that large teams (greater than 20) are less effective than smaller teams, where it is easier to engage members and communicate effectively[33,34]. Geographical separation can be an issue for some teams and/or members. Teams in general practice may be small when formed around the needs of individual patients.

Internal team factors

2.17 Internal factors include people's inertia, satisfaction with the status quo, and an inability to attract support for innovation. Recognising when facilitation can make a useful contribution can help to overcome these factors[35].

2.18 The existence of clear objectives, full participation, an emphasis on quality and support for innovation have been found to account for a quarter of the variation between teams in their effectiveness. In particular, clarity of and commitment to team objectives was key in predicting the overall effectiveness of the primary healthcare team[32]. *'Bad processes rarely produce good outcomes'*[36].

2.19 A study of competencies in primary healthcare teams found that the majority of teams had a strong commitment to developing teamwork and learning. However, many experienced difficulty in planning strategically for the team's development. Competing demands were implicated and, from some team members, particularly GPs, lack of appreciation of the need for strategic planning[37].

Time constraints

2.20 Insufficient time for formal and informal meetings of the team, and the contractual obligations of some important off-site team members, can lead to individual team members not having the appropriate level of contact to fulfil their own and the team's needs. *'Teamwork takes time because each new team member multiplies the need for communication and co-ordination'*[33].

Professional divisions

2.21 Entrenched attitudes of team members can lead to team conflict. These can include lack of understanding and respect for other professional roles. Some individuals or groups may be unable to relinquish positions in a team to other more suitable members, holding on to power or status[29].

Factors which *promote* teamwork

2.22 The published literature supports the view that effective teamwork is most likely to occur where:

- each team member's role is seen as essential
- roles are rewarding, and
- there are clear team goals.

Other factors important in promoting teamwork are:

- effective communication
- optimum team size
- recognition of team members' professional judgment and discretion, and
- adequate time and resources.

Teams could be helped by:

- having a shared learning process, and
- working on team development[36].

2.23 The creation of integrated nursing teams (INTs) represents one example in the development of more integrated primary healthcare[38,39]. Integration has been defined as 'bringing into equal partnership' and teamworking as being about 'sharing skills, not preserving existing roles'.

Group processes

2.24 Good working relationships are built and maintained by team members understanding and acknowledging each other's skills and roles. Team leadership skills are required. Agreeing a process for resolving conflict assists the identification and management of predictable problems[25,29]. Multidisciplinary activities such as audit, pilot projects, and joint education and training can contribute positively to strengthening group processes[36].

Communication

2.25 Agreed and easy to use communication channels are essential for successful teamworking, particularly when individuals are not normally located in close proximity to each other. Mistrust, apprehension regarding role encroachment and a lack of understanding of other professions may well be a direct result of previous poor communication[40].

Team members

2.26 People who work best in a team environment are those who are not only capable of performing their own tasks but who also possess knowledge, skills and attitudes that support their team[29]:

- supporting and building on the work of others
- getting along with others, and
- managing conflict.

Multidisciplinary education, training and continuing professional development (CPD)

2.27 Collaborative practice and work-based learning enable practitioners to learn more effectively together[41]. There are opportunities for teamworking through CPD linked to current healthcare initiatives, for example through the clinical governance agenda and the work of local Primary Care Groups.

2.28 Guidance on the general clinical training of doctors during the pre-registration year reiterates the importance of building on the teamworking skills learnt as an undergraduate[42].

Summary

2.29 The research background and evidence base has confirmed the potential for teamworking in primary healthcare and has identified factors which can help its promotion. A number of barriers to co-operation and collaboration in the delivery of primary healthcare are acknowledged. However, the evidence suggests that these can be overcome.

Discussion

2.30 The review of the evidence during meetings of the Forum generated much lively discussion. Members contributed additional points from their own experience on the following issues:

- specific conflicts in practice
- information sharing and confidentiality
- the patient's perspective, and
- team size and geographical location.

Specific conflicts in practice

2.31 The Forum considered whether the inclusion in teams of independent contractors (dentists, GPs, optometrists and pharmacists) alongside employees could create friction. It was recognised that, with a predominance of self-employed or independently contracted professions in primary healthcare, there were areas from which a financial conflict of interest could potentially arise. However, the Forum received no evidence that any perceived conflict of interest worked against the best interests of either patients or of the taxpayer. Indeed, rather than being a barrier, independent contractor status may confer freedom to provide flexible solutions. By contrast, commercially sponsored practitioners, for example some specialist nurses, were seen by some as a possible threat to teamworking and thus to optimal care.

2.32 The absence of mutual respect between professional groups and, at its worst, the perception within individual professions that they are 'demonised' by others, can also inhibit teambuilding.

2.33 Renewed and more effective attention to teamworking in undergraduate and pre-registration education was thought to be required.

Information sharing and confidentiality

2.34 It was felt that greater sharing of patient information within the team had implications for issues of confidentiality and patient consent. There is potential for conflict between 'sharing information' and 'preserving confidentiality'. Uncertainty amongst professionals about legal and ethical aspects of sharing patient information amongst the team, important for teamworking, can create barriers.

2.35 Following publication of the Caldicott Report (1997), local 'Caldicott Guardians' have been appointed to safeguard confidential patient information. The new national Confidentiality and Security Advisory Body should ensure that all NHS bodies have robust guidance on how to handle confidential information[43].

The patient's perspective

2.36 Clearly, charging for care services can be a barrier within the wider team, from the patient's perspective. This may arise between health services and social services as the latter are often means tested. Also, while younger users of services may expect a team approach, older patients may be accustomed to an individual approach and may be resistant to teamworking.

Team size and geographical location

2.37 Differentiating between stakeholder groups (having an interest in the services provided but not directly providing or receiving them) and members of the team is important, as the former are appropriately represented in a steering group but not necessarily in the 'working team'.

2.38 It was reiterated in discussion that the issue of location was important to some professionals, for example community pharmacists, who often need to be situated within high street or housing estate locations to satisfy patient/client demand and expectations. But this physical separation has caused problems of isolation, which have adversely affected the profession's ability to maximise its contribution to healthcare.

