Office for Health management

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Programme of Support for the Primary Care Strategy Implementation Teams

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1. Background

The Primary Care Strategy, *Primary Care: A New Direction*, was launched in November 2001. In October 2002, the Minister for Health and Children gave approval for the establishment of an initial ten implementation projects, one in each health board area. The Office for Health Management (OHM) was asked at that time by the Department of Health and Children (DoHC) to develop a programme of support for these Primary Care Strategy Implementation teams. This programme includes the following:

- Establishing a network of liaison people across all Health Boards
- Facilitating national meetings of these liaison people, managers and Directors of Primary Care across the country. These meetings have also been attended by members of the Primary Care Task Force from the DoHC as well as Project Managers from the individual teams.
- Providing a development programme for the Project Managers. This is now completed.
- Providing facilitation for the teams for team development purposes.
- Visiting the teams prior to this facilitation to assess their development needs.
- Facilitating a workshop for GPs from the implementation teams following a joint request from the DoHC and the Irish College of General Practitioners.

This report summarises our visits to the Primary Care Teams, the GP workshop, the Project Managers Development Programme and provides some conclusions from our work to date.

2. Primary Care Team Visits

The OHM facilitated three national meetings of liaison people, senior managers, project managers and the Primary Care Task Force in 2003 (March, April and September). It became apparent to us that the teams were at various stages of development and progress. Each team was operating within a unique complex local environment. This greatly limited the potential at that stage for shared learning across the teams on issues such as enrolment, roles and responsibilities etc. We needed to understand why the teams were at various stages of progress in order to design the most appropriate development interventions. We decided to visit each team and assess their individual situations. The teams had been visited previously by the Primary Care Task Force and evaluated in terms of monitoring progress toward implementation of the strategy but the team development aspect had not been specifically examined.

We met with seven teams between November 2003 and March 2004. The three remaining teams were assessed through interviews with the Project Managers. The meetings with the teams were well attended and we appreciated the openness of team members in sharing their experiences. We were also impressed by the motivation and commitment the implementation teams have to their local community and service users.

The key themes that emerged from our visits were:

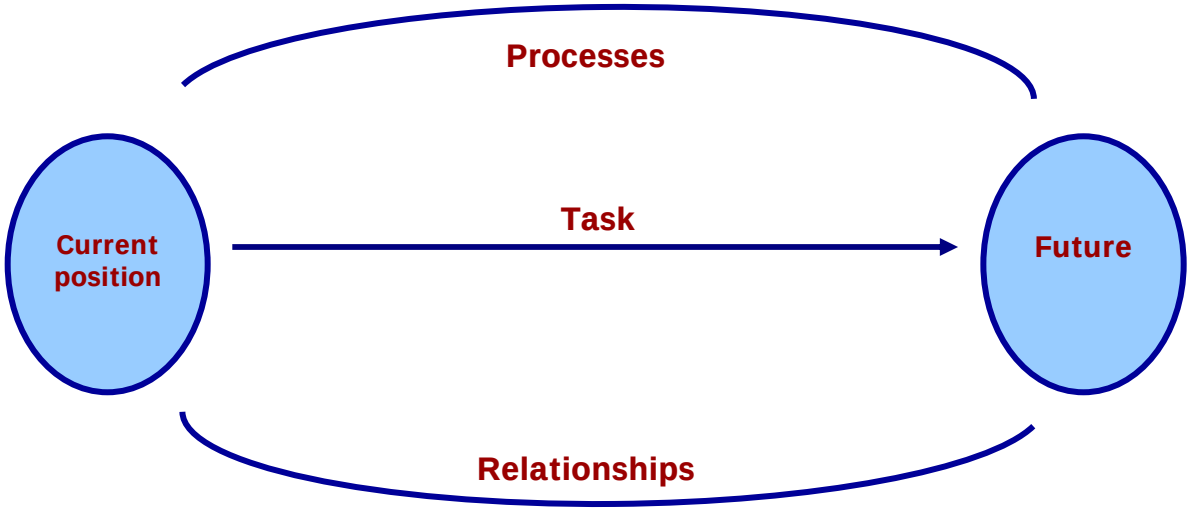
- 2.1 States of readiness
- 2.2 The team itself – current situation, vision and goals, processes and relationships
- 2.3 Culture and structure
- 2.4 Supports – corporate, professional and financial
- 2.5 National Policy and its implementation at local level

2.1 States of readiness

The progress that teams had made in implementing the Primary Care Strategy was heavily influenced by their 'state of readiness' at the time of the launch of the Strategy and its subsequent implementation. In teams where states of readiness were high they were able to 'hit the ground running' and were quicker to take advantage of available resources. Contributing factors included a history of close working relationships on a variety of levels (between the GPs themselves, between the GPs and health board staff, and between health board staff themselves) and systems and processes already being in place for collaborative working.

