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An Exploration of Team Performance within the Irish

Health Service

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Abbreviations

Introduction – Setting the Scene

The delivery of high quality services and the achievement of organisational goals are accomplished through the key asset of any organisation, its human resources. People will always be the key resource in all organisations. Given the complex nature of work today especially in the health service, these very key resources need to be able to work together in order to achieve such goals. This is fulfilled through a team based approach in order to achieve high performing teams.

This research study is an exploration of such team performance within the Irish Health Service. The chosen area for this specific research is an exploration of performance of primary care teams (hereafter referred to as PCT). Not immune to external factors and drivers of change such as changing demographics it has influenced how the provision of health care is delivered to meet the health demands of Irish society. It was recognised in the *“Quality and Fairness – A Health system For You, National Health Strategy 2001”*, a strategy which sets out a new direction for primary care and the formation of PCT's, “Primary care is the first point of contact people have with the health and personal social services”. A team based approach was further directed as an essential requirement agreed upon within the *“Sustaining Progress Social Partnership Agreement 2003-2005”*, (Department of An Taoiseach 2003, 2006)

Deriving from both the Quality and Fairness strategy and Social Partnership agreement a new approach on people management - *“An Action Plan for People Management 2005”*, was born and acted as one of the most mainstreamed and dedicated Human Resources strategies to date within the Health Service Executive. Emphasised within the strategy was nine core themes some of which was the need

for the “implementation of performance management systems, managing people effectively, investing in training, development and education and development of open communication and inclusiveness” *An Action Plan for People Management* (hereafter referred to as APPM). Since 2005 to present one such performance management process rolled out on phased basis was Team Based Performance Management Model (hereafter referred to as TBPM). This process involves team members and leader:

- Agreeing on a number of key performance areas (i.e service priorities) based on the service plan;
- Subsequently agreeing on a number of objectives/goals for each of these key areas;
- Assignment of tasks to each team member in pursuit of these objective/goals;
- Achievement of these objectives/goals being reviewed regularly by the team.

Aims and Objectives:

This primary aim of this research study is to explore team performance within the Health Service Executive, specifically looking at two PCT's based in Laois/Offaly within the Dublin Mid-Leinster region, HSE. To date there has been substantial research carried out both internally within the organisation and by independent consultancy bodies on the effectiveness of teams in reaching high performance levels impacted by the TBPM process. It has been found that there has been significant success to date of the impact of the TBPM model however, areas for improvement also have been identified. Over 320 PCT's to date have been formed and It is anticipated a further 530 teams to be roll out by 2011. Within the Midlands

area there has been four teams set up in the midlands area with a further 20 teams mapped across this area.

This research study aims to explore team performance levels of two purposely chosen PCT's within this area where the process of TBPM is awaiting roll out so as to gain insight of elements outside of the TBPM model impacting team performance which can further enhance the TBPM process and compliment processes of future performance management systems being implemented.

In efforts to explore team performance, it was anchored towards the team performance model taken from Heinemann and Zeiss, (Heinemann & Zeiss, Team Performance in Health Care, 2002). Contained within this model three key domains are identified, incorporating six dimensions and key elements respectively for each. The domains include: A)Structure, B)Process and C)Productivity. Dimensions covered: Organisation and team structure as reference to concept framework for this research study, **refer to appendix 1.**

For the purpose of this study, team performance of two PCT's was explored through qualitative means to gain the perceptions of associated team members, leader and team trainer on team performance within the PCTs.

Firstly, four structured interviews were carried out, targeting as stated, participants across the range of: team leader/transformation officer/PCCC, team based training co-ordinator/corporate, two team members from the social care model discipline/Allied Health professionals both from respective PCT's chosen.

Secondly, a focus group was run, consisting of three participants across the disciplines of health professionals/ Allied Health & Social Care and Management/Administration

Chapter 1: Literature Review

Organisational Context

Within the past decade, the HSE made the shift to a more formal structured method of people working together to achieve maximum performance through teamwork and the set up of Primary Care Teams born out of core strategies *Quality and Fairness – A Health system For You, National Health Strategy 2001, Sustaining Progress Social Partnership Agreement 2003-2005* and *“An Action Plan for People Management 2005*. Making the shift to a team environment through teamwork to eventual high team performance can be a task in itself, but one that cannot be ignored and one that must be carried out with precision. It is important for this reason that Primary Care teams are developed and maintained to be high performing. Historically the HSE has worked in a more independent nature and steps to overcome this through a team based approach deriving from the core strategies in place have been recognised as the a critical factor in order for high team performance and in alignment of achieving the overall organisations goals and objectives.

The current performance management process in place is the model of Team Based Performance Management, one of the key recommendations of the Action Plan for People Management HR Strategy. This process incorporates the importance of effective team working and participative planning which links team actions into the service plans of the organisation and regular reviews by teams. It has been rolled out on a phased basis and elements that are working well are in the areas of more comprehensive understanding of team-working and a more focused planning and review structure (Kearney et al (2004). Noted also were the

improvements that could be made in the provision of training and education and clearer communication documentation surrounding performance management processes and how it relates to the overall goals of the organisation (Kearney et al (2004). To this end the team performance model taken for this research study capture such elements where improvements can be made.

In exploring team performance the model see appendix 1 adapted for this particular research study was taken from Heinemann & Zeiss, 2002, providing a comprehensive guide in capturing some of the key elements within the wider organisational context and that are in line with the core HR strategy, an Action Plan For People Management in the exploration of team performance and specifically honing in on primary care teams. Having identified many recommendations from the TBPM process (Kearney et al 2004), consideration has been given of time that has passed and looking at team performance through adapting such a model to gain insight of any additional enhancements that could be incorporated into the TBPM process or the implementation of an adjoining model to further progress the team based approach performance management within the HSE.

Identified within this model were the domains of: structure, process and productivity (Heinemann & Zeiss, 2002). For the purpose of this research study, attention will be paid to the domains of Structure, Process and Productivity. Under the umbrella of structure is the dimensions of organisational structure and team structure, the process domain is broken into two dimensions of interdependence and growth & development and lastly productivity domain addresses the strategic dimension and accomplishments achieved by the team.

What is Team Performance Management:

Team Performance Management can be described as:

“Performance management is a strategic and integrated approach to delivering sustained success to organisations by improving the performance of the people who work in them and by developing the capabilities of teams and individual contributors” (Armstrong and Baron, 1998:7)

In essence performance management can be described as a system that integrates management of organisational and employee performance (Williams 2002)

In defining performance management consideration needs to be acknowledged in the stages in which a team must travel through. Recognised is the four stages of “forming” where the team is been brought together and who initially have unclear objectives, “Storming” where problems are faced and responsibilities become clear, “Norming” where by more focus and trust is established and “Performing” demonstrating high outputs and commitment to the team (Tuckman & Jensen 1977).

In determining the stage in which a team is at, it can be identified what performance levels will realistically achieved. It also acts as a guide to which development interventions can be realistically impacted in order to increase the team's performance.

Team Performance: Structure:

The organisational structure is one predominant feature that either can enhance or diminish the level of team based performance obtained "The structure of an organisation can benefit or create barriers to a team's ability to function" (Heinemann & Zeiss, 2002:3). (Wheelan 2005:2) "It's easier to create work groups and focus our efforts on group results than to address organisational issues that may be inhibiting group performance". Typically many organisations can focus their concentrations on team outputs and results (Armstrong, 2004)) rather than addressing the team processes or how it functions (Heinemann and Zeiss 2002)

Identified as one area in examining team performance is the resources available to such teams. There is a need to establish "defined team work areas" (Wheelan 2005:2). This can be a difficulty in large organisations such as the HSE as the primary care teams are spread out over a large populated community catchment areas. Brallier and Tsukuda as cited in Heinemann & Zeiss, 2002:4, agree that "for teams in healthcare settings, these resources include such things as supplies and a space in which to work in". Many of the primary care teams do need such defined work areas in order to reach their goals and objectives through high team performance. It is critical therefore, that teams meet regularly and have an accessible location to meet which makes effective two way communication, and "work progresses faster", (Wheelan 2005:2). Failure to supply such resources contributes to poor performance by the team.

The allocation of appropriate human resources to teams is needed and must be provided for by the organisation in order for the team to work effectively. The

resource of providing the team with skilled professionals can be described as a key resource that aids the functioning of the team and its performance (Parker, 1990)

Anderson et al (1994) as cited in Heinemann & Zeiss, 2002:4, states that "providing education and training to teams, their members and leaders is a major element of support from the organisation and its structure". All participants involved within team environment require education and training in areas, such as "developing their teamwork skills". In addition to this, there is a connection to effective team leadership directly influencing team members and their performance, for this reason training and education targeted to leadership is essential, but also to enable leaders to recognise when team members are require such training (Brallier and Tsukuda as cited in Heinemann & Zeiss, 2002)

Other organisational support mechanism that needs to be in place is the mechanism for communication and decision making according to Heinemann and Zeiss. "In most health care organisations, multiple teams work to achieve organisational goals" (Heinemann & Zeiss, 2002, pg48 Chap 4). Effective communication and decision making is required especially since the HSE merged into one unified health service, incorporating huge organisational restructuring. For this reason the organisational structure inclusive of clear direction of the primary care initiative must be clearly communicated to all employees so as to collectively comprehend what is being achieved. In addition teams need to have a mechanism in place that support an open forum to collaborate and discuss information both within the team and to the wider network of the organisation. Involvement in such processes cultivates motivation and commitment, provided this can be channelled through a two way communication means to team leaders or senior managers leading a team (Nixon 2004). Organisational structures that neglects the need of effective collaboration

and team working indicates a lack of communication in this regard (William G Dyer et al 2007).

The dimension of team structure influences how team members work together in achieving their goals and objectives. If roles and responsibilities are not clarified or clear, it causes demotivation among the team, resulting in anger and inevitable conflict (Meyer as cited in Engineering Management Review 1981). The primary care team performance management requirement envisaged by upper management and by all stakeholders involved is to adapt such initiative through “a strategic integrative approach...by improving the performance of people who work in them and by developing capabilities of teams and individual contributors” (Armstrong 1998: as cited in Performance Management Agreement, HSE 2003). In order for an integrative approach to be achieved clarity of roles and responsibilities needs to occur. The first priority for this to occur is to identify and agree the goals of the team. “One of the characteristics of high performance teams, is that members agree with the team goals....the point is that members need to see the relevance of the goals if the team is to be successful”, (Wheelan 2005, chapter 4, 2nd Edition). The team in unison must believe that the goals decided upon will meet the overall goals of the organisation. Once the goals have been established and agreed upon, the team can then organise it so that these are achieved through the development of their roles and thus clarity on such roles. Further to this, in managing, and leading the team effectively ensures the team members understand what is expected of them, therefore have their roles and responsibilities clarified so as to deliver what is expected of them (Armstrong and Barron 2004)

Given & Simmons 1977 as cited in Heinemann & Zeiss, 2002, pg.52 Chap 4, however feel that it travels much deeper in the sense that “often they do not know

how to integrate the skills of others with their own". Subsequently, leading to lack of clarity on the distinctive nature of their specific roles in comparison to the distinctive nature of other discipline roles present within the primary care team, "they do not realise that they are working under different assumptions and value systems", (Heinemann & Zeiss, 2002:4:52). In challenging this, attention turns towards a mind shift, (Senge 1990). Through exploring interdependences and the need for collaboration among the different disciplines within the primary care team, it in effect challenges the way people think, and looking at it from a different view point , changes such assumptions and subsequent actions accordingly, (Senge 1990).

Team Performance: Process

Process refers to how the team functions. Two of the main dimensions being addressed are the dimension of Interdependence and Growth & Development.

With regard to interdependence, team members need to participate in the teams activities which characterises interdependency working. This has a positive impact on the team performance through obtaining efficiencies in decision making and problem solving. This also cascades in effective accomplishments achieved through the productivity domain. Decisions being decided upon takes three levels, where ideas are pooled together, prioritised and chosen on the basis of which idea best overcomes a particular issue that has arisen (Scholtes, as cited in Heinemann & Zeiss 2002).

In order for a team to develop a strategic plan it cannot be developed accurately hence the need for "the different view-points to be accurately interpreted and the sifted through.....to determine how decisions will be made before any attempts to make the decisions..... members of high performance teams spend time defining and discussing problems they must solve", (Wheelan 2005:4). This is to ensure before the final decision is made that it has been well discussed and that all involved have clearly understood the implications involved and what led to the end result or rather the reason for the decision made. Some of the common problems among teams as suggested is when such teams don't spend this time discussing the problems they must solve, which leads to the wrong decisions being made (William G Dyer et al, 2007)

As highlighted, the art of effective decision-making and problem solving leads to educated and well informed decisions being made without this process defined it

can foster bad decisions being made ultimately leading to conflicts arising. The element of conflict management is present in most teams, "conflict is a normal part of group development" (Farrell, Heinemann, & Schmitt, 1986 cited in Heinemann & Zeiss, 2002). The management of conflict in developing teams to become high performing, helps foster trust and promote role and responsibility clarification. If however conflict isn't managed to the way it should be it can lead to a range of problems such as misunderstandings, lack of clarification of roles (William dyer et al, 2007) and serious hostility among team members can occur.

Wheelan (2005) also concurs that, if conflict that is left unresolved can lead to an increase in hostility within the team. Constructive conflict can be conflicts that are managed effectively and that are limited to conflicts about tasks, avoiding conflicts that involve and personality clashes. If conflicts or feuds that involve personal feuds can seem very difficult to overcome can in worst case scenario, never be resolved. It is important to view the conflict not as personality clashes but as "violation of expectations" and that "if expectations are not clearly understood, a cycle of violated expectations may be triggered" (William Dyer et al 2007:7)

Sources of conflict can include employee needs not being met or scarcity of resources. The various styles used to resolve conflict such as competitive, collaborative, accommodative, comprising, or avoidance (Thomas and Bennis 1972) it is crucial to recognise which style is appropriate to resolve certain situations and that it "remains within acceptable limits" so that damage to the team and the organisation does not occur (Gunnigle et al 1999).

To remedy both conflicts and overall remedy and development of team processes with regard to increasing interdependencies of decision making and

conflict management is to “evaluate team processes regularly” (Wheelan 2005:10:113), this can take the simple form of a 10 min slot at a team meeting addressing how the team is functioning as a form as process check. Dyer et al (2007) also concurs that to receive feedback or foster open discussions through an assigned time slot at team meetings is the most enhancing aspects that is managed effectively.

Growth and development must occur both for the team and individual team members so as the team work independently, ultimately sustaining high performance. The Health Service Executive is not immune to the wider forces of change, changing demographics and stakeholder expectation which can impinge directly on the organisations goals and objectives, therefore constant informal learning and feedback is essential. Leadership presence and support is required (Heinemann & Zeiss 2002), creating the reality of team effectiveness and the driving force behind the team and its activities. Coaching by team leaders can act as an important tool to activate informal learning and development and should be carried out throughout the annual year for clear indicators that team members are developing individually for the benefit of maximum outputs being produced (Armstrong and Barron 2004)

Team Performance :Productivity:

Having discussed the team processes through their growth and development coupled with interdependency working, this facilitates team productivity. In order for teams to be productive, teams take direction from national guidelines agreed deriving from such strategies within the Health Service Executive initiating the primary care strategy – *Quality and Fairness, A Health System for You*, detailing the primary care transformation of community based health service. Other strategies followed which included *Towards 2016 Ten Year Framework Social Partnership Agreement 2006 – 2016*, this strategy outlined the team based approach to manage the delivery of health care and the requirements for increased transparency and accountability. The Transformation Programme 2007 policy detailed the technicalities how this was going to be achieved with the development and roll out of Primary Care Teams through a team based approach.

Such strategies provided, allow for clear direction and development of actions plans. Through such action and patient care plans, it permits teams to work together and to allow for cross training among the members of the team. Currently within the Health Service Executive the process model of team based performance management lends itself very well into this process. It takes the form of identifying key areas for action, setting SMART objectives and assigning what members is to carry out certain action interventions. Such an exercise allows for a review mechanism to be built into the process through documenting the process so as to ensure progress is being made. Other benefits for devising actions plans through the team based performance management model adopted, is it strongly links to service planning, fulfilling the organisations goals and objectives. Similarly patient care plans are “the most frequently consulted part of the patient’s record” (Heinemann &

Zeiss 2002). Devising patient care plans requires commitment and effective execution on the part of the team for effective intervention. This is done through assessment of needs of the patient, deciding upon what options or intervention is the best route to take and implementing such actions allowing for a follow up evaluation of the patients progress. William Dyer et al (2007) found that attention must also be paid to the gathering and analysis of data before it can be assessed. Such data collection needs time to accurately analyse all data received and listing them in priority as to what has to be actioned first.

Action and care plans can only be discussed, when team members meet. Ideally, the single most important accomplishment that a team can achieve is conducting effective team meetings (Heinemann & Zeiss 2002). Due to this it can be seen as the single most effective exercise a team can carry out as it requires all aspects of team activities to be joined together and incorporates all aspects to achieving high performance among the team. In respect of the domain of structure when reviewing team performance the organisation must provide a meeting place for which team members need to meet. It aids the development of team processes of decision making, problem solving and communication. Wheelan 2005 describes it as an open forum whereby when the team meet, "have an open communication structure, spend time planning how they will solve problems and impart constructive feedback to members". Through the forum of team meetings it enhances productivity allowing teams to discuss, develop, and decided best care for patients through devising of action and care plans.