3.1 The Forum identified a number of contextual issues, which were likely to impact, whether positively or negatively, on teamworking in primary healthcare. These embraced the changing health and social environment, new Government policies, and professional and technological developments. A brief résumé is presented in this section.

The changing health and social care environment

3.2 *Issues include:*

- demographic changes, which are likely to increase demand
- development of consumer/patient power through both greater access to information and cultural changes
- the acceptance of a patient-centred approach to healthcare
- concern about standards of physical care of elderly people
- preventive care with recognition of wider determinants of health at local and practice population level
- changes in the provision of education, transport and social services, and
- the care of deprived groups being more dependent on partnership between health and social care.

Patients are being empowered to make informed decisions about their well-being, health and social care. Meeting their needs and expectations will demand a more sophisticated approach to teamworking using different models.

Government policy

3.3 There has been a series of Government initiatives which could have a major impact on teamworking in primary healthcare (Appendix 3). *These include:*

- establishment of PCGs/PCTs in England; LHCCs in Scotland; LHGs in Wales
- NHS Direct and Walk-in Centres
- National Service Frameworks (NSFs) and clinical governance
- Health Action Zones (HAZs) and Healthy Living Centres (HLCs)
- quality initiatives in organisation and service provision, for example support for PCTs and PCGs from the multidisciplinary National Primary Care Development Team in England.

The development of 'intermediate care' in the community could potentially have major impacts on primary healthcare teams.

3.4 Primary Care Groups in England, Local Health Groups in Wales and Local Health Care Co-operatives in Scotland are intended to provide a direct means by which GPs and community nurses, working in co-operation with other health and social care professionals, voluntary organisations and lay people, can lead the process of securing appropriate, high quality care for their community.

3.5 New initiatives such as: Health Action Zones; Healthy Living Centres; Walk-in Centres; Personal Medical Services (PMS) pilots, and NHS Direct should stimulate innovative approaches to providing healthcare in the community. In particular, there is potential for integration of NHS Direct and Walk-in Centres with other services, for example the formal referral of patients by NHS Direct nurses to community pharmacists or the potential use of clinical decision support systems by a range of different health professionals in a number of settings, facilitating appropriate referrals. However, there is also the potential for a two-tier system to develop, with the young, healthy and employed being well served by Walk-in Centres, while others with significant health problems remain more reliant on traditional-style primary healthcare.

3.6 Many Community Health Councils are represented on NHS Direct Boards, and CHCs have received largely positive feedback from patients: faster access to health care and satisfaction with the quality of advice given. However, a number of issues have been raised, for example the need for careful integration of multiple primary healthcare services[44].

3.7 The Forum has made a formal request to the Department of Health for the evaluation of new initiatives, particularly Walk-in Centres, to include their impact, if any, on professional teamworking. We were pleased to receive assurance that the research protocol agreed for the evaluation of Walk-in Centres would take account of the issues raised by the Forum. Only full evaluation of Walk-in Centres will demonstrate whether they enhance or detract from effective teamwork.

3.8 A first year evaluation of Personal Medical Services (PMS) pilots[45], where GPs are salaried practitioners, indicates that the majority of sites (in the study) have an internal focus and are using PMS to develop primary healthcare services within the practice. Developing a more community-oriented focus and links with other NHS and non-NHS organisations has been achieved in only a small number of pilots. Of particular significance has been the introduction of new roles for nurses. A third round of PMS pilots has been approved with a view to them going live in April 2001.

3.9 NSFs, if properly resourced, together with the guidance produced by the National Institute for Clinical Excellence (NICE) for England and Wales and clinical governance, as reviewed by the Commission for Health Improvement (CHI) in England and Wales, together with their equivalent, the Clinical Standards Board for Scotland; are likely to enhance and encourage teamworking. These initiatives also illustrate the potential for interprofessional collaboration on a national level to address health priorities. Both NSFs issued at the time of drafting this report (Coronary heart disease and Mental health) refer explicitly to standards in primary healthcare.

EXAMPLE: NSF for Coronary Heart Disease

'OCTOBER 2000 PRIMARY CARE MILESTONE - Clinical teams should meet as a team at least once every quarter to plan and discuss the results of clinical audit and, generally, to discuss clinical issues. PCGs/PCTs and hospitals that together form a local network of cardiac care should have effective means for agreeing an integrated system for quality assessment and quality improvement.

PRIMARY CARE NSF GOAL - Every primary care team should ensure that all those with heart failure are receiving a full package of appropriate investigation and treatment, demonstrated by clinical audit data no more than 12 months old'[46] .

3.10 The prescribing and supply of medicines is an important element of primary healthcare. A report commissioned by the Department of Health[47] recommended an extension of prescribing authority to further groups of professionals with particular training and expertise in specialised areas. The review team's recommendations included the supply and administration of medicines under patient group directions, where appropriate, in limited circumstances. Extending the scope of nurse prescribing should mean more specialist nurses (for example in asthma or diabetes) being able to treat more patients with a wider choice of medicines than they are able to do at present. The Department of Health will be considering legislation to allow 'supplementary' prescribing by other health professionals, such as pharmacists, physiotherapists and chiropodists, for example where repeat prescriptions are provided or dose adjustments are made.

> *'I am delighted that the Government has decided to take forward the recommendations of the Review of prescribing. I have no doubt that the changes that are being introduced will improve our care of patients, make better use of the skills and professionalism of staff and encourage more effective teamwork.'* **Dr June Crown, March 2000, referring to Medicines Control Agency consultation MLX 260.**

3.11 Extending prescribing rights to more health professionals carries with it the real problem of maintaining communication between all those involved. The need for relevant patient records to be accessible to all prescribers, together with effective communication between 'independent' and 'dependent' prescribers is highlighted in the Crown report[47]. *Independent prescribers* are those responsible for the assessment of undiagnosed conditions and for making decisions about the clinical management required, including prescribing; while *dependent prescribers* are responsible for the continuing care of patients who have been clinically assessed by an independent prescriber.