2.2 The team itself

We used the following model to look at the development of each team. The model enabled us to ask questions about the tasks the team had set for themselves, the processes they had established (e.g. managing meetings, communication etc.) and the status of relationships (e.g. between different disciplines in the team, between the team and the health board etc.).



From this analysis several themes emerged as to why some teams had progressed further with implementation than others:

- ***2.2.1 Team vision*** – in some teams the future state and vision for the team was not well articulated and so there were difficulties translating the strategy into action. Where teams had spent time articulating this vision, which was agreed by the entire team and revisited when new members joined, more had been accomplished.

- ***2.2.2 Team development and dynamics*** – where teams had spent sufficient time on initial team building, establishing a vision and building relationships, the progress of the team was positively affected. Appreciating team dynamics is an ongoing process and requires awareness and attention particularly in a multi-disciplinary team where there is such diversity.

- ***2.2.3 Clarity of task*** – if teams were unclear about vision and what they wanted to achieve they became overly focused on tasks and tended to 'dive straight in'. The tasks being tackled were sometimes too large, perhaps inappropriate for the stage they were at and were not linked to any clear vision.

- ***2.2.4 Incomplete teams*** – due to the imposition of an employment ceiling many teams were incomplete and felt unable to proceed fully with implementation.

- ***2.2.5 Roles and responsibilities*** – with such a wide variety of professions coming together, often working with each other for the first time, there was sometimes a lack of understanding and clarity about each others roles and the areas of responsibility in terms of the patient/service user.

- ***2.2.6 Time and incentives*** – working in multi-disciplinary teams involves considerable time commitment for meetings, as well as extra work such as sub-groups and team building. Team members often felt they had insufficient time and were not incentivised to put in the extra time and so they did not always readily see the benefits.

- ***2.2.7 Managing meetings*** – the management of meetings sometimes proved difficult with such large teams and such diversity of membership. The times when meetings took place needed to be negotiated to accommodate the GPs (who often need to organise locums) as well as the health board staff (who often did not want to meet after hours). In some teams a solution to such large teams has been representation at meetings rather than all members attending. However, this raises its own issues and is a process that is only implemented when trust levels in the team are high enough and communication processes are properly in place.

- ***2.2.8 Resources*** – some teams were unsure how much funding was available and whether it was sustainable. They were unclear if this funding was ring fenced and protected and whether it would be available in the longer term. Where there was clarity on this issue, and particularly where a degree of financial responsibility was devolved to the team, this assisted the team development process.

- ***2.2.9 Taking care of relationships outside the team*** – where teams were taking care of relationships with the wider stakeholders in the process it seems to aid progress. These wider stakeholders include the community, other GPs in the area, other health care professionals in the health board etc.

- ***2.2.10 Governance and reporting structures*** – these varied widely. The governance arrangements were sometimes unclear and teams were unsure what level of autonomy they had. Reporting lines varied with some team members having dual reporting both within the team and without up to General Managers or Heads of Discipline.

2.3 Culture and structure

The formation of these multi-disciplinary teams brings together two distinct cultures, often working together for the first time.

Traditionally GPs in Ireland operated in single practices and were seen as local, independent business people. They hired their own staff and were largely autonomous in terms of service delivery and decision making. Even with the increasing trend towards group practices this culture has remained relatively unchanged. GPs in group practices work collaboratively and share resources yet retain their individual independence. The health board culture is more hierarchical in keeping with that of many larger organisations. There is a greater emphasis on the roles of individual professions and some issues need to be referred to a superior for decision or guidance.

The challenge for the implementation teams lies in bringing together professionals from these distinctly different ways of working. This process should not be under-estimated. The two cultures approach all levels of work differently from decision making, managing conflict and running meetings to the use of language and jargon. In teams where this culture difference was

recognised, understood and respected (which takes time, trust and compromise) the ability to build the team and work together was greatly enhanced.