In addition, it can set a blue print for not only development of team processes and essentially, effective execution of action plans productivity of the team outputs but it can as (Waite & Hoffman: Heinemann & Zeiss 2002) state, a critical factor in

inducting new team members into the team for ease of integration into the team and in conjunction with sustaining team performance. Primary Care teams within the HSE primarily are made up of health professionals and professionals from the social care pillar. Whilst additional human resources were added to each team in its set up, many were situated within the old community care model, where disciplines worked very separately. Due to this many disciplines transferred over to the primary care model, Induction of such members requires as Fowler (1990: 69) states that transfer and promotions must not be bypassed or overlooked in assuming that induction training into a new team nature is not required. As Courtis 1976: 45, describes, "The long-term company servant is becoming rarer and to some extent new blood is healthy but losses beyond a certain volume or losses of key people should cause any employer to examine the causes"

Initial reasons for staff to leave can be due to lack of recognition, lack of communication or lack of development (Fowler 1990). In essence once teams review their performance through team processes and seek ways in which to enhance and improve them in order to reach high productivity levels, whether it is through effective team meetings, training provided by the organisation, or through growth and development, all processes clearly need to be developed and evident to the new member who has joined the team this "avoids disillusionment, leaving or bad habits". Torrington and Hall (1991), state that the "key to successful induction is enabling the new employee to be more confident in the new situation" to this end, prevention of high turnover which avoids negative disruption of the team dynamics thus directly and positively impacting team performance. Many organisations address this through formal induction training, but the nature of the work day to day can require a

constant medium of message for full comprehension by the new employee on how firstly what the team is striving towards and the manner in which it is done.

Summary:

Detailed within this chapter is team performance in an organisational context, definition of what performance management is and a detailed look at the team performance model adapted for the framework of this research study with adjoining theorists views in the field of team performance management.

Chapter 2: Methodology

Research Objective:

The aim of this research study is to explore team performance within the Irish Health service specifically looking at two Primary care teams (**refer to appendix 2**) within Dublin Mid-Leinster region. Within the past decade the core strategies and agreements in place have recognised the need for a team based approach to working in the delivery of health care to Irish citizens. Coupled with this was the priority policy of developing and delivering primary care to communities, “a one stop shop” and alleviating the pressures placed upon acute hospital services, thus the formation of PCT’s ensued. Born out of such strategies was the HR strategy detailing how best to management performance of such teams in order for alignment to achieving organisational goals.

Currently the TBPM process model has been developed and rolled out on a phased basis across the organisation to manage such performance, however, where success has shown to be evident within this process there has been areas for improvement identified through recommendations made by independent bodies. The two chosen PCT’s to be explored have not to date participated in the TBPM therefore have been chosen on the basis. The model adapted was taken from Heniemann and Zeiss (2002) looking at three of the core domains of team performance in health care which include: Organisational and Team Structure, Processes and Productivity. As detailed within the HR Strategy, APPM¹ some of the core themes outlined were, implementation of performance management systems, investing in education and training, open communication and managing

¹ An Action Plan For People Management

people. To this end the team performance model taken as the conceptual framework for this research study recognises and complies with the key features of core HR Strategy.

Qualitative Method:

Qualitative methods was chosen for this study in the form of four semi structured interviews in conjunction with a focus group that was run in order to gain complete perspective of all participants relevant to team performance . Qualitative data is subjective and in-depth information presented in the form of words. The most common tool used to carry out qualitative methodology analysis is in the form of structured/semi structured interviews and focus groups. Qualitative data from a combination of both interviews and focus groups was utilized for detailed listing of content analysis. Contained within the literature review is the three main domains identified through researching this study and it has set the framework of the study in terms of testing theory through the testing of hypothesis.

Collection and Organisation of Data:

The collection and organisation of data has been sought through recording and documenting all interviews and focus group conducted. Referring to **appendix 3, 4, 5, 6, 7** details the transcriptions of interviews and focus group, for reference, accuracy, and analysis purposes. Detailed in the key findings is the responses made under each of the domains adopted from the team performance model taken by Heinemann & Zeiss (2002).

Target participants:

Interviewee 1: Team leader/co-ordinator of four teams formed within the Laois/Offaly area (Refer to appendix 9 – TDO's)

Interviewee 2: Lead Trainer in Team Based Performance Management and Team development, HR Corporate

Interviewee 3: Joint team member of both PCT 1 - longer running team – 3 years and cross over member of PCT 2.

Interviewee 4: Team Member of PCT 1 – Longer running team - Five years formed

Focus Group: Participant 1, 2, 3, team members of PCT 2 Shorter running team – two years formed.

Reference table illustration for corresponding breakdown refer to **appendix 8**

The initial interview takes place with the team leader, leading two out four primary care teams within PCT's under the remit of team leader **see appendix 8**, This is followed by a one to one interview with Performance & Development lead on team-based trainer. Firstly, the purpose of consultation with interviewee 2 was to identify the development needs of teams in order to become high performing in achieving its goals and objectives within the Health Service Executive. Secondly, It's is a means in which to identify what current training modules that primary care teams either have participated in and what they can avail of to set the platform on which to build this research on. Thirdly, in meeting with interviewee 2 it gave insight into the supportive organisation structure imparted to this unit to carry out such training needs meeting the criteria of the performance model anchored to this research study.

The researcher felt it necessary for the purpose of this report, to complete a one to one semi structured interview with an individual team members in order to gain a detailed perspective of the attitude towards how teams function and perform from experiences a gained. Such concentration on a detailed account allows for the researcher to gain insight into the general perception of the team members on a one-to-one basis and in a group setting.

Semi Structured Interview Method:

Careful attention was paid in deciding upon the questions to be asked to each individual being interviewed so as to capture a complete overview of the main domains of team performance. To this end, questions asked were directly linked towards the domains of structure, process and productivity, addressing key elements as referred to in the literature review of this report. Below table illustrates this structure:

Domains/Dimensions/Variables:

DOMAIN: STRUCTURE ▶ A) Organisation B)Team ▶Variables:
A) Organisation Structure
Variable 1: Availability and Adequacy of Resources
Variable 2: Education and Training
Variable 3: Communication and Decision Making
B) Team Structure:
Variable 4: Role & Responsibilities

DOMAIN: PROCESS ▶ A) Interdependence B) Growth & Development
▶ Variables:
A) Interdependence
Variable 5: Decision making & Problem Solving activities
Variable 6: Conflict Management
B) Growth & Development
Variable 7: Informal Learning and Feedback

Domain: PRODUCTIVITY ▶ A) Strategies B) Accomplishments ▶ Variables:
A) Strategies:
Variable 8: Action/Patient Care Plans
B) Accomplishments:
Variable 9: Effective Team Meetings
Variable 10: Positive outcomes to new members of the team

Focus Group:

In exploring team performance within the HSE, the very nature of the topic lends itself to gaining insight to a true team environment through the means of a focus

group and allows for advantages to the researcher specifically within the field of health care groups. Group interaction is an enhancement of the focus group method and a further tool used for analysis. It capitalises on communication between research participants in order to generate data. It explores people's knowledge and experiences and can be used to examine not only what people think, how they think and why they think in a certain way. This form of data collection through the focus group method, is an effective technique for exploring team performance. Through the form of open ended questions put to the group, it encourages participants to explore points and issues raised among the discussions that are of importance to them based on open ended questions asked and the overall general themes directed by the researcher. In an external changing climate, the fast pace of change and reform being carried out, the focus group reaches parts that possibly other methods that may not have been tapped into. Many forms of quantitative research methods internally within the HSE of this topic area have taken place to date therefore the researcher felt that choosing a qualitative method was supplementary to previously obtained quantitative data contributing to a more rounded view of the research topic.

Group Composition:

Paying attention to the more newly formed primary care team for the focus group, the composition make up was compiled of three individual team members. The composition of the group represented disciplines from allied health professionals, under the pillar of Allied Health and Social Care and management administration under the pillar of PCCC.

Illustration of breakdown of themes and relative variables pertaining to each theme directed towards targeted Focus group:

Variables:

1. Theme 1: Structure: Attitudes towards the Primary Care Strategy/Policy

2. Theme 2: Structure: Role & Responsibilities within the team

3. Theme 3: Process: Decision Making and Problem Solving & Conflict
Management

4. Theme 4: Process: Informal Learning and Feedback

5. Theme 5: Productivity: Effective Team Meetings & Positive Outcomes to New
Trainees

Chapter 3: Key Findings

Introduction

This Chapter outlines feedback results from participants highlighted in the methodology chapter of this research study. It is divided among the three core domains detailed within the methodology piece exploring team performance.

Section 1: Structure domain looks at questions posed to interviewees through structure interview process in relation to the organisation's structure and support and team structure. The variables covered outlined in chapter three cover the elements of availability of resources to teams, education and training and communication.

Through the dimension of team structure roles and responsibilities was addressed:

Section 2: Process domain covers the two key dimensions enhancing team performance: Interdependency and Growth and Development. The core elements covered which directed to participants of the focus group and individual interviewees was the variables of decision making and problem solving, conflict management under the umbrella of interdependency working. The informal learning element under the dimension of growth and development was also explored in order to gain insight on the development by the teams in achieving high team performance

Section 3: Within the productivity domain, attention is turned, in the quest to explore key dimensions of strategic productivity and accomplishments achieved. Three of the core elements researched through the qualitative methodology means was action/care plans under the domain of strategy employed and the effective team

meetings and positive outcomes to inducting new team members as core accomplishments achieved by the teams targeted.

Section1:

Domain: Structure,

Dimension: Supportive Organisational Structure.

Variable 1: Availability of Resources:

The objective was to ascertain if the resources available both tangible and intangible were present and provided for by the organisation's structure and supportive nature of such structure in order to enhance team performance: Key results found, with regard the element of the availability of tangible resources overall were limited:

Interviewee 1 described that the basic human resources were supplied to team number two (shorter running team):

Interviewee 1: "This Primary Care team got to develop was three extra posts, such as a social worker, physiotherapist and dietitian so that completed the team on services...they could overcome a lot more issues locally than they could previously"

In contrast to this however, interviewee 2, who's primary role is to work in the area of providing training and development to teams stated that

Interviewee 2: "with regards to human resources element of it (of placing the current TBPM model process into teams)..we are probably ..yeah you need more staff, totally without a shadow of a doubt, I mean there's fifteen thousand people across DML (Dublin Mid-Leinster) alone, am, so from that perspective, yeah , If I could get more resources that would be super"

With regard to availability of resources Interviewee 1 further states that there are issues surrounding lack of space resources for new employees joining the team:

Interviewee 1: “typical things would be like new people starting within teams with no offices, or those kind of resources, so we are trying to make best with what we have....other team members use rooms that are available to them but not practically situated..these are the real life situations”

Due to this also highlighted by interviewee 1 it was a contributing factor to conflicts arising among the members due to lack of a “defined work space” (Wheelan 2005):

Interviewee 1: “It’s usually a resource problem, space/room issue, the current climate wouldn’t help either, because everyone is shouting for resources that are not readily available”

Having posed the same question to the participants of the focus group that was run, a similar response arose. Participants of the Focus group (Team 2) concurred that space as a typical resource made available was limited and even under resourced for basic health promotion intervention activities:

Participant 3 Focus Group: “We ran a few physio (Physiotherapy) classes here and we just found that we were really caught for space. The groups that we could handle even at that was difficult”

Participant 2: “resources are limited, maybe in areas where other disciplines haven’t the same time to give us for example in the area of health promotion which in the first year when we all joined the team and

started we are all pretty good in this sense.....but sometimes it's difficult for other disciplines to play a part in that because their resources are elsewhere now so that's a challenge"

In contrast interviewee 4 who as a new team member was afforded with and based in a practically situated office;

Interviewee 4: "I felt more isolated in certain ways (when the interviewee joined the team), I wasn't used to maybe being in my own office.....but because we were all (all team members) in the same building I could access them at anytime and go and talk to them, yes so from that point of view I settled in very quickly and I could quickly see the way they worked, being so near them"

Other resources identified that lacked were the intangible resource of time. The response from participants within the focus group felt that:

Participant 3: "There isn't enough hours in the day....it is creating a problem I suppose the time aspect. We are just finding that it's getting much busier our waiting lists have grown even though there's slightly more staff here than we are used to"

Variable 2: Education and Training:

As outlined within the literature review, a key element of a supportive organisational structure is the provision of education and training imparted by the organisation. Interviewee 3 felt that whilst every effort was made in providing training and education at local level, a requirement of additional training around team process level was required for team members and an area that maybe lacking:

Interviewee 3: "small realities are very often difficulties...the small realities could be a time to get the team to meet, trying to get the resources for team training days, team development days, not that I am saying that there's none of these, there are, but I suppose I am saying that there is a need for more at that level, because this is a huge C change in the way things are done, and it can take a lot of input and a lot of resources"

Interviewee 3 further states that whether participated in any form of formal training, the interviewee informed me that he took part in a team day out. The team had already been formed for at least 2 years and may have had training prior to him joining the team

Interviewee 3: "when I joined the team (more developed team), the team had already been formed for at least two years, I felt that I had arrived at departures at the airport and the rest of the team were at arrivals, it wasn't until the team day out was organised which was facilitated by the TDO that I really got a chance to ask questions and to be brought up to speed with regard to team processes and that sort of thing"

When directing the same question towards the participants of the newly developed team, it was evident from responses made that little or no formal training had been undertaken:

Participant 2: "Purely practical training and on-the-job training. I did attend effective team meeting training that was some time ago"

Participant 1&3: "yes on the job training"

As with interviewee 4 who joined the more developed team two years ago also stated that no participation of any formal training was undertaken:

Interviewee 4: I probably missed a lot of training as I wasn't here when the team first joined and I know they went through team building training I had no official training only perhaps training imparted by team members and the co-ordinator"

Interviewee 1 confirms that the PCT 2 did attend formal Team Building training:

Interviewee 1: "we done two day team building training and it was the best two days spent it really was., I can see the comfort of each other and there is a trust within the team (longer running team) once the training was completed"

Interviewee 1 further states that the personal training received when taking on the role of team co-ordinator:

Interviewee 1: "HR was very much involved and acted as a huge support in this. They were very good in arming us with the level knowledge and skills needed....we got plenty of training"

Participants of the Focus Group responded to the question of awareness of the current TBPM process stated that:

Participant 1: "I haven't participated in this, I'm not really aware of this"

Participant 2: "I have heard of it but have not participated in this"

Participant 3: "No..no I haven't participated in this, I not aware of this"

Interviewee 1 concludes that there is particular time to deliver formal training:

Interviewee 1: "you can't really give it at the very beginning as it's all brand new.....maybe 6-8months could be the real time to give training"

Further compounded by interviewee 4;

Interviewee 4: "I would imagine now if I was to go to a brand new PCT and sit down with that team (in relation to informal unstructured team meetings)that would be just off the wall to them they wouldn't know each other as weil"

Variable 3: Communication and Decision Making:

A predominant theme that arose was the positive impact in the supportive nature of the organisation's structure aiding communication and decision making mechanisms in setting up a committee of the head of each discipline whose staff member is also a member of the primary care team. Interviewee 1 states initially in the interview that:

Interviewee 1: "every discipline of the team has their own line managerteam members would have a thick black line towards their line manager.....more of a grey line towards the team"

Interviewee 1: "what has happened now is instead of myself being the co-ordinating role, the other senior or line managers so managers of physio, nursing.... are being trained now on what primary care team development is all about and you're going to see that slowly, maybe going into their domain so that's a big big shift.....it's too slow they way we are doing it, we have to bring the senior managers in"

Interviewee 3: "the most recent development has been the discipline managers of these disciplines on the PCT, director of public health nursing, speech and language managers..(etc) have now created a primary care implementation group..... one of the local level mediums is the medium of message, the individual managers can't be coming out to individual workers and saying "you need to develop interdisciplinary team work approaches" ...if every-time you turned around, it's clear managers themselves are not doing that, do you know what I mean, so the other piece that that's bringing forward is that these managers whether it be an OT manager, psychology, in social care in public health nursing, manage both workers in primary health care teams and workers in what was the former community care programmes what will be the networks, so they are managing both sides,It's a more seamless and integrative approach to service delivery

Interviewee 4: "The thing that really stood out is that the primary healthcare committee was formed where all the heads of each discipline present on this PCT formed this committee.....(Interviewee is present on this committee)" what is done then is we all meet to discuss what new initiatives can we do and feed back to the team. One of the things for me when Primary health care being roll out in Ireland that there was no public agenda in terms of educating the population, we are not educating people or communities what it actually is. in other countries where primary health care was rolled out this education was part of their primary health care agenda when they rolled this out. If i take New

Zealand for example they rolled out primary health care model the very same time as Ireland did back in 2001”

No reference was made to this recent development by participants within the focus group or the representative from interviewee 2 in this regard.