3.12 Some policy changes might provide 'windows of opportunity' as PCGs, LHGs and LHCCs present opportunities for improving teamwork – *'a coming together of equals'*[48]. However, there are some differences in the current representation of various team members on PCG/LHG/LHCC boards. For example, pharmacists and others are represented as of right on Welsh LHG boards but not on PCG boards in England. Lay members are represented on PCG/PCTs and LHGs as of right and hence involved in strategic decision-making for the local population. In Scotland, there is no 'blueprint' for lay inclusion on LHCC boards but a requirement for membership to reflect local need. These differences illustrate factors which are arguably not conducive to teamworking.

Professional considerations

3.13 *Issues include:*

- numbers of professionals available, planning for future demand, and skill mix to maximise effectiveness of care
- maintenance of professional competencies and life long learning
- rapidly expanding and changing professional knowledge
- lack of clarity of clinical responsibility in multiprofessional teams
- achieving co-ordination of care.

3.14 The number of professionals available currently, especially doctors, is unlikely to meet future expectations for timely provision of high quality care, if services continue to be provided in the traditional model. Workforce availability is therefore likely to shape patterns of service delivery in a way which maximises the contribution of scarce skills. These factors are bound to encourage greater use of delivery of care by teams. This will involve ensuring that the skills of all team members are used by allowing them to contribute to their full potential. However, it is important to ensure that teamworking does not unnecessarily restrict the access of patients to the healthcare professional of their own choice.

3.15 The aspirations of the professions and of individual professional members, some of whom have been described as 'leading edge practitioners', are major catalysts in the development of teamworking. Somewhat paradoxically, limitation of health resources has also spurred innovative approaches, for example in the field of medicines management. The evolution of primary care pharmacists was stimulated initially by the need to introduce additional expertise to GP practices on prescribing issues and through this, teamworking has been developed and supported.

3.16 Continuing professional development is an essential supporting feature of clinical governance. Professionals working together must have mutual confidence in their fitness to practise and in their ability to keep up-to-date. Skills must keep pace with new thinking and new techniques. Joint training opportunities will be important in this respect and in building teams.

3.17 The RCGP's current quality initiatives include: Quality Team Development; the Quality Practice Award, and Fellowship by Assessment. In developing these initiatives the College has worked regularly with other organisations and has drawn on its Patient Liaison Group to ensure the contribution of patients. With support from the NHS Executive, the Quality Team Development programme provides continuous assessment and accreditation of primary healthcare teams.

The Quality Practice Award (QPA):

'An award presented to a practice in recognition of its achievement in meeting criteria that reflect a high quality standard of patient care provided by the whole primary healthcare team. QPA has specific recognition of the working environment within general practice and the increasing inter-relationship of all members of the primary healthcare team in delivering quality patient care. Recognising this teamwork and its benefits to patient care is the ethos behind QPA. By January 2000, 12 practices had achieved QPA and commonly reported the experience to have led, amongst other things, to better teamwork. A further 82 practices had notified their intent to apply for QPA.' RCGP 2000[49].

3.18 Recent practice guidance from the Royal Pharmaceutical Society on the care of patients with diabetes[50] encourages community pharmacists to become members of the extended diabetes team: *'To date, pharmacists have not actively pursued membership of the diabetes team but with an increasing emphasis on teamwork within primary care and 'seamless care', patients must benefit from the integration of pharmacists into the 'extended' diabetes team…in the same way that local optometrists, podiatrists etc are'.*

Technological developments

3.19 *Issues include:*

- potential for IT to improve communication between team members
- more complex care being provided close to home, demanding more teamwork
- developments in clinical genetics (it is unclear how much of this will be undertaken in primary healthcare and how this might impact on teamworking)
- telemedicine and video conferencing.

3.20 There are many developments with the potential to influence, or even revolutionise the delivery of primary healthcare. The use of IT has major potential to facilitate the development of teamworking in primary healthcare because it provides an answer to the problem of immediate communication between team members who are not geographically co-located, whether the district nurse on her round of patients in their own homes or the pharmacist on the high street. Advances in telecommunications and information technology will increase the ease of information transfer between members of the healthcare team, reducing professional isolation. Mobile telephones and e-mail facilities are obvious examples, while the electronic patient record, when achieved, should also contribute enormously to improved communication.

3.21 In addition, there are advances assisting professional development, for example telemedicine and video conferencing. These advances might provide better opportunities for consultation between, and joint education and professional development of, primary healthcare professionals.

3.22 Technological developments in patient care have stimulated a major increase in the number of patients, particularly the elderly, on complex regimens at home or in the community. Near-patient testing; hospital at home; parenteral nutrition; aspects of home-based palliative care: all include such technological developments with direct benefits for patients and also a requirement for effective teamwork.

4.1 The Forum was keen both to acknowledge important work being done on aspects of teamworking and to encourage primary healthcare teams to build on successful examples. The following are a small sample of teamworking initiatives, drawn from the literature or suggested by Forum members.

Communication

4.2 Agreed and easy to use communication channels between health professionals are essential for successful teamworking, particularly when individuals are not normally located in close proximity to each other.

PRACTICE EXAMPLE: Joint workshops

Two pilot projects have helped pave the way to improving local communication between community pharmacists and GPs. The workshops, held in mid 1999 in Nottingham and Manchester, brought pharmacists and doctors together to discuss matters of common interest such as management of repeat prescriptions, self-medication, co-operative working and the links between pharmacists and PCGs. The workshops were organised jointly by the Doctor Patient Partnership and the Royal Pharmaceutical Society. 'These workshops have provided an ideal forum to show how many common agendas there are and how each profession can help the other, for patient benefit'[51].