This merging of cultures and consequent creation of a new distinct multi-disciplinary team culture needs to be appreciated not only within the team but by the external stakeholders as summarised in the diagram below.

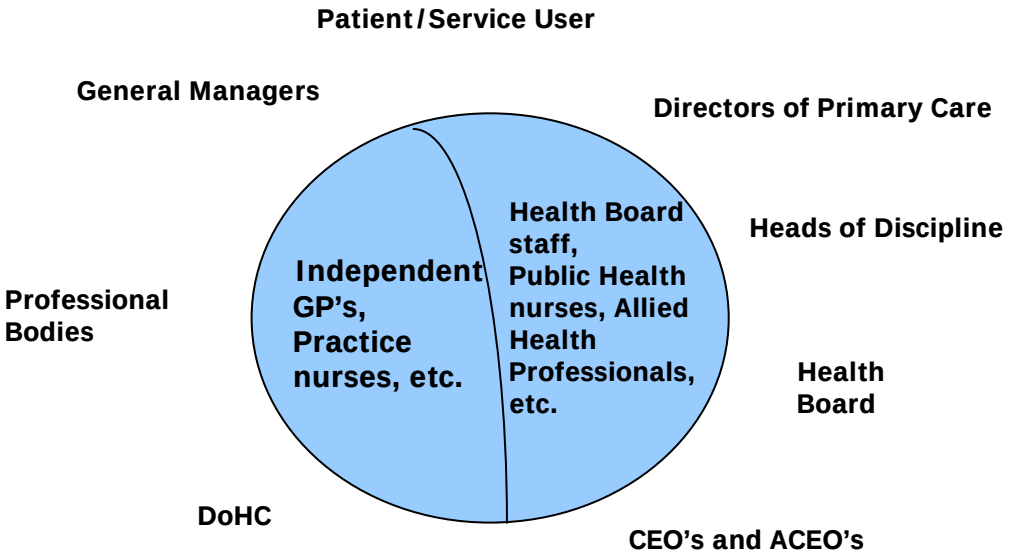


Diagram: Primary Care Implementation Team and external stakeholders

2.4 Supports

There were three areas where teams received outside support and its presence or absence can affect the team:

- ***Corporate Support*** from the CEO and management teams of the health boards. This can include but does not necessarily mean financial support. Where teams felt their organisation was behind them and left them empowered it had a positive effect on morale and motivation as well as the ability to get on with implementation.

- ***Professional Support*** from organisations associated with each health professional group.

- ***Financial Support*** – issues regarding this were raised in the previous section.

2.5 National Policy and its implementation at local level

Initially teams seemed to be tackling issues that may have been more appropriately addressed at a national level. These issues included eligibility, enrolment and IT systems. Teams were unclear about the appropriate level for policy formulation and whether certain issues were to be resolved at a national or local level. This consequently slowed down team progress.

3. GP Workshop

In December 2003, the OHM facilitated a workshop with 8 GPs' representing seven of the implementation teams. The workshop was designed to explore the GP experience of being a member of a Primary Care Strategy implementation team. It also provided an opportunity for the GPs to discuss key issues with representatives from the Primary Care Task Force and the Irish College of General Practitioners.

Several themes emerged from the GP experience thus far:

- GPs' identified time as being a critical element, particularly in terms of the extra time needed for planning, team building and collaborative working.
- Their availability to meet was not as flexible as health board staff and involved organising locums or other cover or asking for meetings to be held after hours. Locums were particularly difficult to get in rural areas.
- Decision making was much slower than they were used to and the language and 'jargon' used at meetings was often unfamiliar to them.
- They stressed the importance of support from their professional bodies.
- They had limited opportunities for networking with each other.

The GPs' also see themselves as having greater accountability and responsibility for patient management than other members of the team. They also believe the public expects this of them. This led to discussions about team leadership.

3.1 Team Leadership

The Primary Care Strategy does not specifically assign leadership within the teams. GPs felt that, more than any other profession, they have a leadership role although they do not always want it. Given a choice, GPs' prefer to have clinical leadership to any other team leadership. In the higher functioning teams leadership has been split between clinical and administrative but it is highly dependent on good working relationships to ensure a quality service. Where the issue of leadership has not been specifically addressed and agreed within the team there can be confusion around decision making, and task setting and progress has been slower.