Reference is made to the physical organisation structure in terms of leadership support and specialist managers supporting and communicating the primary care message:

Interviewee1: “I don’t think anyone involved, including myself and my colleagues realised the huge task of forming these teams and turning them into high performing teams until now, until its really bedded down into people’s thinking and it was very much left to us in the beginning to try sort through a lot of the issues and it’s kind of being mainstreamed now, which is two years down the line....Mr Brian Murphy who is the national Primary Care Manager, that’s a post that now has grown and that was really created because it needed to be further pushed, so you have the top and then you have Local Health manager, who is one of the four leads in the country based in Laois Offaly, the Primary Care Specialist, myself and the team, so there is a good support structure there”

However, also apparent in the discussion with interviewee 1 acknowledgment of the undertaking of forming such teams to fulfil this policy priority was a huge undertaking and a slow process:

Interviewee 1: I think for everybody involved the undertaking was underestimated how slowly this change needed to happenits slow because you need one person focusing on one team for 6 months to a year to get them ready, whereas I am currently spread between four teams which is a lot slower, now we always knew that that was never going to work but we never knew who or how it was going to change, the system, the system sort of changed itself where the management has taken on another role"

Interviewee 3 acknowledges the support of the organisation through this period of reconfiguration of service delivery but further states that it is a slow process:

Interviewee 3: "the other thing is that there has been tremendous input into organisational change,in context however it is very difficult as people have been working out of the model or best part since 1970 or since the healthboards have been set up, change is going to be slow, difficult and it takes time to win people round, and there's been tremendous work in the top level around, encouraging that change, resourcing that change"

Whilst this is recognised as a huge step going forward in development of PCT's to become high performing interviewee 2 feels that management are under supported:

Interviewee 2: "As an observation from working in the HSE for the past 10 years, I would feel that line managers are very much under supported"

Dimension 2: Team Structure:

Variable 4: Roles and Responsibilities:

From the standpoint outside the immediate team structure and a representative of a corporate function support towards primary care teams for the Dublin Mid-Leinster region, Interviewee 2 states that the current team based performance management model to develop teams and processes of teams is positive aid for clarification of roles and responsibilities:

Interviewee 2: "it probably opens up that forum, to say, well I am a public health nurse and maybe, you're a speech and language therapist, 'I'm not really sure what you do and your probably not sure about what I really do',.....so that conversation needs to happen....'I'm a nurse this is what I do ...this is my role and responsibilities'....and that is something core to team based (performance management) as well."

Interviewee 2 goes on further to state:

Interviewee 2: I wish every team in the country could go through it from the perspective of getting the level of understanding around roles and responsibilities"

Interviewee 3 states that being involved with a longer running team and partially committed to a shorter running team points out that:

Interviewee 3: "not everybody knows what everybody else's role is, like people like don't and I will include myself in that, the full range of each of what the disciplines role is or does"

Interviewee 3 continues to state that currently:

Interviewee 3: "there isn't a forum, like the discussion you and I are having now there isn't a forum for that discussion to happen.....it all gets back to what I referred to earlier the whole concept of what title primary care teams is given, in essence they should be called Primary health care teams, because it's the medical model joining the social care model, it's a complete mindset shift."

In an aim to shift the mindset and attempts to gain greater clarity on roles and responsibilities to team members Interviewee 2 explains the current work being done in developing a primary care development training programme in addition to TBPM process which addresses further training development on the element of clarity on roles and responsibilities:

Interviewee 2: "Fifth discipline from Peter Senge basically takes a learning organisation approach...so I thought the principals of that could be transferred to primary care.....it's very much a system approach and it's a process approach,..... it looks at cause and effective relationships, if you were a public health nurse and I'm speech and language you would think one way I would think another way, you have your systems and process and I have another just because they are your systems and process and these are mine doesn't mean that you are right and I am wrong so straight away its creating a bridge insofar as this is..I am and this is how I do what I do that would be a starting a point and that needs to be said when you are bundling a whole pile of disciplines together

and saying off you go and become a team that foundation needs to be laid before anything is built on top of it

Interviewee 1, the co-ordinator of four teams currently within the area of Laois/Offaly confirms that there is lack of clarity of roles and responsibilities but eagerly awaits the delivery of the Primary Care development training programme to address this:

Interviewee 1: "there is a lack of clarity there and that's where the primary care development training programme is very very important, where people can say well that's outside of my boundary of my professional role. To work around this role clarity can be explained in two ways, one: them understanding their role within the team but also two: understanding each other's role, What a physiotherapist does?, what's the limits of their capability or within their capacity?"

Section 2:

Domain: Process

Dimension: interdependency

Variable 5: Decision Making and Problem Solving:

Turning attention now on how such teams function. Interviewee 3 felt that not enough was being done by the team surrounding the process of how decisions are made or problems are solved:

Interviewee 3: “just at that team process level, and kind of meeting once every year, or once every couple of years for a team day, is not really enough”

Interviewee 3 further states that it is dependent on what stage the team is at. In discussing the time spent on the longer running team in relation to how teams make decisions and problem solve:

Interviewee 3: “it’s actually with a team that’s very developed it’s very impressive, even with the most complex cases and it will take a about 10 mins....for a an assessment of needs, a discussion of options and develop a care plan or action plan, so that’s a very well oiled machine kind of working in that way”

Interviewee 3 refers to the TBPM process on how this aids with team processes:

Interviewee 3: “But another area that’s really high on the agenda is the process of TBPM. This has helped in the area...and the whole process around what I mentioned earlier key areas for discussion in relation to

assessment needs, the discussion of options. However the sharing of ideas and discussing them outside of the day to day decisions on care plans ,....there isn't space for that to happen insofar as sharing what each other does, reflectively. TBPM is effective for outputs I feel, most certainly. But in reality I feel that there is no scope to measure team processes within TBPM."

In contrast Interviewee 2, describes the elements of TBPM which brings about an open forum to discuss:

Interviewee 2: "through the nature of everyone's typical understanding of what a nurse does or a typical understanding of what a speech and language therapist would suggest, but am, if we are to work together we are trained from two different disciplines, you are clinical discipline I'm , I suppose from the social model essentially, for speech and language therapy, so that conversation needs to happen well you know where you actually sit down and go well "I'm a nurse this is what I do, this is how I make decisions, this is my clinical remit"

Interviewee 1 states that the manner in which decisions are made and problems solved is clear and effective but confirms that there is room for improvement on this aspect of team processes:

Interviewee 1: (discussing team meetings) "We bring our clients to the table, we discuss them we agree actions and we go home, we are all very clear on the objective and what is involved. With regard to developing out skills in decision making, we have had training on

effective team meetings which will again be pushed in this training (Primary Care Development Programme)”

Interviewee 2 stipulates the training development programme in relation to this area:

Interviewee 2: “The next one then is the mental models, this probably is the one that throws up a lot of the stuff or issues... there’s element in it on how you make decisions”

Interviewee 4 comments on how the team is functioning in relation to being a member on the more developed team:

Interviewee 4: “I feel that there is space there to see how we improve our process of decision making”

Interviewee 4, does reflect on this and makes reference to the length of time for the meeting, there can be restrictions:

Interviewee 4: “I suppose we are conscious that the GP’s are there...like I said we have to run the meetings at lunch time.”

Variable 2: Conflict Management:

The element of conflict and management of conflict is present in team developing teams.

Interviewee 1 agrees that:

Interviewee 1: ““Yes, there is conflict in every team, there needs to be..... The biggest conflict I feel is between disciplines.....so there is a kind of a clash of disciplines,..... but it’s mainly due to lack of role appreciation or lack of clarity about the different roles on the team and I

am hoping that this training (Primary Care Development Programme) will be of huge help”

It is managed by:

Interviewee 1: “I usually have to talk to both sides involved, depending on the relationship I have with their respective line managers..... it's usually a resource problem, room/space issue, it's never anything professional really, they don't come to me for that they would go to their line manager in such cases.”

Interviewee 2 discusses how if interpersonal issues/conflict is present among a team, this impacts on how effective the TBPM process:

Interviewee 2: “you know if there is interpersonal issues, unresolved conflict, team based (performance management) will not work.”

Interviewee 3 feels that conflicts can arise case by case and that there is some avoidance to such conflict, however conflicts that arise usually over certain cases are overcome. Within the first statement below is an example of a fundamental conflict surrounding the clash in nature of the work from the different disciplines within the team and the latter a typical case assessment disagreement arising out of this:

Interviewee 3: “if I worked more than two months without supervision I'd lodge a complaint, other disciplines don't work to supervision, they should they aspire to it but it's not practiced, but some of it is that they find it very daunting and if you insisted a bit, it's because they don't understand the support management that you need when you work with the public, in a community. It's almost essential in order to continue

best practice. So its two very different ways of looking at working but it also depends on what supervision is, like from a social work perspective, it's a very strong support management tool but in other disciplines another way of looking at it, it can be looked at as a very strong monitoring tool, do you know...so there kind of subjected expectation of it."

Interviewer: "And due to this does this cause any form of conflict so to speak?"

Interviewee: "Yes, it can cause conflict...it obviously can, there are tensions and possibly unspoken conflicts"

Interviewee 3 gives an example of two differing assessments for a patient, one by interviewee 3 and the other from medical professional team member:

Interviewee 3: "It was referred to me more in line of could I see about getting more support for the family because they feel awful that this has happened and are feeling the stress of it all. Now the initial assessment that came in on that case was that is was high risk and that she should be placed in a nursing home, and that was generally by all the disciplines involved.....that would be basically wrong that there was no need to put this person in a home..... they were looking at it in terms of risk assessmentI am looking at it from a needs assessment...I would be a lone voice coming from my background, the OT would be closer to the social care need... what developed was that myself and the OT came back to the team with a proposal and with the family's

agreement for these things to be put into place and for it to be monitored and reviewed..... We won, it was accepted, it made common sense”

Interviewee 4 highlights also that due to differing ways in which to work and the background of where the different team members originate from can cause certain amounts of disagreement:

Interviewee 4: “My perception is and I rather like to call them disagreements, of agreeing to disagree!, Of course that would happen in a team...in my opinion the medical opinion predominates a lot...that’s natural with GP’s, Nurses....they come from a common background..the positive of the team, they are open to listen to my point of view”

Dimension: Growth and Development:

Variable 7: Informal learning and Feedback:

Evident in the research conducted was the positive responses from all participants, in relation to the element of informal learning and feedback received given the nature of PCT’s:

Focus Group Participant 1: “yes it’s very different...it’s good to see how all the different disciplines work together..... It’s interesting when you see what input from the different disciplines has decided upon ”

Focus Group Participant 2: “all the disciplines are coming in and out, so if you did have a problem you’d know that the OT will be coming in to have a chat and sometimes you can get an awful lot of information that

way than say through a letter, email or phone call so things can happen much quicker in that way...it makes my job an awful lot easier”

Focus Group Participant 3: “any question you have, any worry that you have about a client that you’re seeing is answered much quicker face-to-face rather than trying to track the person down”

Participant 3 of the focus group further states that whilst during team meetings it can be a form of informal learning when there is less cases to be discussed:

Focus Group Participant 3: “when things are quiet....there are times when we have the time to discuss and chat about what’s going on, what’s new”

Focus Group Participant 2: “And we have fed back on things on some of the initiatives that we have done....at the team meeting...so it gives us that forum at the meeting to say..... what we are currently doing and what we plan do in the future.....its a case of us learning off each other”

Interviewee 3: “I suppose is there is tremendous advances being made around the interdisciplinary work with Physio’s, O.T’s, social workers, GP’s and Public Health Nurse’s and so forth.....because it’s being opened up”

Interviewee 4: “for me ...dealing with older people in families...I never worked in that area....It opened up a whole lot of areas that I wasn’t aware of.....I suppose how it was dealt with.....so what I have learned as a social worker in that area, maybe differences we have as professionals,

social workers can do assessments and include risk along with needs assessment and can make recommendations and to live with risk and that we need to put it on the table sometimes”

Interviewee 2: (refers to segment of the Primary care development training programme in the process of being rolled out) ..The team learning then is keeping to the development side of things...what’s working well what’s not working well....the TBPM ties in very well here, they are going to have to build a review mechanism to actually stand back and say right, what have we learned?”

Section 3

Domain: Productivity:

Dimension 1: Strategies

Variable 8: Action/Care Plans:

Unanimously, the strategic presence in relation to the Primary care team initiative coupled with the team based approach on how to fulfil such a policy priority was agreed upon by the majority of participants involved within this research study.

Interviewee 1: “Consistently from the very top of the organisation, the CEO, is really pushing the strategy of the PCT along with the National Director of Primary Care.”

Interviewee 3: “I would say is that at the very top level the strategy is there, the policy is there, in a way that it was never before”

Interviewee 2: “Its acknowledged and been referenced in many documents throughout, from strategies to service plans, business plans, the CEO in a lot of Leadership correspondence be it through Health matters publications or circularsis very much about teams and team working and the effectiveness of teams...It’s named within the organisation”

Interviewee 2 continues to clarify that with the aid of TBPM in relation to devising effective action and care plans:

Interviewee 2: “probably planning structure which is TBPM, setting your key result area, or setting a goal, or setting a priority or whatever it is

that needs to be done..... so if they at the very least walked away with the three steps of taking a key result area, a smart objective, and (devising) action plans”

Interestingly even though acknowledging the primary care strategy and marrying it with the team based (performance management) approach in order to develop high output of such teams, interviewee 2 feels that after working within this role for the past 6 years there is a lack of awareness of the process:

Interviewee 2: “one would question why after 6 years, why isn’t it (team based performance management) on everybody’s agenda, it’s certainly talked a lot about, it’s certainly something that teams who do participate in it always go....”Why haven’t I heard about this, why hasn’t it come to the fore prior to this”...a lot of it is by word of mouth, because we are not in a position now that we can advertise our services, so a lot of my work comes to me by “oh I heard or I know someone on a team who...”

Interviewee 3 whom has had a limited experience with TBPM, agrees that the TPBM process has helped in the area of devising action and care plans:

Interviewee 3:“But another area that’s really high on the agenda is the process of TBPM. This has helped in the area...and the whole process around what I mentioned earlier key areas for discussion in relation to assessment needs, the discussion of options, and the development of care plans, breaking it down to into certain areas, objectives for intervention and actioning this”

Dimension 2: Accomplishments

Variable 9: Effective Team Meetings:

Effective team meetings can be a prerequisite in achieving high team performance. The recurring constant referred to by all participants involved in this research study in reflection is around the element of effective team meetings:

Interviewee 1: "the Portarlinton team meets weekly, Abbeyleix/Durrow meet fortnightly and Birr and Banagher meet monthly"

Interviewee 1: "The work and goals of the team members hasn't changed what has changed I suppose is they formally meet now on a regular basis, discuss patients but also to share information, to maybe do some educational sessions, the GP could give a talk on something and then the Physiotherapists could also as well for 10 – 15mins slots at the meeting so there is a sort of a forum for them now to get together as a group where they do their business but also learn from one another. That would be the easiest thing to define a team at the moment and an aid to achieve the team's goals, such as interventions: health promotion initiatives"

Focus group Participant 2: "(team co-ordinator) facilitates the meetings in general what is brought up is client cases that might concern more than two disciplines so that's how it's run really so the clients that you want discussed get discussed or if we have any concerns"

Focus group Participant 3: "there's times when we have the time discuss and chat about what's going on what's new"

Interviewee 4: "It was much more democratic.....the team meetings are set here the very informal nature where everyone sits down and its hands on and what needs to be said is said..... you know...it's whoever really decides to chair a particular meeting goes around and gets input from everybody..... so nobody is dominating the meeting everybody has input. It's an open forum and there's cases that are brought up that I might not have referred to me but because something is discussed about them at the meeting everybody's opinion is welcome....well that's the way I feel about it anyway...there's no set agenda, no minutes driven agenda, people can get bogged down in that kind of approach"

Variable 10: Positive Outcomes to New Team Members:

Having identified the importance of effective team meetings it can serve as another key advantage coupled with developed processes carried out by the team and supported by the organisation, this being the positive impact it can have on a new member joining the team.

Interestingly interviewee 4 states that:

Interviewee 4: "a lot of team processes were in place and my predecessor was here with me for a couple of weeks so I got to go around with him....so it was a combination of the team being well established and having my predecessor there to show me the ropes"

Interviewee 3 describes when he first joined PCT 1:

Interviewee 3: "the best way I can describe it is that I felt that I had arrived at departures at the airport and the rest of the team were at

arrivals!. The team had a really good sense of their own identity and the identity and functions of the rest of the team. It wasn't until there was a team day organised which was facilitated by the TDO that I really got a chance to ask questions and be brought up to speed with regard to the team processes. So for the purpose of joining the team, a team day out away from the service and the day to day business and just concentrating on the team, it would give new members the chance to get an overview of what's happening and to see the way things are being done and manner in which they are being done"

Interviewee 2 states that a buddying system is encouraged for new members joining a team, however it's not something that has been clarified in terms of how the new member can really see the way in which the team functions:

Interviewee 2: "I don't think it's written in stone, it's not a solid structure...it's certainly something I would encourage and that I would advocate for..... it's doesn't necessarily have to be a course or formal training, I suppose it's really just sharing information, sharing knowledge."