PRACTICE EXAMPLE: SCIPiCT Consortium, Powys, Wales

Sharing Clinical Information in the Primary Care Team (SCIPiCT), an initiative of the National Assembly of Wales, is a 3-year demonstration project, which promotes a patient focus based on one multiprofessional electronic clinical record. The record is maintained in partnership with the patient and the process enables electronic clinical information to be shared across the primary healthcare team at the point of practice. A standard clinical language is used. SCIPiCT is a consortium between the primary healthcare team (centred on Arwystli Medical Practice in Llanidloes & Caersws), the local NHS Trust and County Council, commercial suppliers and academic partners. The rural geography had contributed to difficulties of traditional information transfer and communication, particularly for peripatetic staff. An ongoing core activity of the project is the development of a multidisciplinary clinical information system and piloting of applications and technologies[52].

Multidisciplinary education, training and continuing professional development

4.3 Organisations such as CAIPE (UK Centre for the Advancement of Interprofessional Education) support the view that shared educational experiences lead to shared understanding.

PRACTICE EXAMPLE: a collaborative education and training initiative for community pharmacists and GPs.

An invited group of community pharmacists and GPs in the Greater Glasgow Health Board area shared a series of three direct learning courses commissioned from the Scottish Centre for Post Qualification Pharmaceutical Education. The underlying goal was to promote better understanding between the professions and to explore methods of strengthening the primary healthcare team.
Course topics included: 'cost of non-compliance in hypertension', 'managing minor ailments', and 'repeat prescribing and medication review'.

The topic areas were chosen to be as inclusive and relevant to the practice situation as possible. Course providers deduced from the evaluation of the initiative: increased awareness of each of the professional roles, more positive attitudes towards each profession and the potential for collaboration. The benefits of this initiative were found to be mainly in terms of impact on the professionals themselves[53].

EXAMPLE: ENB research project, Brighton University

A study involving analysis of the role of collaborative/shared learning in pre- and post-registration education in nursing looked at the extent and nature of shared learning and the problems related to its provision. The findings revealed that very little of the current provision of multiprofessional education in universities addressed inter-professional issues. But professional bodies were not identified as creating barriers to shared learning[27].

New services; new roles

4.4 Medicines management is a problem that concerns all those involved in primary and community care but it affects vulnerable people and their carers most of all[54]. The frail, the elderly and those with learning difficulties or mental health problems are particularly prone to poor medicines management. There is a strong rationale for attempting to address the problem because the consequences are so costly in both financial and human terms.

4.5 Medicines management is an ideal example of teamworking between health and social care. Several examples, which follow, illustrate a variety of such developments in practice.

PRACTICE EXAMPLE:
Improving medicines management for the elderly and housebound

North Staffordshire Health Authority established a scheme for domiciliary visits by pharmacists, incorporating referrals from GPs, community nurses and social services. Patients' medication-related problems were identified and recommendations on changes in medicines made by the pharmacists to the GPs[55].

PRACTICE EXAMPLE:
Glasgow repeat medication clinics

The aim of this study was to compare the impact of a pharmacist-directed medication review clinic within a general practice setting to the practices' usual system. The study design was a randomised controlled trial, with control patients compared to a pharmacist intervention group (active group). Six practices recruited to the study had a total practice population of 26,000. All patients aged 20 years or more and who were receiving four or more medicines on repeat prescription were invited to attend a pharmacist-directed medication review clinic. The pharmacist reviewed the case notes and computer-held records of patients before each interview to determine the continued appropriateness of the medicine regime. All drug-related problems in the active group were identified and referral made to the GP with specific recommendations. For the control group, the process was identical except that the care issues were recorded but not passed on to the GP. All recommendations agreed with the GP were implemented by the pharmacist. Outcomes, including cost effectiveness and measures of health gain, were measured at 6-12 months after implementation of changes.
The referral rate was high (63-94%) and the rejection rate low at only 3%, indicating that GPs were receptive to the pharmacist recommendations. The study demonstrates that a pharmacist-directed medication review clinic, within the GP practice setting, can reduce inappropriate prescribing. The results contribute to the evidence base on which to develop the proposed 'dependent prescribing model' contained in the Crown Review on the prescribing and supply of medicines[56].

PRACTICE EXAMPLE:
New lifestyle clinic in South Wales

Three GP practices in South Wales have teamed up with a local pharmacist to try to improve their patients' lifestyles. Patients are being referred to a new lifestyle clinic in Neyland, run by a local community pharmacist. The clinic is aimed at people at risk of heart disease. Referred patients have their general health and risk of heart disease assessed by the pharmacist. The scheme is being run as a pilot scheme initially, with financial assistance from Dyfed Powys health authority[57].

4.6 Problems with repeat medication are generally recognised. An increasing number of pharmacists are employed by GP practices and PCGs, PCTs, LHCCs and LHGs. These primary care pharmacists have a legitimate role in contributing to cost-effective prescribing and medicines management.

PRACTICE EXAMPLE:
North Yorkshire community pharmacist

A community pharmacist is employed by her local medical practice to spend half a day a week rationalising the practice's expenditure on drugs, appliances and special feeds. She has also advised a rural dispensing practice on matters relating to the Drug Tariff, labelling of medicines and buying stock. The work is 'rewarding and fascinating and gives a wealth of new professional contacts: GPs, community nurses, practice receptionists and health authority advisers'[58].

4.7 The creation of integrated nursing teams (INTs) in primary care has required devolving budgets to team level, removing hierarchical restrictions, and implementing training to enhance the change process and the concept of self-management. A monograph on INTs[59] stresses the importance of teamworking and the necessity of time for team-building activities and for developing lines of communication between nurses and with the wider primary healthcare team.

PRACTICE EXAMPLE:
Hillingdon Health Authority, 1997

The authority developed extended primary care teams, consisting of GPs, nurses, administrative staff, wider nursing services (school nurses, community mental health nurses, Macmillan nurses and midwives) as well as other specialities such as podiatry, physiotherapy and pharmacy. Evaluation demonstrated improved communication within the extended team and much closer working between practice and attached nursing staff[38].