4. Project Managers Development Programme

The OHM commissioned a development programme to focus on some of the key competencies needed to assist Project Managers in implementing the Primary Care Strategy and which could enable them as a group to work and learn from each other. A workshop took place on 16 September 2003 involving Project Managers and their colleagues from the implementation teams. During this workshop the design of the programme was agreed. It comprised seven contact days beginning with an insight day and followed by 3 x 2 day modules each with a key theme as follows:

- Module One: Understanding Self and Others
- Module Two: Developing a vision and implementation strategies for our work
- Module Three: Understanding and managing our interventions in the system

The programme concluded in May 2004 and was evaluated. Participants identified the following benefits:

- They were positive about the programme and felt it increased their overall effectiveness and confidence in project managing the implementation teams.

- It provided them with opportunities to focus on their own personal development.

- It provided them with practical tools, methodologies and approaches which they then applied within their teams.

- The programme provided them with an essential networking opportunity and was a way for them to share their 'pioneering' experience as the project managers of the first phase of implementation teams.

4.1 Learning Day – Recommendations from Project Managers

The OHM also held a Learning Day during the course of the programme asking the project managers to reflect on their experience to date and to identify critical success factors for team project management. While each project manager has had a different experience there was general agreement when they were asked 'what advice would you give to new project managers':

- ***Be aware of the different cultures that are coming together*** i.e. both the GP and Health Board side as well as the different professional cultures within the Health Board itself.

- ***Be an advocate for team building.*** Project managers recommend that facilitation is provided early on to help with firstly, a clear understanding of each others roles and professions and secondly, to help build an agreed team vision. This vision should be re-visited regularly, particularly when new members join the team.

- ***Communicate constantly.*** There should be constant communication within the team through both formal and informal processes. The project managers believe they play a pivotal role as a bridge between both sides of the team, particularly in the initial stages.

- ***Manage meetings effectively.*** Implementation team meetings should be held regularly, have a clear agenda and start and finish on time. The timing of these meetings may have to be negotiated to accommodate all team members as generally GPs prefer to meet after clinic hours and Health Board staff prefer to meet within business hours. In as much as is possible send out agendas and draft documents in advance so the meeting is focussed.

- ***Address the issue of representation.*** At first, professionals may not be happy to have their interests represented by others at meetings until sufficient trust has been built up. Once representation is allowed the representative must be aware of their responsibility in communicating back to the group they represent and processes should be in place to facilitate this.

- ***Build relationships***. Be aware of building relationships on many levels – within the team, outwards to the community, with other GP practices in the area and throughout the Health Board with other General Managers and Heads of Discipline.

- ***Identify quick wins***. These, and long term goals, should be identified early on. Quick wins will boost team confidence, commitment and morale. An example was focusing on providing a new service to a particular care group.

- ***Understand the services that are already in your area.*** There may be a need to map these services and/or carry out a needs assessment in consultation with the local community.

- ***Establish sub-groups where appropriate.*** Sub-groups can be very useful in accomplishing tasks, should be voluntary if possible and with mixed representation to ensure power and influence is balanced. Examples of subgroups are Premises, IT, Needs Assessment, Community Input, Links to Secondary Care, Record Sharing, Access, Enrolment and Referral.

The project managers also recommended that:

- **New project managers should shadow colleagues in established projects as part of their orientation.**

- **Networking at a national level should be continued to maintain the sharing of experiences.**

5. Conclusions

- The Primary Care Strategy implementation teams are the 'pioneers' of the strategy. They volunteered for this role and are working hard to find their way.

- All those we met were committed to, and believed in, the principles of Primary Care and could readily see the benefits it would bring to their service users and local communities.

- Some teams have had more success than others. Generally those who are more successful had higher 'states of readiness' and so were better able to adapt quickly and take advantage of opportunities for progress as they arose.

- The teams are working in a complex environment and are establishing new collaborative ways of working. They are merging two distinct cultures and creating new processes, systems and procedures for multi-disciplinary team working, all within a changing external environment. The difficulties of establishing these new teams should not be under-estimated particularly within the current context of health reform.

- Multi-disciplinary teams do not naturally emerge. Their establishment and success requires considerable resources, support and time as well as a compelling, clear vision.

- Networking and shared learning opportunities benefit ongoing team performance.