Additional Key Findings:

Additional Key Findings and recurring themes among the participants throughout detailed the stages in which the team is at determined the level of team functioning and performance:

Interviewee 1: "I'll refer to the stages of the development of teams, forming, storming, norming, performing....storming is where these newer teams are at...Abbeyleix/Durrow PCT. Portarlinton are really at the performing stage"

Interviewee 2: (gives an example of placing a TBPM process into a team that has been functioning for 6-7 years under the mental health umbrella) "I would have linked in with them to do TBPM....(after preparation of such).....it never lifted off, My first question was why didn't it work?, so then it comes back to ...readiness"

Through interviews conducted an emergent theme was the actual title given to Primary Care teams from interviewee 3 and Interviewee 4 who derive from the social care discipline and how a distinction between the medical model disciplines and social care model disciplines carried out multidisciplinary working:

Interviewee 3: "we are not just talking about health policy here we are talking about health and social care policy....people talk about primary care teams and that's old language...they should really been deemed primary health care teams"

Interviewee 4: "my point of view is different than from most people on the team in terms of a very medicalised model.....my view of primary health care I would be coming from a completely the opposite end of the spectrum, in terms of the social deterrents of health"

Summary to Key Findings:

Organisation Structure:

- Clear direction and presence among the core strategies for Primary Care and Primary Care teams, to be achieved through a team based approach
- Limited availability of resources both tangible and intangible
- Limited education and training delivered to both PCT's to date
- Limited communication and awareness of education and training available
- Positive steps in the formation of PCT committee compiling of each head of discipline representing each discipline on the team.
- Whilst physical management structure in place management under supported.

Team Structure:

- Lack of clarity of roles and responsibilities

Process: Interdependencies and Growth & Development:

- Positive steps to be taken in the delivery of impending roll out of Primary Care Development Training Programme
- Conflict present due to lack of resources or lack of awareness or knowledge of task or roles of the different team members
- Informal learning found within the more developed longer running team.

Productivity: Strategy & Accomplishments:

- Effective patients care plans devised, inefficiencies of action care plans.
Can be aided by TPBM process
- Informal team meetings more effective versus the more structured meetings.
- Where team processes are well developed can have a positive effect on new team members.

Conclusions & Recommendations

Conclusion:

The purpose of this research study was to explore team performance within the HSE, by taking a team performance model addressing the organisation and team structure, processes and productivity domains. To fulfil such requirements perceptions were gained of team members and leader of a specific primary care team environment and from the perspective of corporate team trainer, a function that supports team performance.

Drawn from the key findings found under the domain of structure, evidence of the mission and goals with clear direction in fulfilling the primary care priority policy is present and playing a positive impact towards achieving high team performance. Coupled with this the recent formation of the PCT committee compiling of each head of discipline of members on the PCT's to speed up the change process and in support of PCT's team performance is seen as another significant step in obtaining overall effective team performance. However such a significant step as found is playing a positive role in further development and support to PCT's but evidence shows through the key findings that management structures are under supported. This is seen from a corporate perspective historically and evidence of the physicality of one sole leader who has the responsibility of currently four teams formed with a further 20 teams to be mapped to the Laois/Offaly Area by 2011.

Additional limitations come in the form of lack of resources provided, one specifically being the limitation of defined spaces in which to work in, inhibiting the delivery of health promotion activities going against the organisation's goal of preventative primary care priority. Whilst human resources were supplied to complete the composition of teams on services to be provided, shortages appeared

in the human resources available to delivery team development training. Due to this, and noting that the two teams targeted for this research study have been operation for the past 5 years and 2 years respectively the amount of education and training on team development inclusive of the current performance management system - TBPM process delivered has been a below average rate. Notable improvements once such training was received in respect of the longer running team proved to be effective confirming that education and training is impacting positively on team performance.

In relation to the team structure, the clarification on roles and responsibilities of each team within the PCT are lacking. This is due to and as found through the key findings of the shift in thinking and the combing of medical model of care to the social model of care. It is evident that TBPM is a process which promotes such clarity and understanding, a more effective tool will be the impending delivery of the Primary Care Development Training Programme which is addressing the areas of role and responsibility clarification and addressing team processes such as decision making and conflict management elements and acting as a reflective piece on team learning. To this end the researcher concurs with the Givens and Simmon's (1977) that teams need to understand and learn what other team members roles and responsibilities are and how they can be joined and interlinked. The delivery of the Primary Care team development training programme which is anchored to Senge's Fifth Discipline model will be placed within the PCT's to achieve this, ultimately to achieve high team performance in line with the organisation's goals. Coupled with this the roll out of TBPM process will be included within the training programme. Both PCT's found that there could be significant improvements to be made around the areas of team processes. This is further clarified by the team leader that with the

aid of the Primary care training programme such improvements can be achieved on an initial basis.

With regard to productivity, team meetings that are being consistently carried out have proven to be effective in devising patient care plans. Clearly evident is the effectiveness of team meetings carried out by the longer running team with an informal approach taken. Equally with the PCT 2 where although more of a structured approach taken to team meetings it is proving effective in devising effective patient care plans. In conjunction with this, the frequency in which the teams meet is positive in meeting the expectation of high team performance. However as previously stated, a high degree of attention is paid to patient care plans and case management within team meetings and not to team processes where it could be used as a tool to display such team functioning to a new member joining the team if regularly checked and reviewed.

The researcher concurs with Armstrong and Baron (2004) that overall, since the formation of PCT's in order to reform the way in which to deliver health care, primary concentration has been paid to the outputs of such teams with restricted planning and implementation mechanisms of how such teams will develop and perform, ultimately to become high performing.

The pace in which such teams have developed is relatively limited due the pace of change in a organisation wide context. Tremendous work has been achieved to date and outputs are striving, but in a more reactive rather proactive healthcare delivery. To this end evidence of frustrations are experienced at the pace in which teams are being developed. Having noted the four stages in team development within the literature review, identification of what intervention can be

impacted on each team at the appropriate time is critical. Such interventions in a timely manner can greatly enhance a team's performance. In summary, whilst positives have been displayed of the current piloted TBPM process, through the key findings, team members and teams face challenges that needs to be addressed.

Recommendations:

Going forward, an implementation three phase strategy issued from the top level needs to be devised detailed, defined, in depth, and inclusive of timeframe action implementation plan (**refer to appendix 9**) of this initiative where limitations have been found. Assessment of the current status of needs required can be the tool of requirements needed to devise such a strategy.

Phase One:

- Firstly, It can take the form of defining the leadership roles in the form of the recently formed PCT committee compiling of senior management to lead and manage teams within the area. This is to be supported by intensive management development training programmes and Primary Care Development Training programmes. As this is present within this area, it may also be replicated throughout other regions within the Health Service Executive.
- This is to act as an effective two-way communication and decision-making medium from the organisation to each team at local level as highlighted within the Literature review.
- In order to monitor and review such progress, it is recommended to produce a database outlining such activity in meeting this criteria.

- Hold information briefing sessions outlining the steps of implementation action plan.

Phase Two:

- Secondly, standardise and deliver primary care development training to each PCT across the organisation, so as it is named and recognised as the communication outlining the fundamental developments through a learning organisation that needs to occur.
- Place the current TBPM process piloted within certain sections of the Irish Health Service within each team, in order to identify and fulfil team goals and objectives and that can be aligned to the organisations goals.

Phase Three:

- Phase three can move towards revising the role of the Transformation Development Officers. To date this development role has acted as both leader and development officer. This can in conjunction with senior management leadership roles aid the development of team processes, coach and mentoring and impacting on day-to day functioning and restating training received.
- Aid effective meetings being held, creating an open forum for team processes can be developed.
- Organise team "day outs" to review progress made and highlight further processes.
- As teams expand, Primary Care networks grow. See appendix ~~1~~²: Review resources available to teams and report proposals for example extra short term of

long term leasing on vacant buildings to facilitate team productivity and promotion of health initiatives within the community.

Summary:

It is evident in such a time of economic instability the scarcity of resources and time to meet the health care demands in the backdrop of the Irish Health Service undergoing quiet significant restructuring, enormous strides have been made in aims to achieve such a reform. The process as significant as this is going to be slow however, in an act to remedy this cost effectively, through using what is available a review of the implementation stage of this reform can act as assistance to existing teams and the further roll out of PCT's across the country.

Limitations:

Possible mixture of both qualitative and quantitative methodology could have been used. Focus Group comprising of early development team that was carried out possibly may not have been the correct method in which to obtained information, due to time constraints.

Further Study:

- Progress analysis in the aftermath of the implementation action plan at local level can be carried out to measure the effectiveness of the development of teams in order to enhance team performance.
- Possibilities of developments made can be incorporated into current performance management systems such as TBPM.

Conclusion to Research Study:

Undertaking this research study, has allowed the researcher to explore the complexities of team performance. Putting simple performance management measures in place is a must. However many challenges face teams as the recognition in the first instance is of the nature of the team being formed. It involves a shift in thinking within a reforming organisation that must learn a new way of working and acknowledgement of the expected performance.

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Appendices:

Appendix 1: Conceptual Framework – Team Performance Model

Appendix 2: Sample PCT (Primary Care Team Composition)

Appendix 3: Interviewee 1 Team leader/Development Officer Interview

Transcript

Appendix 4: Interviewee 2 Team Development Trainer Interview

Transcript

Appendix 5: Interviewee 3 Team Member of PCT 1 & PCT 2 Interview

Transcript

Appendix 6: Interviewee 4 Team Member of PCT 1 Interview Transcript

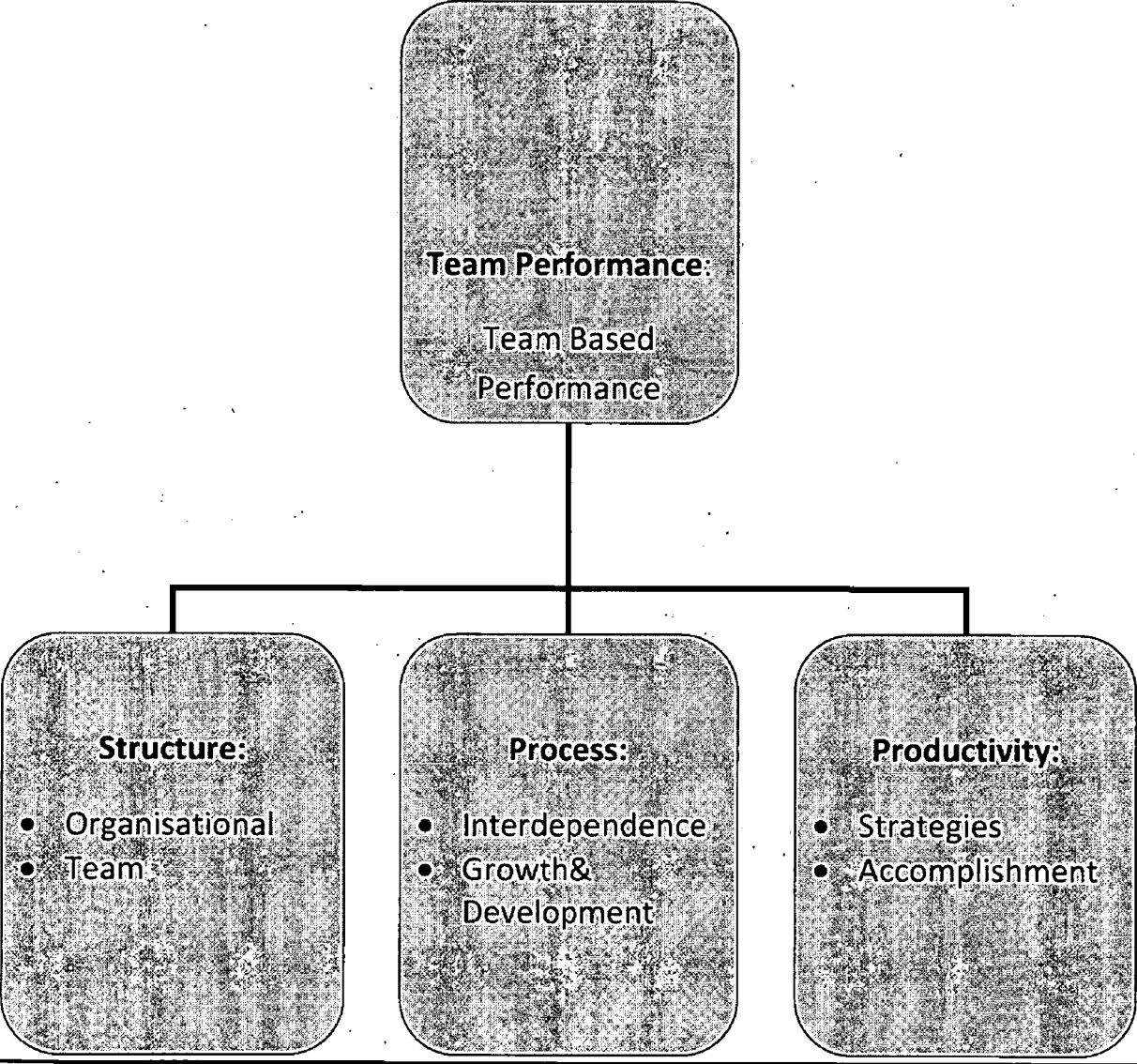
Appendix 7: Focus Group Participants of PCT 2 Focus Group

Transcript

Appendix 8: Target Participants Illustration of Breakdown

Appendix 9: PCCC Transformation Implementation Structure

Appendix:1: Conceptual Framework – Team Performance Model



Appendix 2:

Sample PCT

Sample PCT

Core

GP = General Practitioner

PHN = Public Health Nurse

Phy = Physiotherapist

OT = Occupational Therapist

SW = Social Worker

Extended

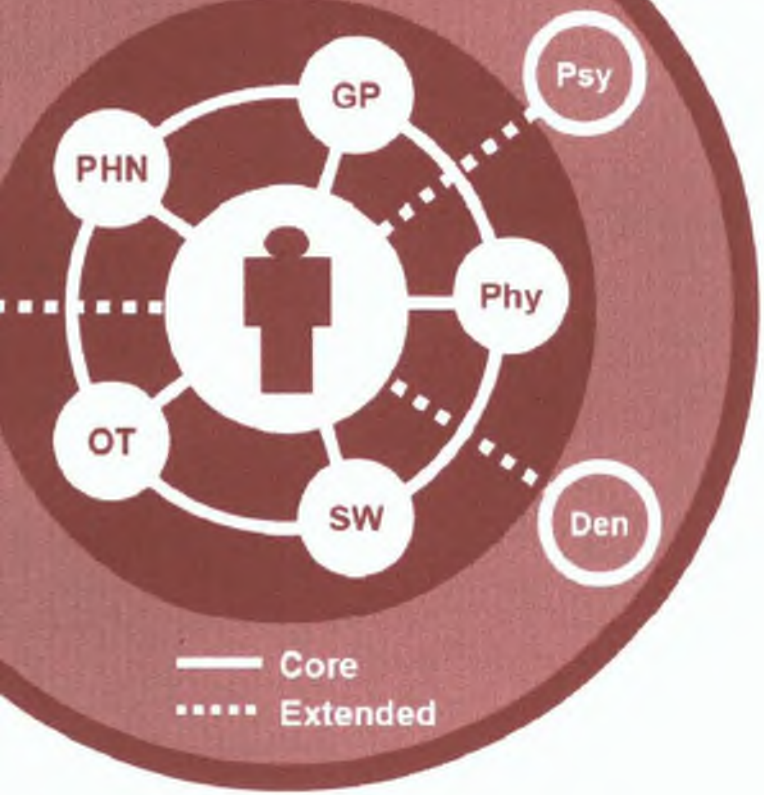
Psy = Psychologist

Den = Dentist



Other

PCT





Appendix 3: Interviewee 1 Transcript on Interview

Interviewee 1: Ms Carol McCann, Reform Development Officer

Primary Care Team - Laois/Offaly, 30th March 2009 at 12.00pm

Organisational Structure

Q1: Carol could you briefly describe your role - Reform Development Officer:

“Back in 2006 this post was advertised and recruited as Reform Development Officers the title has since changed to Transformation officers, the reform was really about how they were going to transform the way in which the Health service was delivered and the main way they felt this was going to change was through team based services in local communities, so as a transformation development officer its about basically developing primary care in the local health office. There has been 20 teams mapped in Laois/Offaly and 500 hundred mapped across the country and my role is to try and develop those teams in Laois Offaly specifically”.

Q2: Having researched this topic, it has been identified by the main theorists that there is four main domains specifically within Healthcare team performance is based on these being structure, context, process, and productivity. Within the team performance based on the organisations structure is the allocation of Resources as a main element, What kind of Resources are allocated to the PCT of Laois/Offaly?

“Well, the Primary Care Team work, what we would have called community care areas, previously you would have Laois community care and Offaly community care

and still do in some respects as there is a dual system going on, so basically we had before and still do to some extent is unidisciplinary, so we have public health nurse services, Physiotherapy service, Occupational Therapy service, Speech and languages service, and social work service and GP service which have always being working in the community and still do, what's changed really is the people who worked in those areas on their own in the areas such as Abbeyleix, Durrow or Birr are now formally working within a team with a mixture of the mentioned health care professionals. Some of them may have already being working together but its much more structured and identifiable and based on population in each community area, so its moving away from one discipline specifically doing there work

What resources Primary Care Teams got to develop was three extra posts, so Abbeyleix got three extra people and no new buildings, such as a social worker, physiotherapist and dietician so that completed the team on services they could deliver and this proved much more effective with the team approach and with the extra professionals, they could overcome a lot more issues locally than they could previously.