PRACTICE EXAMPLE:
Downfield Surgery, Dundee

An upper GI clinic run at the surgery has provided early serological testing for Helicobacter Pylori. The protocol has involved each patient presenting with symptoms of dyspepsia being reviewed by the GP. Patients on long-term treatment with H2 antagonists or proton pump inhibitors have also been reviewed. Following assessment and initial treatment, the patient has been managed by the practice-based pharmacist, being referred back to the GP for a clinical decision in difficult cases or where no diagnosis has been confirmed by endoscopy. Patient counselling has been an important component for successful outcomes as eradication of Helicobacter is dependent on patient compliance with prescribed medication.
The Golden Helix Quality Award (run by Manchester University's health services management unit) was awarded to the pharmacist-led team at Downfield Surgery for the work of this clinic[60].

Perceptions and understanding

4.8 There is evidence from practice to show that changes in perceptions are taking place among primary healthcare professionals. Pilot projects can be successful engines for change.

PRACTICE EXAMPLE:
St Helens & Knowsley HA multidisciplinary programme for the management of ischaemic heart disease.

The success of a GP-pharmacist prescribing initiative over a 3-year period provided the foundation for this feasibility/pilot study.
The ways in which community pharmacists could positively contribute to the care of community-based patients with stable angina, when working with GPs in their practices, was explored. Six evidence-based interventions and pharmacist-run review clinics were utilised. Pharmacists', GPs' and patients' perceptions relating to the review clinics were explored.
Findings from this pilot study show that a number of community pharmacists were motivated to extend their professional role and were able to work in harmony with co-operative GPs. This enabled the delivery of a defined community-wide secondary prevention programme for patients with angina. This was accepted and valued by the patients who participated in the study. The outcome in terms of the six interventions was improved patient management and quality of life[61].

New policy initiatives in primary care

4.9 Teamworking in smoking cessation can be seen in Health Action Zones, where innovative smoking cessation services are being developed. Many agencies contribute to the services. There is some evidence from trials to show that most involve referral to community pharmacists as a service element.

4.10 The NHS Direct initiative, whose telephone helpline is staffed by nurses, works alongside existing health services. The accompanying Healthcare Guide publication is available to the public from community pharmacies. A project in Essex has piloted formal referral of callers to the helpline to community pharmacists for further advice/assistance. A further development is NHS Direct on-line, an internet version of the scheme, while use of interactive digital television technology is likely to be harnessed to further extend the scheme in the future.

4.11 Healthy Living Centres

PRACTICE EXAMPLE:
The Bromley by Bow Centre

Britain's first healthy living centre, described as 'a jewel in an east end London sea of congested roads and tower blocks', is seen as a prototype for the Government's healthy living centres. At the heart of the Centre is a primary healthcare team bringing together not just GPs, nurses and health visitors but also complementary therapists, artists, nursery workers, benefits advisers and other community workers. The Centre's health centre has an open and integrated approach, where receptionists help patients access a range of services: the GPs, the nursing team and the Centre. A 'health market place' offers a wide range of services in an accessible way. Patients are involved in their own care and are used as a potential resource linking health professionals with the community[62].

4.12 Beacon Awards

PRACTICE EXAMPLE:
Beacon Award winner

'The NHS Beacons Services programme celebrates success and spreads best practice'.
A decade of development has culminated in a Hertfordshire surgery gaining beacon status for its integrated and inclusive approach to service provision. The culture of the partnership is one of team working, promoting life-long learning and continuous service improvement. The practice has adopted a multidisciplinary approach to meet the needs of the local community. Extended services include physiotherapy, travel, Citizens Advice Bureau satellite, counselling, and a patient library [63].

4.13 A third wave of Personal Medical Services pilots will go live in April 2001. The first pilots are reported to be making real differences in tackling health inequalities and improving access for patients[64]. Innovative PMS pilots have been offering new and flexible ways of delivering primary healthcare services.

PRACTICE EXAMPLE:
Isleworth, West London

Hounslow and Spelthorne Community and Mental Health Trust and Ealing, Hammersmith and Hounslow Health Authority have identified a major gap in the provision of primary care services in Isleworth. A new, trust-run, PMS practice in Isleworth provides accessible primary, community health and social services under one roof in a deprived area with diverse need. The practice team consists of a salaried GP, a primary care clinical nurse specialist, other health professionals and social services, operating as an integrated team. The scheme is intended to complement local GP primary care provision[65].

4.14 Many of the initiatives described in this section will influence the development of teamworking over the coming years. In view of the rapid pace of change and, at the time of drafting, the imminent publication of a national plan for the NHS, we believe that this topic should be revisited in three years' time to assess progress.

5.1 These have required very careful consideration by the Forum. The evidence we have been able to adduce during our deliberations has confirmed the thesis that high quality primary healthcare can best be delivered by effective teamworking. We have found many good examples of this in practice. It is clear that some teams have been able to surmount the quite formidable barriers that we have also been able to identify and it is likely that many other teams are struggling to do so.

5.2 We were asked to bring forward proposals by which the national organisations representing primary healthcare professionals could support and promote teamworking in primary healthcare. However, we feel that we can best assist the development of teamworking by providing two sets of recommendations: one set for teams and their members currently engaged in hands-on clinical care and another for the national organisations with responsibilities for these professionals.

Teams and team members

5.3 These recommendations are intended to represent the principles for establishing a primary healthcare team and to describe what a team member should expect as the basis for successful teamworking.
The team should:

1. Recognise and include the patient, carer, or their representative, as an essential member of the primary healthcare team at individual patient-centred team level or at practice level. *(1.11)*

2. Establish a common agreed purpose, setting out what team members understand by teamworking, what they aim to achieve as a team and how they propose to do this. *(2.18)*

3. Agree set objectives and monitor progress towards them. Build into its practice, opportunities to reflect as a team on the care provided and how it could be improved. All team members to be actively involved in the delivery of the agreed objectives and in the decision-making process. *(2.19)*

4. Agree teamworking conditions, including a process for resolving conflict. Identify predictable problems, which the team might encounter, and plan ways of managing these. *(2.24)*

5. Ensure that each team member understands and acknowledges the skills and knowledge of team colleagues and regularly reaffirm what each member contributes. *(2.24)*