Q3: When you mention the extra skilled professionals recruited to the PCT team in Abbeyleix/Durrow. How is that new team member inducted into the team insofar as what mechanisms are in place if any to bring that team member up to speed as soon as possible so as to be effective within the team?

" Yes, this is the key thing, for example if a Physiotherapist has joined the team, they would have a line manager, every discipline of the team has there own line manager where as I am the team co-ordinator, team members would have a thick black line towards their line manager whereas they would have adopted more of a

grey line towards the team, so in terms of what their role on the team was and not as a physiotherapist but as a team member and what their function was, was my domain. Due to this there is a dual reporting relationship. So for example a new physiotherapist is to come and join the team tomorrow, his/her manager would go through the standard induction and it would be up to me as the co-ordinator on informally inducting them into the team and to explain the basics of how the primary care team works, these are the services, and giving them a kind of overview of the primary care team and how it operates.

Q4: Are you equipped with all that you need to do that in terms of the organisational support and structure?

"Yes, I would have done a three day training program back when I was recruited first as the reform development officer for Laois Offaly. HR was very much involved and acted as a huge support in this. They were very good in arming us with the high level knowledge and skills that we needed to induct the new team members. We had to act as effective influencers and really change management was our main role. That would be the most important aspect in my role as development officer. We got plenty of training and there was also a Primary Care specialist, Mr PJ Smith. He helps all of the Development Officers within Dublin Mid Leinster region of the HSE. We would also have regular meetings of our own which consisted of the other development officers which they are nine of where we would have our own group meetings to discuss and share issues, share information so we had good organisational support and also through the HR performance and development dept. I think for everybody involved the undertaking was underestimated how slowly this change needed to happen in order to be high performing. For example one team member might consider working together involves sitting at a table and working

through issues whereas another might say we'll go and do a joint visit now, "you do this and I'll do that" so its really considering where people are at.

I don't think anyone involved, including myself and my colleagues realised the huge task of forming these teams and turning them into high performing teams until now, until its really bedded down into people's thinking and it was very much left to us in the beginning to try sort through a lot of the issues and its kind of being mainstreamed now, which is two years down the line. The other important thing is that consistently from the very top of the organisation Prof Brendan Drumm CEO, HSE is really pushing the strategy of the PCT along with Brian Murphy, who is the national Primary Care Manager, that's a post that now has grown and that was really created because it needed to be further pushed, so you have the top and then you have Liam O'Callaghan, one of the four leads in the country based in Laois Offaly, P.J smith Primary Care Specialist, myself and the team, so there is a good support structure there"

Q5: With regard to inducting new employees do you think the team themselves could contribute to inducting the new team member

"That's actually just where we are at now. What has been agreed is that we need to develop more teams more quickly and faster, so what will happen now is instead of myself being that co-ordinating role, the other senior/line managers, so the managers of physiotherapy, nursing etc, are being trained now on what primary care team development is about and you're going to see that slowly, maybe going into their domain so that's a big....big shift and we're lucky here because its something we have realised as its too slow the way we are doing it , we have to bring other senior managers in.

Q6: In what way is it slow?

Its slow because you need one person focusing on one team for 6 months to a year to get them ready, whereas I am currently spread between four teams which is a lot slower, now we always knew that that was never going to work but we never knew who or how it was going to change, the system, the system sort of changed itself where the management has taken on another role

Q7: In light of this do you feel that the system is working as it has drawn your attention to certain things that needed to be changed

"Yes, yes, I suppose from living and breathing primary care teams for the last 5 years, I could see that it was never going to truly work where there was just one person co-ordinating per team, I suppose we should have looked at this 2 years ago but no one understood primary care back then. Now we in devising our service plan see with having five more primary care teams to develop this year, have to do this right, so everyone has to put their biggest effort and expertise into this going forward both from our service plan and nationally we have to drive this as there is pressure to do so, but its very positive going forward.

Q8: Is there a mechanism in place for the team to come to yourself if there are problems/issues/questions to be asked etc?

"Generally although it can be clear it can sometimes be unclear also. If they have an issue within their own service they go directly to their line manager, but if they have a resource issue in the team or a if they have a problem with another team member, if they are unhappy with a team meeting, they would come to me, so it's quiet clear the roles there. This means that I could get three or four calls in one day which isn't

manageable either; you don't really get to give your full attention. So typical things would be, new people starting within the teams with no offices or those kind of resources so we are trying to make best with what we have. Other team members use rooms that are available to them but not necessarily practical situated,... like these are the real life situations, so I feel that my role is very much trying to bring in new people into an old system that is reluctant to change or where primary care means nothing to them really. So I think that primary care is the new baby on the block and some team members are not very sure of it.

Q9: Have management permitted the teams members to have input into the policy and planning?

There are national guidelines derived around information sharing, clinical meetings, how the public can access the services, for example they may be able to go directly to a Speech and Language therapist and might not need a GP referral letter. There are a few key guidelines and what happens then is locally is that we develop our own protocols on how we are going to work in light of these guidelines. There is that flexibility there. As there is very few agreed national protocols as its relatively new what is worked at locally can be brought back up through the Organisational structure to upper management if something is being carried out locally that is effective that might not be stipulated within the agreed national protocols.

Q10: Due to this are team members clear on their role and responsibilities?

There is a lack of clarity and that's where the Primary Care Development Programme training is very very important, where people can say well that's outside of my boundary of my professional role. To work around this role clarity can be explained in two ways 1) them understanding their role within the team but also 2)

understanding what each other does. What a physiotherapist does?, what the limits of their capability or capacity?, can GP push his priority up on a physiotherapy list?.. no they have their own service, just because they are on the team it doesn't mean it's a free for all.

Team Process

Interdependence:

Q1: Is there a common language used among the team?

"Most know what the primary care is.....a big part of my work would be what is the aim of the primary care team?, what are we here to do, work together, making it easier for patients to get into the service. The team at times doesn't see it as huge change of working within a primary care team, they are still working in the same places, in the same buildings what's happening now is they are working more closely together with people who are working in the building beside them and that they are communicating in a more structured way, everyone is more clear, everyone is in the loop and so its more of a case of cross communication processes has improved. There's no radical change, they haven't changed their core roles, like a public health nurse isn't now a practice nurse. Its very gentle change I'm talking about here, but huge in other ways because the approach is very gently gently, as you don't want to get peoples back up. I suppose a good example would be you could have a physiotherapist who just works with children, a primary care team is in place to work with all, the whole population of the area, I cant turn around and say to this particular therapist, forget solely working with children your are now dealing with everybody....that's where eventually where you want to get to but its how you get there that's important for the service.

Q2: Are there certain skills developed to make decisions and solve problems within the Primary Care Teams?

“Yes that would be their group meetings, at the moment I chair them as a kind of facilitator not as a chair as such, like I don’t dictate who comes up, they decide this, it’s a very flat structure, and it works very well. Its just a way of working now you know we bring our clients to the table, we discuss them we agree actions and we go home , we are all very clear on the objective and what is involved. With regard to developing our skills in decision making, we have had training on effective team meetings which will be again pushed in this training (Primary Care Development Programme) as well as the importance of understanding others.

Q3: How often do the teams meet?

Portarlinton meets weekly, Abbeyleix meet fortnightly and Birr and Banagher meet monthly, it depends on the geography a lot of it and how far out people are travelling, or how many clients they want to discuss, it’s really in their own control.

Q4: Conflict Mgt: Is there conflict evident in the team?

“Yes, there is conflict in every team, there needs to be, I think the people who are on these teams, were bought into them so there is sort of some willingness to be at the table but that’s stops them in some ways whenever there is an argument. The biggest conflict I feel is between disciplines so where you have one discipline that traditionally always worked in an area and sees a new person coming and roles again are not clarified or clear. The other conflict could be people who worked for years in an area they feel they know people inside out and are reluctant to let new people in and sometimes don’t value their opinion, so there is a kind of a clash of

disciplines, that includes GP's and HSE staff as well and then its a clash of old and new and I'm the one trying to balance, and its not easy. There is quiet a lot of conflict but it's mainly due to lack of role appreciation or lack clarity about the different roles on the team and I am hoping that this training (Primary Care Development Programme) will be of huge help. I know in Portarlinton is the longest running team as it was five years ago since it was developed, we done two days teambuilding training and that was the best two days spent, it really was, because whereas the resources and timing wasn't right really for these other teams at beginning, I can see with the Protarlinton Primary Care Team, the huge disparity in terms of their conflicts, the comfort of each other and there is a trust within the Portarlinton PCT once the training was completed.

Q5: When you mention the timing, when do you think is a good time to give this training?

"Yes, timing is key. You can't really give it at the very beginning as it's all brand new to the newly formed team. If a team is brought together and told, "look we are going to start developing a primary care team then start working/interacting with one another, they might refer to each other, they might start linking in the group meetings and then maybe 6 to 8 months, could be the real time to give the training rather than giving the training on day one, you know they need to sort of get to know one another. At the beginning it might be a little too much you need to get them to gel a little bit because you are going to get people not gelling together straight away.

Q6: How is the conflict managed when it does occur?

"If they come to me with an issue around the team or the way the team is interacting, I usually have to talk to both sides involved, depending on the relationship I have



with their respective line managers, I might link in with them and I have quiet good relationship with all senior managers which is important, I might pull them in if I think its relevant and that's the way it generally works, unless its a very serious problem which hasn't happened, you kind of work one off the other, its usually a resource problem, room/space issue, its never anything professional really, they don't come to me for that they would go to their line manager in such cases. The current climate wouldn't help either, because everyone is shouting for resources that are not readily available.

Q7: Leadership is important with regard to team's processes, could you describe the role leadership plays and how it aids the team?

My role is to support the development of the team for people working in teams and managers whose staff is working within Primary Care teams. You are the one port of call for staff for primary care teams in Laois Offaly and there is 32 of us around the country, we are very much recognised as developing teams and line managers join us to come out with me to the teams so there is two of us pushing this, so you might have a nurse manager, taking a lead role where there is GP's, physiotherapists within the team and so say there is an issue I also feed that back to the senior manager or general manager of primary care who in this case would be Gerry Raleigh. I feed back an issue to him that has arisen where it gets discussed, currently I am very much seen as the leader but that's going to change the senior manager on the team will be in effect take more of the lead and I will be more of a support, but its not at that stage as of yet.

Q8: Do you feel sometimes that they way in which you lead the team, how do you adapt your leadership style to develop the team?

"You usually sort of...they off load their issues. There are issues they won't say to a colleague that they would say to you, like, "I don't like the way that was talked out at that meeting..." So then I have to engineer a way without naming and shaming if you like, it can be quiet petty sometimes and sometimes I say: "well could this not be discussed with the person involved with themselves" people are too new working with each other and they don't want direct conflict they want you to sort of deflate the situation so its very non aggressive, and the leadership style has to be influencing. You have to sort of take the bit of the flack as I would be seen to push them into the situation that they don't want to be and you have to listen to their views and then the other persons and then you go and try and meet in the middle - compromise. So you wouldn't want to be very highly strung, you have to be quiet open to take flack from the group at times, not personally but you know, people get disgruntled because of this change because the change is hard for them.

Adaptable leadership is needed its all part and parcel, this is what developing teams to be high performing is all about. It's about supporting people when they are going through these things and just you have to recognise that these things will happen, its natural and I'll refer to the stages of the development of teams, Forming, Storming, Norming and Performing. And storming is where these newer teams like Abbeyleix/Durrow PCT are at and have been at for the last couple of years.

Portarlinton are really at the performing stage as they have been in existence for the last 5 years. The storming teams are nearly now at the norming stage and getting into the ways of the team and how things need to be done. So having said that, you really need in this case a five year timeline to get from the very beginning "forming "stage to performing Primary Care Team, specifically in the Laois/Offaly Area knowing the resources and skills available in the area.

Q9: Do you feel in your experience of developing teams is that the standard timeframe to develop a performing team?

"No not strictly, every team is different, if you form a team tomorrow that could just take off, its human nature, every group can be different. It can depend on your members, what sort of composition you have. Like Portarlington would have done the Belbin roles so they see that there is a creator, planner, worker, etc. Where this is only happening now for Abbeylax when they undergo there training if this is the method they want to build their team or choose another method to develop their team into a high performing team.

Growth & Development

Q10: Is there an opportunity while all of this is taking place, to maintain their technical/professional skills?

"The professional or technical development reverts back to their line manager it's still retained and ongoing through their line manager. This is healthcare there professional skills can't be neglected, maybe perhaps the development of teams is sometimes delayed due to this where as if you worked in the private sector selling products ...can suffer while a team develops, and where by sales can be recouped, that luxury isn't in the health service.

Productivity:

Q1: Could you tell me goals have changed and achieved and one intervention that has been successful - (Accomplishment)?

"The work and goals of the team members hasn't changed what has changed I suppose is they formally meet now on a regular basis, discuss patients but also to

share information, to maybe do some educational sessions, the GP could give a talk on something and then the Physiotherapists could also as well for 10 – 15mins slots at the meeting so there is a sort of a forum for them now to get together as a group where they do their business but also learn from one another. That would be the easiest thing to define a team at the moment and an aid to achieve the team's goals, such as interventions: health promotion initiatives they would be doing work that has never been done in the community before, they might be doing very primary care community based ideas and initiatives and stuff like that”.

Q2: In relation to service planning process then at the beginning was this process known because prior to the PCT's they had there line manager involved in the service planning process do they now, being part of the PCT have more input to this?

“At the senior manager level Liam O’Callaghan who is the Senior manager for Primary Care for Laois Offaly who had to put a committee together, an implementation committee, where all those heads of those staff sit and they review every month how the primary care teams are going, where we all meet we sit down and say look this is where we are at, they are doing this etc, so they are well aware they have a forum of group of senior managers so its not if you like new to them. The service planning process is still done by discipline rather than by team and by care groups it hasn’t changed as of yet but it will, and this change is not to far away. No primary Care team is at the stage of identifying what’s needed for example a team are not deciding yet right, we don’t need a chiropodist but we need a physiotherapist you know, we need to change our requirements, that hasn’t come down the system as of yet, but effectively that’s where it will go, or that certainly would be the ideal. In time there will be a manager on each time PCT time making

these decisions on behalf of the group that has decided on what's best and the service requirements needed.

It came up about insofar as who is responsible for the decisions its called governance - who's responsible for the decisions that the team make, or who's responsible that cases are followed up because its a team so they are looking at teams that they have the responsibility to govern the teams because at the moment everyone is doing their own thing in the teams and they go away and do this, so how the teams are developed and managed is being developed its not out here as of yet. It's a big issue so say a team decides for example that a particular patient doesn't need a walker, she's fine and she has fall the next day, who is ultimately responsible if they all have agreed so it's a case of accountability. This accountability and governance hasn't been agreed yet so that's very high the agenda and that's positive step as its not there as of yet and it needs to be.

Interview concluded 12:55pm March 30th

Appendix 4: Interviewee 2 Interview transcript:

Interviewee 2: Nessa Lynch – Team based Trainer Performance and Development section, Human Resources Dept, Head Quarters, HSE

Interview Date April 30th at 9.30am

Interviewer: “Nessa can you describe your role?”

“I am a part of the Performance and Development team here in Naas, We are a regional service here in Dublin Mid-Leinster, so we would provide training and development interventions across the region. The lead project that I would have is Team Based Performance management for the region and I would have also responsibility for the team development functions that come within that area as well. I suppose the nature of the work that I do lends itself to being very diverse because once it starts off initially teams look for team based performance management go to perhaps start that process and then very quickly realising that maybe the teams in terms of readiness aren't at the stage where they can perform for want of a better word as a team so a one often has then to go back to the start almost and build the team and look at their core functions, purpose of their functions, their roles and responsibilities, what is a team, the likes of what is multi-disciplinary working, what is interdisciplinary working, what's trans-disciplinary working and you know finding, ...finding where they are and getting the foundations laid before team based can...can then ensue. But... am... The team development interventions that I would use and the model I come back to all the time is the team based performance management model, so that would really be the nature of the work that I would do...and I work across as I say all, all disciplines in all areas

Interviewer: "Within Dublin Mid-Leinster"

Interviewee: "Within Dublin Mid-Leinster catchment-area yes"

Interviewer: "Ok, In researching team performance three core domains were identified, Structure, process, and productivity, I just want to ask what ...or is there support from the organisation to carry or deliver team based training ?"

Interviewee: " There is essentially, as team based performance management was born out of the action plan for people management strategy a number of years ago, which was the first Human Resources Strategy, so from that perspective the foundations are solid. You knowits acknowledged in that. It's been referenced in many of the documents throughout, from strategies to service plans, business plans, ..am Professor Drumm in alot of his leadership correspondence be it through "*Health Matters*" or circulars that have come down through the..the system. So he is very much about teams and team working and the effectiveness of teams, so from that perspective yes, I suppose the organisation is certainly, is you know....it's named within the organisationemm..nationally, there would be my equivalent in each of the four areas around the country as well, So that would be the West, Dublin North East, the South and of course here in DML. So yeah from that perspective it's on everyone's agenda, with regards to the human resources element of it am, we are probably ...uh yeah, ...you need more staff, totally without a shadow of a doubt, I mean there's fifteen thousand people across DML alone, am, so from that perspective, yeah, If I could get more resources that would be super .

"Em , financially its a very cost neutral programme and has been since I have been involved in it, so I am doing it almost it must be 6 years, I'd say at this stage and ...em, the costs have been, I don't think there has been any costs actually incurred

as result of it. I am paid by the HSE naturally but the cost perhaps comes in terms of people being released for their time to attend the programme but with regard to actually getting the structure into teams, no there's no costs incurred really from that incurred. I suppose with regard to the organisation as well one would question why after 6 years why isn't it on everyone's agenda, it's certainly something that talked alot about, its certainly something that teams who do participate in it always go..."Why haven't we heard about this, why hasn't it come to the fore prior to this, am, alot of it is by word of mouth, because we are not in a position now that we can advertise our services, so alot of my work comes to me by,..."oh I heard, or I know someone on a team who, or could you help us or could you come in and work with us."

Interviewer: "Actually just to pick up on a point that you made there actually, there's has been a recruitment drive over the last three years to increase the resources of skilled professionals on Primary Care teams, in relation to what you have just said there, was it known or was there an awareness that extra professionals had to be recruited to complete many of the skill on each team, was it know to target these people on team based on entry or what way did this pan out"

Interviewee: " It would have been there prior to the initiative but yes I know what you are saying, initially when we started off it would have been before the reform piece, so we would have been the former south west and there was a huge drive on team based, I suppose our department here, was probably quiet responsible for influencing that programme nationally as well, we had massive success of team based and raised the profile of it very very quickly and word spread then because Ollie Plunkett, my line manager would sit at , am, regional and national level at HR

meetings and what not so he was able to bring the success of team based from our area to that table and share that you know that...achievement essentially so from that perspective it was probably key in raising profile of team based and marrying it with the likes of "oh well Primary Care need work", there are a number of disciplines coming together for a Multi - D approach, whats the best way of doing that, is looking at a team based model , or a team based approach to develop systems and developing teams, and developing processes.

Interviewer: "When you say the disciplines there, in terms of support, how supportive have they been have they taken it on because ultimately it involves alot of disciplines, do you find that it works insofar as are they appreciative of other disciplines then coming together and working, listening and sharing?"

Interviewee: " I suppose through the process of team based, It probably opens up that forum, to say, well if your a public health nurse and maybe I'm a speech and language therapist, I'm not really sure about what you do and your probably not really sure about really what I do, we would have assumptions.... am.... through the nature of everyone's typical understanding of what a nurse does or a typical understanding of what a speech and language therapist would suggest, but am, if we are to work together we are trained from two different disciplines, you are clinical discipline I'm , I suppose from the social model essentially, for speech and language therapy, so that conversation needs to happen well you know where you actually sit down and go well "I'm a nurse this is what I do, this is how I make decisions, this is my clinical remit this is my role and my responsibilities you know , within the work that I have to do" .. likewise from the speech and language perspective well I need to say, I am this is I am.responsible for, this is how I assess , this is how I intervene, this is how I discharge , or what not, so that conversation really needs to be had. And

that is something core to team based as well. Particularly with new teams, TBPM isI wish every team in the country could go through it from the perspective of getting that level of understanding around roles and responsibilities, getting the level of understanding of what our purpose and function is, it can be quiet difficult if a team has been up and functioning an go then and do that retrospectively, you know...because you have been functioning in a dysfunctional manner...maybe, and then all of a sudden you know your stopping at a point in time and saying right what we are doing right now isn't working if we were to start all over again, or start fresh from today, you know your almost trying to undo the functioning that has happened, prior to the intervention, so the ideal would be, yeah for new teams and that's where I suppose where the Primary Care Teams comes into the equation, that if we are looking to set up a primary care team tomorrow and ..you know we are a part of the process, at least then we can seat down, and say right well, what don't we know and what do we know and we can start from a starting point and say well the roles and responsibilities and clarifying those different pieces”

Interviewer: “ Ok , its interesting you say that actually the point there, do you feel that the timing is everything, insófar as you made a valid point that in that “you have to undo what’s being done”, am how difficult is to undo what has been done?

Interviewee: “ I am thinking currently, really with some of the teams that I would be working with right now, multi –D teams who be from a variety of services, be it mental health, addiction services are two that stand out, they have been probably functioning for the last 6 or 7 years, and we say “functioning” and probably really just getting by. I would have linked in with both of them actually, ironically enough about a year and a half ago to do a team based and we did our team based, we set

our key performance result areas we set our set our SMART objectives , we set our action plans everything was tickety boo all ready to go and it never, it never lifted off so am, I have been called back to both of these particular teams now for them to say we tried team based it didn't work I want you back in,...you know can you help us. My first question is in response was why didn't TBPM work?, so then it comes back to the fact of readiness, so that then TB has to be parked, so all of the other stuff for want of a better word, the interpersonal stuff, the roles, the responsibilities, the purpose and function of the service even can be addressed before TB is picked up. So it is very much...actually its very individual in many respects , you know if there is interpersonal issues or conflict, unresolved conflict, team based will not work.

Interviewer: How is a new team member brought up to speed to be a an effective team member within a high performing team, when you talk in terms of readiness for the group to give training, how is that new member targeted, when training is done collectively with lack of human resources etc?

Interviewee: " The ideal would be that they get an insight into team based performance management when they receive their induction or employee resource pack when joining the organisation from their line manager and the process starts from there. There is a section within the pack on TB so alot of that responsibility would go back to the line manager, my aspiration or my vision would be that all line managers in the system clued into team based, you know... the manager really is the linchpin, of of really spreading the word of basically TBPM, so if I am a line manager out in the service and I don't have an awareness of team based I could google it or I could go onto HSE.net and find some information about it but if I haven't actively participated in it, its not necessarily going to be something I have great awareness of, that I've seen fruits of its labour, that I've experienced great success with , so

there is a gap definitely , it has its place, but as I said it's almost like a bridge that's needed to join the two, but the line manager is definitely a key person there"

Interviewer: "As you have said there that the Line manager is key do you feel with the amount of strategies, changes, reform of the HSE is there a resistance from the key people to support TB that you need to have on board in order for TB to work?"

Interviewee: " As an observation from working in the HSE for the past 10 years, I would feel that line managers are very much under supported, yes we do have management development training programmes and we run various other courses to help to support managers, I think that it can be a very individually specific thing, down to the competencies, the character even the personality of a particular manager and how they would embrace one change, secondly development and thirdly service development, competencies are definitely a core part, if you have a manager who is dynamic, innovative, highly motivated, will you know,... get out there and find what's in the system or how they can use the system and the supports from within HR to support not only them but their service and their team, then you're on a winner but definitely there is a gap there as well. I suppose what I have noticed as well over the years is people tend to become managers, because they have almost been in a position for a period of time it's almost they have subsumed a managerial role and that's the historic part of the organisation, but that's changing now naturally with the likes of the interview skills training and you know different systems and what not, but there's still ah core group if you like that have almost fallen into their posts and haven't necessarily had continuing professional development or haven't had management development or you know...if...am...someone wasn't interested in educating themselves through

schooling through the academic support programme or why not your kind of ..well if I was a manager choosing not to do any of those things where am I at or does it come back to maybe the skills I have acquired maybe life skills, experience.

Interviewer: “that’s great because what your saying is that they need the training to support themselves as well”

Interviewee: “Absolutely. The development of managers is key absolutely and utterly key because I have found that...I think there’s ..you’ll probably find a correlation between the line manager and the success of team based performance management within teams. Managers who have developed themselves, will develop their teams and their team will have achieved success and you know....service development as a result of that”

Interviewer: “ Ok great, in terms of training and the training for managers in order for teams to be successful how would the team train in a new team member if a new team member did join the team?”

Interviewee: “ I know the guys through the induction would encourage maybe a buddying system, where’s if you were to join our team, this morning that maybe you might shadow me for a week, or that I would spend time with you letting you know what I do, how I process work, how I develop programmes, how I meet the needs of teams, I would run through that with you to give you an awareness of ...you know what goes on within the team, I think it’s probably more something, I don’t think it’s written in stone, it’s not a solid structure...it’s certainly something I would encourage and that I would advocate for and that I would have definitely seen the success of generating a buddying system or its almost like creating a CPD time or a personal development time, you know that there is an hour to that you can sit down with

someone from your team from within that week, to kind of say ...well..let me know what you do..Why do you do this or how do you do that, you know even the transfer of skills and I suppose that system is there from the performance and development or no from the PDP system, whereby if you had a set of skills, that I found or that was key or core to me so that I could say...right Mairead could we actually sit down because I want to know how you go about doing what it is you do and I might make an hour then or we would sit and we would transfer that skill from you onto me. So in that way I have actually met my needs through my personal development plan then, so it's doesn't necessarily have to be a course or formal training, I suppose it's really just sharing information, sharing knowledge.

Interviewer: "I'll now look at team processes Nessa, I might just address the Primary Care Training Programme that has been produced, what is the programme all about, maybe you will talk me through it"

Interviewee: Sure I suppose the Primary Care Programme as you mentioned earlier we engaged with the Primary Care area ..I think it was about three years and looked at the likes of effective meetings and some other various kinds of key components, you know or whatever for setting them up. So we were approached then with regards to the next steps essentially for the development of Primary Care. So am I had a bit of a think about it, with regards to how I could best approach it looking at where Primary Care is right now, looking at what's been done before and try and put it into the melting pot and say right well what are the next steps where's the vision for primary care am we would have met with the likes of PJ Smyth, Primary Care specialist and with the TDO's as well (Transformation Development officers)for their input with regards to you know ...like I'm not involved directly in Primary Care so I think it's always core to go out say guys, what do you want, what

are the gaps and what are the biggest challenges that you are facing right now. So you spend a lot of time gathering facts, gathering information. I would have looked at current literature with regards to primary care models say in the UK and Australia. I would be a bit of a nerd so I would do my lit reviews and have a great relationship with the Library here so I would spend time looking at primary care models and looking at teams actually need in order to function as a primary care team. So through my own studies I took a masters programme where we looked at the fifth discipline as part of or one of our HR modules and the Fifth Discipline from Peter Senge basically takes a learning organisation approach to developing organisations and that was something that kind of stood out which was key or core to me so well I thought the principals of that could be transferred to primary care. So that would have been the model or framework that I anchored just to have something solid and to take a learning organisation approach to it because primary care isn't going to evolve or develop overnight or in two months or in three months...you know it's going to be a journey so I felt that the core themes and the nature of the model lent itself to quite effectively to primary care and I anchored it to that. So then I sat down and tried to transfer what was there and so the structure of the model of the learning organisation is based on the fifth discipline but it's very much anchored into...it's very much a system approach and it's a process approach to development and as it looks at things the core themes would be system thinking would be one, which looks at cause and effective relationships so the cause and effective could be and I'll refer to what I mentioned earlier ...if you were a public health nurse and I'm speech and language you would think one way I would think another way, you have your systems and process and I have another just because they are your systems and process and these are mine doesn't mean that you are right and I am wrong so straight away its

creating a bridge insofar as this is..I am and this is how I do what I do that would be a starting a point and that needs to be said when you are bundling a whole pile of disciplines together and saying off you go and become a team that foundation needs to be laid before anything is built on top of it. The same can be said when you are building a house, if the foundations aren't solid it ain't going to standam the second element is personal mastery which kind of ties into your intrinsic motivation in terms of what gets you out of bed every morning and I suppose it's down to the basics. It also looks at how or what is my own personal vision how I understand how or what primary care is what direction primary care is going if we don't make that explicit or we don't talk about it as a team that assumption stays with me so I have one idea and one vision and one shared vision so it's getting into that idea that shared vision piece so its again having that cushion and making all of things that we have internally that we don't necessarily talk them out or put them down in black and white, like we now have consent or we now have agreement on where things are...are going. The next one then is the mental models, this probably is the one that throws up a lot of the stuff or issues am...mental models are kind of believe, I suppose how you see the world through your own eyes. I don't know if you have come across Maurice Briggs....He would pick up ...there's element in it on how you make decisions, your perception of the world, also where you get your energy from, where your motivated from ...all of those kind of things. Its ties in with mental models am I could have had an experience with public health nurse, it may have been a very negative experience that then comes my mental model of public health nursing, so straight away I am thinking, primary care and we're going to have issues with public health because I've had an experience in the past, it could be that I didn't have an experience in the past and I'm making an assumption on passing you every-

day with regards to public health...oh I wonder what does she do, does she actually do any work and then that becomes my mental model ...God I am creating an awful perception of public health nursing ...so that would be the mental models. There's also a piece on where those mental models come from and challenging them.

There's an exercise contributing to this (refers to Primary Care Programme) its called the left had column, that's where you may write down em...maybe you may write down a disagreement, I might write down on the right hand side of column, you know, the pattern of that actual disagreement , on the left hand side of the column i'll write down what I was thinking and again it's bringing back mental images around your thinking and your thought processes directly linked to your behaviour how that then impacts on services. Now that's quiet deep, I suppose in terms on the theory side of things but actually through the training it will be on a lighter level, but its just to have the core concept knitted and one ties into the other all the way along. So it will be challenging the mental model and then getting an overall mental model to say right...this is where we are at this is where we are going to go, this is going to be our vision, the steps and what not.

Shared vision then cements the mental model stuff when that piece is done, it develops a common sense of purpose, because I suppose a team cannot go, it can't drive, it cant go anywhere unless they have a very very clear road and a very clear sense of purpose, clear functioning and clear roles responsibilities so all of that is ironed out then in the shared vision piece.

The team learning then is keeping the development side of things, clued in tuned in all of the time but yes we are evolving, yes we are developing, yes we are going to have to step out and take an hour or two in the quarter and look at you know, what's working well what's not working well as a reflective piece and that ties in very

very well with the team based performance management because if the guys were setting key result areas, actions, and objectives they are going to have to build a review mechanism to actually stand back and say right, what have we learned , ok maybe we set a key result area and we haven't achieved it but we have to look at why we didn't achieve it, maybe the timing was wrong maybe the readiness was wrong. Maybe there are other factors, in terms of organisational influences and what not.

With the review then of the team based process that's where the team learning is going to come in because they need to be looking at what's working and what's not working, you know, I suppose keep what is working going and nurture that, but also look at what's not working, and try something else or we know that particular approach didn't work, we now maybe try this approach. So that would be the team learning side of things.

Its a two day programme so I suppose that the theory side to it. There's, because we are hoping to do it in conjunction with the TDO's , because they are the people with the expertise in the primary care and I think that its key if they are seen to be championing the programme and you know support the development side things, and reinforcing .

There's going to be a definition of best practice of primary care around the world, you know I have done some research myself in looking at the models and what not and there's our own primary care strategy as well, and other bits and pieces of the TDO that will lead out on that.

The idea I suppose is that this is seen as a programme in conjunction or consultation with TDO's that's its seen as that we are both working in harmony all the way along

so that it's not just seen as me coming in spending two days with a team and going out and the TDO spending more time with them and that it's not seen as doing this separately, so at least it's a joint approach again, it's more cohesive, its back to that foundation piece all the way along. At the end of each day through the training programme, there's a lot of group work involved where am, the guys are going to be challenging themselves and challenging the team, challenging what realistically we can do in terms of the population demographics that they are providing services for. It's almost breaking it down to build it back up again and looking all the components individual parts where we have all of these single entities its now almost like the lego bricks and putting one on top of the other , getting them fitting in a in a solid way. This like a foundation programme as well but its going to give them good strong foundations to start building you know the house or the lego brick or whatever analogy or metaphor that's best suited to it. So that's essential the programme. At the end of each session as well they're going to have action plans so I am taking the team based approach from that perspective. So its not just where you come for a day's training and you go off and forget about it because the two training is not necessarily going to be consecutive, so at the end of the first day they are going to have literally a plan akin to team based performance management, homework essentially, to have it done and prepared to come to the next session, am..as that keeps the connect between the two days.

So that's the training programme for Primary Care.

Interviewer: " Ok great, it's a very interesting course, this may sound like a basic question, out of all of this, what is the major element that you want the training groups to grasp if they were to take one aspect of the training, obviously it's all important..."