6. Pay particular attention to the importance of communication between its members, including the patient and off-site or peripatetic members, and use, to the full, technological developments to assist this as they become available, where co-location is not practical. *(2.25)*

7. Take active steps to ensure that the practice population understands and accepts the way in which the team works within the community. *(1.12, 1.13)*

8. Select the leader of the team for his or her leadership skills rather than on the basis of status, hierarchy or availability and include in the membership of the team all the relevant professions serving a practice population. *(2.24)*

9. Promote teamwork across health and social care for patients who can benefit from it, using team members' joint efforts to help to reduce both ill health and social exclusion. *(3.4)*

10. Evaluate all its teamworking initiatives and as a result, develop its practice on the basis of sound evidence. *(3.7)*

11. Ensure that the sharing of patient information within the team is in accordance with current legal and professional requirements. *(2.34, 2.35)*

National organisations

5.4 If teamworking is to be taken as seriously as we think it should be, and practised as effectively as it could be by the primary healthcare professions, the national organisations must set an example to their members by a much more active co-operation and collaboration in achieving the necessary conditions to support teamworking. The recommendations of the Forum to national organisations involve aspects of support for national priorities, education, research and guidance.
They should:

Supporting national priorities

12. Promote and publicise interprofessional national initiatives designed to address health priorities. *(3.9)*

13. Impress upon Government the potential for primary healthcare teamwork in modernising the NHS and the importance that Government guidance is seen to support such teamwork whenever appropriate. *(3.3, 3.7)*

14. Seek opportunities to discuss with Government the cost-effective potential offered by the provision of appropriate resources in IT for facilitating teamworking in primary healthcare. *(3.20)*

15. Take full advantage of the opportunities offered by National Service Frameworks (NSFs) and national guidelines and give positive guidance to their members on developing teamwork to achieve the objectives of the frameworks. *(3.9)*

16. Seek to ensure that the knowledge gained from effective teamworking is incorporated into the design of future public policy and NSFs. *(3.9)*

Education

17. Take active steps to facilitate interprofessional collaboration and understanding through joint conferences, education and training initiatives. *(3.16)*

18. Establish an over-arching structure to help provide continuing support and education for teamwork amongst the primary healthcare professions. *(2.15, 3.16)*

19. Discuss with Government the resourcing of facilitation and education on teamworking to ensure the most effective use of professionals in primary healthcare. *(2.15, 2.17, 3.16)*

20. Within the responsibility of national bodies for, and their capacity to influence, undergraduate and/or postgraduate education of primary healthcare professionals, recognise that teamwork is a skill, which needs to be taught and learnt, and build opportunities to develop this into relevant basic curricula and post-basic training. *(2.28, 2.33)*

21. Highlight in their educational and service development initiatives the importance of organisational factors to the effectiveness of teamworking, including the provision of protected time and resources. *(2.15, 2.24)*

Research

22. Take positive steps to secure investment in research on teamworking and its impact on primary healthcare. *(2.2)*

23. Promote the evaluation of all new initiatives in teamworking by having an evaluation component built into their design. Track these initiatives, collate and publicise evaluation results, and disseminate information on good practice to their members. *(2.2)*

24. Give some priority to evaluating teamworking initiatives which include health and social care staff. *(2.2)*

Guidance

25. When defining primary healthcare teams, include patients and, where appropriate, carers, as full team members. *(1.11, 1.12)*

26. Promote the development of information for the public on the skills and knowledge of different health and social care professions, what they do and the links which exist between them. Also explore ways of empowering people to care for themselves, when that is appropriate, to access primary healthcare services at the most appropriate point, and to make effective and responsible use of services. *(3.2, 3.4)*

27. Publicise the value of teamwork and the factors that facilitate good practice in teamworking in their communications to their members. *(2.22, 2.24)*

28. Acknowledge and promote the existence and value of various team compositions in primary healthcare, while accepting the importance of the general practice-based primary healthcare team. *(1.12, 3.14)*

29. Promote primary healthcare teamworking in partnership with social care, when appropriate for the benefit of patients. *(3.4)*

30. Take necessary steps to explore with the NHS Executive, NHS Wales and the Scottish Executive NHSiS, the issues of confidentiality and sharing of information as they relate to teams in primary healthcare, so enabling the provision of clear guidance to their members on these important and sensitive issues. *(2.34, 2.35)*

31. Provide guidance to primary healthcare professionals on legal and ethical aspects of sharing patient information between team members. *(2.34, 2.35)*

Membership of the Forum

Dame Deirdre Hine	Chairman
Mr. Charles Butler	National Pharmaceutical Association
Dr. John Chisholm	British Medical Association
Mr. Tony Crosby	Association of Directors of Social Services
Ms. Susan Dewar	Royal College of Nursing
Mr. Digby Emson	Royal Pharmaceutical Society of Great Britain
Mr. Gary Fereday	Association of Community Health Councils for England and Wales
Ms. Rosey Foster	Institute of Healthcare Management
Dr. Simon Fradd	Doctor Patient Partnership
Dr. Iona Heath	Royal College of General Practitioners
Prof. Clare Mackie	Royal Pharmaceutical Society of Great Britain
Prof. Michael Pringle	Royal College of General Practitioners
Ms. Thelma Sackman	Community Practitioners' and Health Visitors' Association
Mr. Ashok Soni	National Pharmaceutical Association
Dr. Gordon Watkins	British Dental Association
Mr. Simon Williams	The Patients Association
Secretariat	
Ms. Christine Gray	Royal Pharmaceutical Society of Great Britain
Mrs. Barbara Stewart	Pharmacy Practice Consultants

Teamworking in Primary Healthcare - common definitions

One of the first tasks faced by the Forum was to define its terms as this was seen as essential to progress. We considered definitions of the following: a team; teamwork; primary healthcare, and a primary healthcare team.

Defining a team

A team can be defined simply as *'a group of people who make different contributions towards the achievement of a common goal'*[36]. A more comprehensive definition reads:

'A team is a group of individuals who work together to produce products or deliver services for which they are mutually accountable. Team members share goals and are mutually held accountable for meeting them, they are independent in their accomplishment, and they affect the results through their interactions with one another. Because the team is held collectively accountable, the work of integrating with one another is included among the responsibilities of each member'[66].