Interviewer: "That's an interesting question, what I would say is that I suppose, the one message, I would say is and I often say to teams " if you remember nothing remember this"...probably planning structure which is TBPM, setting your key result area, or setting a goal, or setting a priority or whatever it is that needs to be donewhether it's the challenging of waiting lists, whether it's reducing them, getting more people into clinics, whatever the goal may be, it needs to be looked at, how you break it down with regards to a mini forced field analysis ..em...I suppose looking at your present situation or your desired situation and looking at your threats and weakness and what not, getting that then into a smart objective and getting action plans, actions plans are probably just the back bone of getting things done, and it has to be an ethos that this organisation takes on, you know that we can go to meetings or that we can go to training and go "oh yeah..that was great and do you remember your one from P&D" ..you know ..."and we did something with her and I'm not really sure what it" ..so if they at the very least walked away with the three steps of taking a key result area, a smart objective, and action plans,.....then I have done my job, because that's going to transfer individually, within the team, within the primary care, within their own discipline team as well, it's a model that stretches all across all areas so I think that would probably be it and effective team working..you know the concept of working together as a team and the importance of the interdependence piece, because I think historically this organisation is quiet ...we work very independently we not a team working or we are not a team thinking organisation so if we start to value the importance of depending on others to get the job done, if that transfers I would be very happy.

Interviewer: "What do you think the attitudes of the people that attend the training courses that you train in your experience, both during and after the training, how do they perceive it?"

Interviewee: "Sometimes I get a lot of resistance, and a lot of suspicion and a lot ...am..."does this mean more work" type of statements, that's usually the primary thing.... am....come the end of the day...people are usually highly motivated, enthusiastic...am...there's definitely ...they call it a metanoya in the fifth discipline which is a shift in thinking, so that definitely happens throughout the process there's a lot of PR attached to this also, as there's a hard sell in this, but I can sell this programme, because our own team have had massive success with it, we built our own team based on the team based performance management approach, so it works and I know it works, em...I have seen success with teams, I've seen teams basically turn around , I have set teams up using TBPM. So the success is there the writing is on the wall, I have the evidence, I have the tangible fact to say teams have made changes so that in itself...it's very very hard to argue with that and that's what I say to teams...TBPM gives you evidence to show how it really works.

Interviewer: "and communication mechanisms Nessa is also a huge part in obtaining high performance within each team..."

Interviewee: "it is certainly, one of the outcomes or one of the critical success factors is effective meetings so in order for an effective clinical meeting to occur communication skills and effective meeting skills have to be a core component of that. So one can't make an assumption that we have meetings effectively, definitely the communication structures will be very strongly addressed along with the effective meeting stuff as well. The importance of communication and the team based gives

you that and the actions plan gives you a very solid road map as you are recording what you are doing all the way along, plus you are coming together as a team, to have that level of group discussion and communication. We will also touching on effective skills for feedback, you know a lot of us make an assumption, you know....just because we are talking are we actually communicating effectively.....but the irony of it is, I mean you can talk along but actually say anything. So it will be looking at these differences between the two of those, you know...the transfer, the exchange and what actually goes on. Plus I suppose having a solid system where one has an agenda or one has keys areas that you want addressed, you keep to those keys areas on the agenda.

Interviewer: "So now the team is aware of the primary care after participating in the primary care training programme, and TBPM, how is this then measured or reviewed to ascertain if the team is high performing?"

Interviewee: "There's a review mechanism built in, a quarterly review mechanism built in within the TBPM, so when they come together on a quarterly basis as a team and reviewing specifically their TBPM, but TBPM must be on the agenda of every other team meeting as well as an agenda item, even if it's just how are things going, or brief update or what not, so that's keeping alive the process as well, because a quarter is a long time within the HSE, a lot of things can happen, you know if you are dealing with front line services which include patients or clients, that's not necessarily going to be at the fore front of your mind day in day out. It's at the fore front of my mind because I do it every single day delivering training, so to keep it alive on for example primary care teams it needs to be on the agenda at regular meetings. So for example how do they measure success, they measure their own success because they are identifying ...say ...we'll take the example of clinical meetings if it

didn't exist before and its going to exist in six months time there's your measure straight away, we hadn't had it ...now we do. So there's achievement in a quarter straight off...it could be addressing waiting lists or assessment times maybe the waiting list was up by 300 or 400 now, I hope that in six months time that that list is now down to 100, then coming to the review at the quarterly meetings ...it was a 400 six months ago now it's at 100. It's a very simple mechanism for achieving and for getting results and for basically seeing what you have achieved because once you look back over a 6 month period you go well, what changes have we made, what have we done, where is the evidence of this where is it written down...my own big thing is if you don't have it written down ...it simply didn't happen as there is no record of it happening. So you know the team based process and the action plan process makes it clear and as a written record or document of you accomplishments and achievements all the way along.

Interviewer: " So what do you feel to date is the best achievements of Team performance specifically PCT's insofar as what has been achieved in comparison to the they way people worked prior to the team based approach. In essence what's the main difference?"

Interviewee: "I suppose we hit some of the teams quiet ad hoc and it was very much dependant on the persons within the team. I ended up coming in to do Team based because an occupational therapy group had become engaged in team based a number of years ago and a member the team moved into a primary care team and this person felt that it was suitable or fitting or what not for PCT's so then we blitzed all PCT's in that particular area. So from that sense they are still continuing their team based process, their systems and processes, they are still setting their

priorities, they are putting their smart objectives and action plans in place so that a result.

Interviewer: “ When the initiative of the primary care strategy came on board which started at the very top and it was decided upon in later strategies that team based approach was to be adapted for PCT’s in order deliver that primary care priority, what sort of implementation plan from senior management aided this approach for your selves even..at the beginning.?”

Interviewee: “when we were approached to this we automatically decided that it was going to be TBPM, so from our perspective that’s the approach that we have taken. We do it with all of our work. We are working with the acute hospitals at the moment with the team based approach, the very same approach. There is also further plan at some stage whether there’s going to be efforts to try and build a bridge between acute hospital services and primary care services. So they will be talking to each other, this approach will be TBPM. We have to date received a lot of recognition and we received an achievement award for the reconfiguration of services and we received that through team based and that’s the fruit of our labour “

End if Interview, concluded at 11.30 am

Appendix 5: Interviewee 3 Team Member of PCT 1 & PCT 2 Interview

Transcript

Cyril Marron: Social Worker Team Member interview - From the Primary Care Team Portarlington, Laois/Offaly – PCT 1, and Social Worker PCT 2, Abbeyleix/Durrow

Held: May 4th at 12pm

Interviewer: “Thank you for joining me here today, could you briefly explain your role on the PCT?”

Interviewee: “I am a social worker on the Primary Health Care team on the Portarlington team and the Abbeyleix /Durrow. I suppose there's a whole development of social work and primary health care in Ireland it's relatively new in particular in Canada and Australia and also in England to some extent. The perceptions of what social care is, are very controlled to some extent the historic developments of the Irish Health care system. Way way back in the 70's social care was very generalist approach working with all people within the community. The Child Care Act in 1991, social work became very focused on children, child welfare, child support so very often even among professionals the concept of social work is generally to serve people of the community from womb to tomb, where you work with everybody in the community and its very much population health based, which is about and include social inclusion, impact on poverty, looking at how community development and community anticipation can enhance people's self in the community, so that's a kind of a broader role of social work which on certain levels it's a refocus of what social work was.

Interviewer: "Ok Great, what are your attitudes since the primary care teams initiative has been set up?"

Interviewee: "There are advantages many advantages in the development of individual teams, the whole language has changed and I firmly believe that the language we use creates the reality we live in coming from a social worker member on the team and from a social work theme if you like. We are now not just talking about health policy we are talking about health and social care policy and we are talking about what began as primary care networks that's been transmuted if you like into health and social care networks, and again people talk about primary care teams and that's actually old language, the primary care bit not the team bit because they should really be deemed primary health care teams or primary health and social care teams. The reason I say this is because the primary care is a very early 20th century medical model where you have the GP, Nurse, the clinic type of development, primary health care, is not focusing on illness its focusing on wellness, what are the things that keep people well what are the things that keep whole communities well, so the concept of primary health care are the social deterrents of health is extremely important. These would be things like employment opportunities, education opportunities, social inclusion in the community, social capital and level of trust within the community, these kind of things all become important to some extent at primary care team level that's still a long way down the road but the thing is that it's the policy now, it's in strategies it's in the language now so as I see it when you ask me that question what's the immediate buzz is that it is making strengths to fulfil the population health dream, which will not only change how health services are delivered at local level in Ireland but actually will change the very nature of Irish

society in ways we weren't able to do in the 20th century so that the impact of this approach will make Ireland a more inclusive more healthy in every sense in society.

Interviewer: "What are you enjoying about it the most?"

Interviewee: "It's more upstream, whereas before I worked in the mental health and that was very downstream, and what I mean by that is it was a rescue model which is similar to the medical model combating illness, so for instance even at the moment if you want to refer a child to a service, they must be at risk before an intervention can be carried out unfortunately, let's say the parents just become unemployed and let's say other factors have come into play, such factors as addiction problems, conflict, and I can see from my professional background that in 6 months time that child will be at risk and in need of protection but there not at risk now so I can't intervene.

Interviewer: "So more of a reactive rather than proactive"

Interviewee: " yes certainly, it is possible to a certain degree to make some interventions now, it's a bit like spoon in the ocean it can become more important in some ways so for example would be the development of crèche facilities things like say, for one parent families or for families where there's unemployment and that can alleviate a lot of not just one family's distress but a whole range of families within a community and the opportunities to do that in primary health care the two priorities this year is number one priority needs a assessment and number two community participation, so the opportunities to get out there and look at the means of the whole community not just the needs of individuals and then to encourage community participation and development of their own social care service and the certainly more up stream than we simply go out and rescue the individual persons

Interviewer: “So in terms of job satisfaction, then you must receive a lot of motivation and satisfaction from your role?”

Interviewee: “Yes yes, the outputs are far better”

Interviewer: “Are you given the resources to do what you need to do?”

Interviewee: “That’s kind of complicated!, the first thing that I would say is that at the very top level the strategy is there the policy is there, em...it’s there in a way that was never before, but at local level don’t know always know that so for instance you go on the HSE website and look up the HSE’s model of care, things I’m talking about population health, social inclusion, development of preventative upstream programmes all that’s in there ...am....likewise the primary care strategy itself and subsequent documents arising out of that, so at policy level and even at strategy level quite a lot is there as supportive mechanisms that wouldn’t have been there prior to 2001, its developed and got stronger stronger as time has gone on. At the same time at local level, actually before I go onto that the other thing is that there has been tremendous input into organisational change, in context are very difficult as people have been working out of the model or best part or since 1970 or since the healthboards have been set up, change is going to be slow, difficult and it takes time to win people round, and there’s been tremendous work in the top level around, encouraging that change, resourcing that change, at local level, its like...high ideals and small realities is the phrase I would use. At local level the small realities are very often difficulties...do you know what I mean...the small realities could be a time to get for the team to meet, how often to meet, trying to work through how the team works, trying to get resources for team training days, team development days, now I’m not saying there’s none of those, they are there, but I suppose I am saying that

there is a need for more at that level, because this is a huge C change in the way things are done, and it can take a lot of input and a lot of resources, just at that team process level, and kind of meeting once every year, or once every couple of years for a team day, is not really enough. The change process is too slow in this situation. The other piece around this is I suppose is there is tremendous advances being made around the interdisciplinary work with Physio's, O.T's, social workers, GP's and Public Health Nurse's and so forth and indeed now moves to work also with services within the broader network, psychology, speech and language, nutrition"

Interviewer: "That's interesting that you say this, how is that done?"

Interviewee: "Because it's being opened up, the most recent development has been the discipline managers of these disciplines on the primary care teams, director of public health nursing, speech and language managers, dietitian managers and so on, have created now a primary care implementation group.

Interviewer: "Within Laois/Offaly"

Interviewee: " Within Laois/Offaly, so that they can are meeting as a management team because one of the local level mediums is the medium of message, the individual managers can't be coming out to individual workers and saying "you need to develop interdisciplinary team work approaches" ...if every-time you turned around, it's clear managers themselves are not doing that, do you know what I mean, so the other piece that that's bringing forward is that these managers whether it be an OT manager, psychology, in social care in public health nursing, manage both workers in primary health care teams and workers in what was the former community care programmes what will be the networks, so they are managing both

sides, so the possibilities of becoming a more integrated structures become greater managers themselves and there's a need for more of that. It's a more seamless and integrative approach to service delivery"

Interviewer: "Training and education and the wider network itself, to date what training has been available to you, or what have you undergone in relation to team based performance management for example and so on?"

Interviewee: " Within the Portarlinton team, there was an annual team day, which turned out to be two team days as GP's couldn't all attend on just one day, but just to note that I have joined Portarlinton two years after the team was brought together. And I have been on the team for the past 3 years so I attended this team day, but I think they may have had training prior to my joining the team. Here we have had one team day which was fairly basic looking at team process and how to hold team meetings and that sort of thing. So it was just right down to basics and that's goods and Carol McCann has been good at that kind of process. The other part of that process is that Carol chairs the meetings, the team meetings. I suppose that I would say it's on a professional basis almost embarrassing, two years down the road, from my point of view because social workers and as long as I have been a social worker I have been meeting as a member of a team every week so it's a little embarrassing to be part of a professional group that isn't and you know without external inputs. Having said that I suppose that's fine that's my professional experience it's not everybody's and other people have been working for many years without team meetings and working as a team, I mean the whole concept is very new it must be for them, and challenging and threatening in some instances so I suppose I have to take that on board as well. Em.....and it's just, an example would be supervision, like supervision in psychology is very strong, like if i worked more than two months

without supervision I'd lodge a complaint, other disciplines don't work to supervision, they should they aspire to it but it's not practiced, but some of it is that they find it very daunting and if you insisted a bit, it's because they don't understand the support management that you need when you work with the public, in a community. It's almost essential in order to continue best practice. So its two very different ways of looking at working but it also depends on what supervision is, like from a social work perspective, it's a very strong support management tool but in other disciplines another way of looking at it, it can be looked at as a very strong monitoring tool, do you know...so there kind of subjected expectation of it."

Interviewer: "And due to this does this cause any form of conflict so to speak?"

Interviewee: "Yes, it can cause conflict...it obviously can, there are tensions and possibly unspoken conflicts"

Interviewer: "How is that overcome if at all?"

Interviewee: "It did happen in Portarlinton and it happened before I arrived. It happened more frequently at the early stages, its quiet difficult to manage it, because essentially what happens is that interaction develops on a case by case basis, so a case comes in so here's an example:

An older person...this is an actual case and they are living on their own but they are living directly opposite family care givers, but the report comes in that this comes in that this unfortunate 75 yr old has burnt their feet black on the range. The primary reason for this is that there is a memory problem, who had just put on a very large fire ...this person would have done this habitually for years ..putting their feet up

against the range but when the fire has gone done and when the range was just warm and not as hot. So a public health nurse is involved, OT is involved, physio involved and the GP was involved in the sense that initially it was a burn and it had to be treated. It was referred to me more in line of ..could I see about getting more support for the family because they feel awful that this has happened and are feeling the stress of it all. Now the initial assessment that came in on that case was that it was high risk and that she should be placed in a nursing home, and that was generally by all the disciplines involved, I had not yet met this person or the family so I went to the family's home. My own assessment was that, that would be basically wrong that there was no need to put this person in a home. The family were very happy to look after her, the person was happy to stay within her own surroundings. It is well known if you take them out of their familiar surroundings it can reduce their life expectancy from 10 years to two years. So it's a big decision and it's also big decision resource wise as a bed here (Abbeyleix Community Nursing Unit) costs a huge amount and a very expensive form of service delivery.

So there was a clash of opinion, from two different assessments. They are looking at it in terms of risk assessment and what happens, who's accountable if this woman does set herself on fire and I am looking at it in terms of needs assessment, and risk control"

Interviewer: "So where is that bridge gapped then??"

Interviewee: "Thing was I was a lone voice, as I very often am, which is the difficulty in this social care model as they aren't social care workers, they aren't community development officer's do you know what I mean. OT's are closer to the social care need in this particular's patients life....for example a rail in the bathroom and so

forth. Its rather like being from different cultures if you out a French, Irish and Dutch persons on a team and they don't speak each other's language so to communicate is difficult, because it's very different culture from the medical model culture and the social care culture as I mentioned earlier. So what I had to do is win the OT over, they could act at least as an interpreter and asked to do a joint visit which we done when we came I pointed out that ..and this was dangerous as I was almost telling an OT how do their job, but I gently persisted that it was an old fashion range and that a range guard could be fitted equally, the OT accepted this and also came up with an alarm fitted to the family care giver's home so that whenever the person got out of bed the alarm would go off at night in their home...sorry the incident took place in the middle of the night when the woman got up out of bed forgot the fire she had topped up before she went to bed hence the incident happened. So basically what developed was that myself and the OT came back to the team with a proposal and with the family's agreement for these things to be put into place and for it to be monitored and reviewed.

Interviewer: "And what was the result of what was being proposed?"