Defining teamwork

The forum took as one of its starting points the WHO definition of teamwork: *'Co-ordinated action carried out by two or more individuals jointly, concurrently or sequentially. It implies common agreed goals, clear awareness of, and respect for others' roles and functions. On the part of each member of the team, adequate human and material resources, supportive co-operative relationships and mutual trust, effective leadership, open, honest and sensitive communications, and provision for evaluations'*[4].

Another useful definition from a medical perspective states: *'The purpose of teamwork in medical practice, as of every professional activity by doctors and other health care workers, is to provide the best means of serving patients' interests'*[42].

Defining primary healthcare

The WHO declaration of Alma-Ata also defined primary healthcare as: *'Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation. ..It is the first level contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.'*

This broad definition describes a service of 'first contact'.

Defining a primary healthcare team

There is no generally agreed definition of the primary healthcare team. We have identified several definitions, including one in common usage: *'all members of staff who provide health care services to a given population registered with one or more general practitioners'*. And similarly: *'GPs and practice-employed staff'*.

A fuller description states: *'those professionals associated with a particular GP practice, usually including GPs, practice managers, practice nurses, receptionists, administrators, and attached community staff including health visitors, district nurses as well as community midwives'*[29].

The Forum considered these published definitions, acknowledging their limitations. From this, the Forum developed the concept of *the team in primary healthcare being dynamic rather than static, professional input changing to meet the changing needs of patients and groups of patients in different circumstances.*

Defining multiprofessionalism

A report of the Standing Committee on Postgraduate Medical and Dental Education (SCOPME) on multiprofessional working and learning used the following definition of multiprofessionalism: *'a team or group of individuals from different disciplines with different and complementary skills, shared values, common aims and objectives'*[67].

Government policy likely to impact on teamworking in primary healthcare

The importance of teamworking in primary healthcare has been emphasised in numerous reports and policy documents on the National Health Service. A report on nursing in primary care[68] emphasised the importance of teamworking if health and social care for people in local communities were to be of the highest quality and efficacy.

A Department of Health discussion document[69] set out proposals aimed at removing barriers to joint working between health and social services. The proposals included suggestions for pooled budgets; lead commissioners; guidance on joint priorities; new performance frameworks, and joint review of services at the interface.

Following the Government's 1997 White Paper for the NHS in England[48], primary care services have been reorganised, including the dismantling of GP fundholding and the introduction of Primary Care Groups. Scotland and Wales have undergone similar reorganisation[70,71]. Primary Care Groups/Trusts in England, Local Health Groups in Wales and Local Health Care Co-operatives in Scotland are intended to provide a direct means by which GPs and community nurses, working in co-operation with other health and social care professionals, will lead the process of securing appropriate, high quality care for local people. Lay members are represented on PCGs, PCTs and LHGs as of right and hence have first-hand involvement in strategic decision-making for the local population.

Clinical governance is an important part of the Government's policy for achieving excellence in the NHS. It embraces quality initiatives around four main components:

- clear lines of responsibility and accountability for the overall quality of clinical care
- quality improvement programmes
- risk management policies
- procedures for all professional groups to identify and remedy poor performance.

Quality improvement activities include, amongst other things, clinical audit and continuing professional development. The coming together of these different components offers significant opportunities for teamworking amongst professional groups within primary healthcare.

In England, Health Authority-driven Health Improvement Programmes (HImPs) require collaboration between the NHS, local authorities, social services and the voluntary sector.

In 1999, a White Paper for England[72] contained proposals for improving the health of the population as a whole. An important factor in achieving required change will be partnership working between organisations and local communities, making it incumbent on all Government agencies to work in collaboration.

New initiatives like Health Action Zones, Healthy Living Centres, Walk-in Centres, NHS Direct, Personal Medical Services (PMS) and PMS Plus pilots should stimulate innovative approaches to providing health care in the community. PMS and PMS Plus pilots, for example, offer different methods of delivering general medical services and possibilities of extending the scope of service provision to include elements of the hospital and community health services budget, through new contractual relationships[45,64].

The consultation paper *A First Class Service*[73] described the establishment of a National Institute for Clinical Excellence (NICE), which aims to give clear, consistent guidance for patients and professionals about which treatments work best for which patients and which do not. The Clinical Standards Board for Scotland has a similar role. The development of national service frameworks (NSFs) is an essential element of the process. NSFs should be an important catalyst for teamwork.

The *Health Act 1999*[74] will allow the principles of *A First Class Service* to be put into effect. Areas of professional regulation will come under greater scrutiny so that patients and their families can be assured that their treatment is up to date and effective and is provided by those professionals whose skills have kept pace with new thinking and new techniques. Section 31 of the Health Act refers to Partnership Arrangements, whose aim is to improve services for users and fulfil national and local objectives, through pooled funds, lead commissioning and integrated provision. Partnership arrangements are intended to support better co-ordination and innovative approaches to securing services across a wide range of NHS and local authority functions.

1. Braithwaite J, Lazarus L, Vining R, Soar J. (1995) Hospitals: to the next millennium. *International Journal of Health Planning Management,* **10:** 87-98.

2. Joint statement of BMA, NPA, RCGP, RCN & RPSGB. (1998) Responsible self care including self-medication. *Royal Pharmaceutical Society of Great Britain,* London.

3. Guzzo RA. (1996) Fundamental considerations about work groups. In West MA (ed) *The handbook of work group psychology,* Chichester: Wiley.

4. Kekki P. (1990) Teamwork in primary health care. *World Health Organisation,* Geneva.

5. Marsh GN. (1991) Caring for larger lists. *British Medical Journal,* **303:** 1312-1316.

6. Hasler J. (1994) The primary health care team. *Royal Society of Medicine Press,* London.

7. Association of Community Health Councils for England and Wales. (1997) CHCs making a difference. *Health News Briefing.*

8. West Sussex Community Health Councils. (1999) Primary Care Groups and Community Health Councils in West Sussex. Building a Partnership. *Worthing & District CHC.*

9. Feiger SM, Schmitt MH. (1979) Collegiality in interdisciplinary health teams: its measurement and its effects. *Social Science and Medicine,* **31A:** 217-229.

10. Wagner EH. (2000) The role of patient care teams in chronic disease. *British Medical Journal,* **320:** 569-572.

11. Rubenstein L, Josephson K, Wieland G et al. (1984) Evaluation of a geriatric evaluation unit. *The New England Journal of Medicine,* **311:** 1664-1670.

12. Wood-Dauphnee S, Shapiro S, Bass et al. (1984) A randomized trial of team care following stroke. *Stroke,* **15**(5): 864-872.

13. van Weel C. (1994) Teamwork. *The Lancet,* **344:** 1276-1279.

14. Palm B, Kant C, Van den Bosch W et al. (1993) Preliminary results of a general practice based call system for cervical cancer screening in the Netherlands. *British Journal of General Practice,* **43:** 503-506.

15. Parnell S, Zalin A, Clarke C. (1993) Care of diabetic patients in hospital clinics and general practice clinics; a study in Dudley. *British Journal of General Practice,* **43:** 65-69.

16. Marsh GN, Channing DM. (1988) Narrowing the health gap between a deprived and an endowed community. *British Medical Journal,* **296:** 173-176.

17. Charlton L, Charlton G, Broomfield J et al. (1991) Audit of the effect of a nurse-run asthma clinic on workload and patient morbidity in a general practice. *British Journal of General Practitioners,* **4:** 227-231.

18. Charlton L, Charlton G, Broomfield J et al. (1992) An evaluation of a nurse-run asthma clinic in a general practice using an attitudes and morbidity questionnaire. *Family Practice,* **9:** 154-160.

19. Jewell D, Hope J. (1988) Evaluation of a nurse-run hypertension clinic in general practice. *The Practitioner,* **232:** 484-487.

20. Gurney P. (1999) Counsel homes. *Health Services Journal,* 15 July, 29.

21. Bradley M. (1996) The role of the practice pharmacist - the new member of the team. NHS Executive, V*FM Update Primary Care Focus Issue,* 2 January: 26-27.

22. Macgregor S. (1997) Practice makes perfect. *Chemist & Druggist,* **247:** vi-viii, 19 April.

23. Hassell K. (2000) Diverted traffic. *Health Services Journal,* 6 January, 22-23.

24. Howie JGR et al (1992) Attitudes to medical care, the organisation of work and stress among general practitioners. *British Journal of General Practice,* **42:** 181-195.

25. Borrill C et al. (2000) The effectiveness of healthcare teams in the National Health Service. Final report submitted to the Department of Health, March 2000.

26. Cott C. (1998) Structure and meaning in multi-disciplinary teamwork. *Sociology of Health and Illness,* **20:** (6) 848-871.

27. Miller C et al. (1999) The role of collaborative/shared learning in pre- and post-registration education in nursing, midwifery and health visiting. English National Board for Nursing, Midwifery and Health Visiting, *Research Highlights,* No. 39.

28. Lamberts H, Riphagen F. (1975) Working together in a team for primary health care - a guide to dangerous country. *Journal of the RCGP,* **25:** 745-752.

29. West MA, Slater J. (1996) Teamworking in Primary Health Care: A review of its effectiveness. *Health Education Authority,* London.

30. West MA, Pillinger T. (1996) Team building in primary health care: An evaluation. *Health Education Authority,* London.

31. Audit Commission. (1992) Homeward bound: a new course for community health. *HMSO,* London.

32. Poulton BC, West MA. (1999) The determinants of effectiveness in primary health care teams. *Journal of Interprofessional Care,* **13:** (1) 7-18.

33. Royal College of General Practitioners. (1995) The Nature of General Medical Practice. *RCGP,* London.

34. Stott NCH. (1995) Personal care and teamwork: implications for the general practice-based primary health care team. *Journal of Interprofessional Care,* **9:** (2) 95-99.

35. Field R, West MA. (1995) Teamwork in primary health care. 2. Perspectives from practices. *Journal of Interprofessional Care,* **9:** (2) 123-130.

36. Pritchard P, Pritchard J. (1994) Teamwork in primary and shared care: a practical workbook. *Oxford Medical Publications*. Oxford.

37. Usherwood T, Newton P, Long S, Joesbury H, Matthews D. (1996) All together now. Competences in primary health care teams. Summary of a study by the Institute of General Practice and Primary Care, University of Sheffield. *Report for the Department for Education and Employment and the National Health Service Executive*.

38. Elwyn G, Smail J, Ed. (1999) Integrated teams in primary care. *Radcliffe Medical Press*.

39. Rink E, Ross F, Furne A. (2000) Integrated nursing teams in primary care. *Nursing Times,* Clinical Monographs, No. 49.

40. West MA, Poulton BC. (1997) A failure of function: teamwork in primary health care. *Journal of Interprofessional Care,* **11:** (2) 205-216.

41. Barr H, Waterton S. (1996) Interprofessional education in health and social care in the UK. *CAIPE, the UK Centre for the Advancement of Interprofessional Education*. London.

42. General Medical Council. (1999) Statement: Teamworking in medicine. *GMC,* London.

43. Department of Health. (2000) press release: New Body to Advise on Patient Confidentiality. Ref. 2000/0151. London.

44. Association of Community Health Councils for England and Wales. (1999) NHS Direct and Walk-in Centres: gateway to the NHS? *Health Perspectives*.

45. Walsh N, Allen L, Baines D, Barnes M. (1999) Taking off: a first year report of the Personal Medical Services (PMS) pilots in England, *School of Public Policy, Health Services Management Centre, University of Birmingham*. Birmingham.

46. Department of Health. (2000) National Service Framework for Coronary Heart Disease. London.

47. Department of Health. (1998, 1999) Review of prescribing, supply and administration of medicines, first report and final report of the Crown Review. London.