Interviewee: "We won, it was accepted, it made common sense. (In Portarlinton)

Interviewer: "that example that you have given me was that soon after you joined the team or was this further down the line"

Interviewee: "I would have been on the team about a year and a half", it wouldn't necessarily have the same outcome in Abbeylax at the moment, but it might in time. It about really people carrying the responsibilities

Interviewer: “Just in relation to the meetings when you brought the example of such a case back to the team how was that trashed out, is there or was there a certain forum on how to listen to all opinions and how was the decision made to bring about this outcome”

Interviewee: “ Again it depends on whether is a new team or a developed team I mean like...it's actually with a team that's very developed it's very impressive, even with the most complex cases and it will take a about 10 mins....for a an assessment of needs, a discussion of options and develop a care plan or action plan, so that's a very well oiled machine kind of working in that way. Where you have teams that have just been brought together or a new team is that number one, not everybody knows what everybody else's role is, like people like don't and I will include myself in that the full range of each of the disciplines role is or does. In a multidisciplinary team within the Irish Health Services, the other thing that is important is maybe what other are doing that belongs to other disciplines and what I mean by that is the GP's and the PHN's have taken on over time quiet a lot of work that is in the psychology, and the social work and the mental health arena to an extent that they might not even know that they are stepping outside of their own kind area. And so part of the struggle of the change is that these other disciplines are here now, “you don't have to be doing all that anymore” sort of thing. Like there's no point in a nurse going out and assessing whether somebody needs a chair lift or not, because there's now an OT there to assess that. Likewise there isn't ...actually the GP's...actually this is a glorious example deals with an immense amount of family conflict and its probably one of their biggest headaches, they are trained and structured to go in an deal with the individual patient one by one by one, so they have a husband and a wife coming in and they are fighting with each other it takes away from their service delivery

because they haven't got the resources and the equipment or the competencies to address this, but it takes some time for them to realise that social workers do have all those things. So it can happen where they can refer one case to me where there is a lot of conflict going on, but on review another three cases could have been referred to a social worker because there is that lack of understanding and awareness there. It's something that GP's who have worked without these resources for so long that there's a not knowing how to use them"

Interviewer: Is there a medium for that to happen, will say at team meetings?"

Interviewee: "well no, there isn't a forum, like the discussion you and I are having now there isn't a forum for that discussion to happen now. One of the things that I mentioned, community needs assessment is being looked at. But another area that's really high on the agenda is the process of TBPM. This has helped in the area...and the whole process around what I mentioned earlier key areas for discussion in relation to assessment needs, the discussion of options, and the development of care plans, breaking it down to into certain areas, objectives for intervention and actioning this. However the sharing of ideas and discussing them outside of the day to day decisions on care plans ,.....there isn't space for that to happen insofar as sharing what each other does, reflectively. TBPM is effective for outputs I feel, most certainly. But in reality I feel that there is no scope to measure team processes within TBPM. It all gets back to what I referred to earlier the whole concept of what title primary care teams is given, in essence they should be called Primary health care teams, because it's the medical model joining the social care model, it's a complete mindset shift."

Interviewer: "In relation to again the team meetings and in light of certain areas that needs to be discussed as in such areas of community needs assessment how do you think a new team member joining the team.... is their a forum for the new inductee to be brought up to speed on team processes and functioning?"

Interviewee: "Well... within the last two years, two members joined the team and actually left within the first 6 months. There can be a few reasons for this. Some people just like clear a work structure ...a base if you like to work out of, and I think that this was one of the reasons one of the members left and that's fair enough. When someone new joins the team the group dynamics changes, whether one person joins the team or one person leaves the team the dynamics of the group change which can impact on the group and its functioning. I think overall joining a team such as this can be very daunting but all recognising that the environment being entered into is of such change which is very fast paced it must seem to the new person very daunting indeed. When I first joined the team the team already had been formed for at least 2 year period in respective of the longer running team. Looking at it from the point of view of new person joining ...the best way I can describe it is that I felt that I had arrived at departures at the airport and the rest of the team were at arrivals!. The team had a really good sense of their own identity and the identity and functions of the rest of the team. It wasn't until there was a team day organised which was facilitated by the TDO that I really got a chance to ask questions and be brought up to speed with regard to the team processes. So for the purpose of joining the team, a team day out away from the service and the day to day business and just concentrating on the team, it would give new members the

chance to get an overview of what's happening and to see the way things are being done and manner in which they are being done

END OF INTERVIEW

Appendix 6: Interviewee 4 Team Member of PCT 1 Interview Transcript

Interviewee 4: Pearse Murphy, Social Worker PCT 1 Portarlington

Interview Held: 5th May 2009 at 9.15am

Interviewer: "Thanks for taking the time out to meet with me, so how long have you been a member of the team?"

Interviewee: "No Problem at all. I have been with the team two years since 2007 so I'm just over two years now in the team"

Interviewer: So would you have come from another PCT or from the old Community care model or mental health model?"

Interviewee: I would have some from the mental health model which is multi-disciplinary team working just the setting is different in that it is a primary care team which combines health and social care professionals which is really the new thing. It was a similar scenario in a certain sense. Mental health is a secondary service where the primary care model is a primary first service to the community so I had certain expectations that there would be parallels in terms of the process and how the teams would be set up so ...am...I suppose when I started here am.....that's the first thing I noticed was things weren't the same. What I mean by that is on a positive level I felt it was much more democratic if you know what I mean, in the mental health team it was much more top down team...so even though we are all professionals on the multi-disciplinary team, it's lead by the clinicians, which is the consultant psychiatrists. Whereas here the positive perception was that it was much more democratic, now the GP's come in but it was much more democratic, like the chairing of the meetings were shared around. So from that point of view I felt it's

much more open. The thing I noticed that was different was the mental health team because it was clinician lead and consultant driven....am ...as a team we might have been seen as much more together and close knit, but this is much more you're in a team but your independent as well. So ah..... at the beginning I felt more isolated in certain ways, but my predecessor stayed on with me for a couple of weeks, to show me the ropes here and he had already you know...been here a few years so the team was very well established as you know, so I settled in very quickly and everybody was very friendly. I suppose what I mean by the isolation is I wasn't used to maybe being in an office on my own...you know...in the mental health team we were meeting all the time or it seems that you are meeting more often and your co-working more often. It's a very informal set up here which is nice and you get to know everyone very quickly and they are all very friendly and because of the informal nature for that's a positive the way the team meetings are set here the very informal nature where everyone sits down and its hands on and what needs to be said is said. So it's rotated around the table so it's never really ...you know...it's whoever really decides to chair a particular meeting goes around and gets input from everybody. So everybody at the table gets to have something to say, or if they say they have nothing to say they are at least given the opportunity to say that even. So the other good thing about it then is that its run very efficiently from that point of view, whatever needs to get said gets said, it's done and dusted and over very very quickly which suits the GP's in particular because their time is precious and important. The other way it's set up here which suits everybody when we meet not just the GP's it's established now that we kind ofwe all meet either a Tuesday or a Wednesday weekly an em....we run it during lunch hour on either of these weekdays. It's just more effective that way, do you know what I mean"

Interviewer: "Yes, and what do you think is the key thing that makes it informal, but open and efficient?"

Interviewee: "The fact that it's not consultant led, you know...that it's not lead by just one person. Now when I say consultant lead, the consultant is seen as leading the team within a mental health team that perception is there. So they would be the ones chairing the meetings, saying what's being said, again very much top down as I said earlier, whereas in this process like you sit down, whoever chairs the meeting takes the checklist, as in who's there, goes around the table to ask each individual have they anything to contribute or any input in this week's meeting ...you know who wants to talk about a patient or a case or a client and am so nobody is dominating the meeting everybody has input. It's an open forum and there's cases that are brought up that I might not have referred to me but because something is discussed about them at the meeting everybody's opinion is welcome....well that's the way I feel about it anyway. So sometimes I will contribute in a case that hasn't been directly referred to me like and say "what about this or that...or have you tried this, has you talked to the family", so everyone can have a little bit of a say. In the mental health team meetings, if you weren't personally involved in a particular case you were in a way kind of looked at funny because you were seen as "you're not involved in this case or with this patient..." where here there's that kind of openness where if someone as a dilemma or difficulty that's brought up then everybody can have an input, it's on the agenda"

Interviewer: "Actually just to pick up that point as you made a good point there if someone does make a point on a particular client and the person making the point might not be involved in the case at all but the comment is taken on board, your saying that that does happen"

Interviewee: "Of course it can lead to a referral of the case to that person that might not have been directly involved to begin with. Like for example if a GP began discussing a difficult scenario like a like recently there was a family brought up where a GP was having a complex case, there was family conflict and he was struggling with it insofar as different family members coming at him at different angles so I suppose I had a bit of a reflective take on it and asked "what about this or what about that" and from that he asked me would I meet with some of the family members and talk with them because a part of the social work remit might have been do to some family therapy or kind of resolve conflict within a family"

Interviewer: "Could you give me an example of a time where you would have learned something that you wouldn't have known prior"

Interviewee: "I would come from mental health background before coming here so I would feel quite comfortable dealing with mental health issues where as some other disciplines might be a little bit nervous about that an area that would have been new to me would be dealing with older people in families and older people requiring nursing home care or where professionals where you kind of have differences of opinion and something where I organised, I am thinking of one scenario where I organised a family meeting where I brought in a GP and nurse and we all sat down together and am the learning process for me was thatam...you know professionals need to say your dad or mum needs nursing home care, the family member can agree or disagree with that but also the person themselves, sometimes that's the difficulty around that what kind of they want and is that a possibility. So it's kind of needs versus risks around older people in the home and things like that and kind of thing. So in my area and as a professional that was a huge learning curve to

step into that kind of area and advocate not just for the family but for the person themselves, where everybody might be saying professionals included the family members included we just can't look after you anymore you need to be in a nursing home and the person themselves are saying that they have lived at home all their life "I want to be able to stay at home" and that's a very complex and difficult area to work in with family but to kind of get that out to be able to even say that. That's what springs to mind the biggest learning curve for me in primary care in terms of not being comfortable with it because I never worked in that area before with older people. It opened up a whole lot of areas that I wasn't aware of"

Interviewer: "Can you give an example of one area in particular?"

Interviewee: "I suppose how it was dealt with, how a doctor might say to a family "your mum or you dad needs to be in a nursing home now" and how the family need to go away and regurgitate that and say it back to the family member in question and say this is what the professionals are saying and that there is a risk that if you don't go into a nursing home and then where I fit into that, I can balance that and say oh well the person themselves don't want to be in an nursing home is there an alternative to that. So what I have learned as a social worker in that area, maybe differences we have as professionals, social workers can do assessments and include risk along with needs assessment and can make recommendations and to live with risk and that we need to put it on the table sometimes."

Interviewer: "Ok great I'll move onto training and what kind of formal training to you receive or even informal training"

Interviewee: "In terms of training, now I probably missed a lot of training as I wasn't here when the team joined first, and I know they went through team building training,

because I came in later only in 2007 and they have been together since 2003/2004 I had no official training only perhaps training imparted by team members here. I mean a lot of the team processes were in place and as I said my predecessor was here with me for a couple of weeks so I got to go around with him, attend the team meetings and really see how things were done through observation I sat back I suppose for a couple of weeks and really observed how things were done and in the way I could do things and contribute going forward, also seeing and knowing the process that was there, so it was a combination of the team being well established and having my predecessor there to show me the ropes. After that I settled in very quickly. Another positive I saw was, what I was saying earlier that I felt a bit isolated at the start but on another level, because we are all here in the same building I could access them at anytime and go and talk to them, yes, so from that point of view settled in very quickly and I could see very quickly the way they worked being so near them.

Interviewer: "I suppose I just want to talk a little about how the team is functioning, from what you said it appears to be working quite well, but in terms of decision making how is that done in terms of the team meetings is decisions made case by case or is there a time in the meeting where you all can stand back and look at how these decisions are being made away from the case load?"

Interviewee: "Like I said before what I personally like about the team meeting and how it's run it's run more informally in terms of that there is no set agenda no minutes driven agenda, people can get bogged down in that kind of approach. It's more efficient as it's more hands on and there is no restriction in what's brought to the table, like what are the emergencies, what they feel needs to be talked about straight

away and it gets done. It's all clearly communicated, but having said that I feel that there is a space there to see how we improve our process of decision making, I suppose we are conscious that the GP's are therelike I said we have to run the meetings at lunch time, normally over 40 minutes if it runs to an hour that's kind of rare, there's space at the beginning of the meeting that people have been made aware of that so that someone can make mini presentations, so at this slot we offer that space to a presentation for anyone to come in to give a presentation

Interviewer: "Is anyone brought from outside the team to come in and do a presentation?"

Interviewee: "Within the wider network we'll say, so for example the case worker for elder abuse, she's a social worker, she might come in, introduce herself, say a little bit about what she does, where's she at and so on. This is great because you can get to see who you will be working with and what that person does so it makes it work more efficiently,....do you know that sort of way. So that's an example within the HSE, but also from outside the HSE also people can come in to present for 10-15 mins such as local groups, like local community worker has come in a couple of times to talk about what does and that sort of thing, so that's pretty good. The GP's also are quiet good as well, although at times I can see they get a bit nervous about going over the time of a presentation or the meeting itself, so again just to say it's very informal ...it's not like setting up a bit power point presentation and sitting there for the next hour or two looking and listening to this. So far it works quiet effectively, then we get down to talking about actual cases or what people want to talk about or what needs to be done or what referrals are being discussed and because it runs fairly efficiently 30-40mins there's a space at the end where the chair we'll say is there any other business or is there any else we need to talk about, you know....so in

that space we might discuss initiatives what initiatives people are working on, like I might say to the team I at the stage where I have set up a couple of groups, I have said where I am with the groups that I set up, or if they want to refer people to it or things like that. I think it's like an unwritten rule now, that we all know each other so well that we know the way things play out and what to discuss, the information is shared through our own way but that it's captured at the meeting in an informal way that makes it relaxed. I'm sure it probably should be more structured in a way but it works the way we do it and for me to be last to join the team I certainly feel it works well."

Interviewer: "It seems to really work,

Interviewee: "Well yes I think it does but I would imagine that at the beginning of this team back in 2003 it probably was very structured in the way the team meetings were carried out but over time, I suppose or I would imagine now if I was to go to a brand new PCT and sat down with that team that would be just off the wall to them, they wouldn't know each other as well, so I guess the structure at the beginning needs to happen. As I said I have been here two years maybe it's evolved from a kind of rigid structure into a team that's performing now"

Interviewer: "Are you aware or do you follow TBPM model process?"

Interviewee: "No I haven't participated in TBPM, so I won't make reference to it, but we do devise our own care plans, but it's in reference to cases, where I document what actions need to be taken by which professional on the team, it's carried out and then it's followed up at the next meeting this particular's case's progress"

Interviewer: "And conflict, does that arise in the team and what's the nature of conflict or disagreements within the group?"

Interviewee: "My perception is and I rather like to call them disagreements, of agreeing to disagree!, am....of course that would happen in team and am, I feel overall people accept that to a certain degree so I suppose , in terms of my training and from where I am coming from a different place, a different starting point than other people and sometimes I can feel like my point of view is different than from most people on the team in terms of a very medicalised model, in my opinion the medical opinion predominates a lot. Ok now that's natural, with GP's and Nurses and they come from a common point of view and background, you know sickness model, I feel it's a positive now that where if something is being discussed that all the team will listen to my point of view, and so I feel comfortable to disagree with people at a table yeah, and I am reluctant to used the word conflict because it's not like you know.....people don't give me like you know....."who's your man???" sort of a thing, so am that's again another positive of the team that they are open to listen to my point of view, which I put out there as an alternative, in terms of for example, can I give you an example?"

Interviewer: "Yes of course please do"

Interviewee: "OK let's say a dietitian at the table discussing a case and.... am.... on the professional level I was disagreeing with a couple of points in what she was saying because I feel that she was coming from a very medical model and maybe from her experience she was coming from a hospital where it was very medically driven and my view of the primary health care I would be coming from completely the opposite end of the spectrum, in terms of the social deterrents of health, so your life

style your behaviour, healthy eating and healthy living and so on. The dietitian was discussing zenacol and bloods and all the medical aspects which is ok that's fine, with GP's she gets referrals and everything, I sometimes so one day for example she might have been saying about ...amirritable bowel syndrome and discussing that as a condition and in very medical terms right at the meeting and everyone else is of the same opinion and they understand medically, so I felt comfortable enough to put my opinion out there, which was completely different which I explained from my point of view irritable bowel can be stress related it can be brought on by anxiety and one of the vicious cycles if you have this syndrome you become a much more conscious about where your bathrooms, toilets are because your bowel movements are completely out of sink or your worried, so that worry begins to grow and grow inside you and to the point where the worry can be a factor to why the problem is reoccurring. So I was trying to explain the anxiety itself can actually make the problem worse, where the dietitian is looking at it as how to control the problem when it's at it's worst and I am looking at it in a way, how can we prevent it from becoming that bad in the future, so am...so mean ok, maybe you can call that conflict of opinion but I was listening to this and the positive of this was I got the referral from the dietitian the following week for the person who wanted me to look at the amount of stress in this particular patient's life. So the positive about that both outlooks need to be brought to the table, granted the patient needed to be treated medically but also the social care need needed to be addressed also. So without that disagreement this wouldn't have come about, so learning from each other."

Interviewer: "So do you think that there is a shift in thinking do you think from this outcome?"

Interviewee: "I think there is, now I am only giving that example, you see the difficulty here is each profession have their base, where there base is, social workers are coming from a social base, social deterrents of health, what's socially what effects your health, poverty obviously is the biggest thing there, family conflict, unemployment, all of these things cause stress in your life, what's causing the stress, I'm looking at it in the sense of early upstream type of thing, so I try and see people at the earliest point, trying to look at the factors in their life so from me personally social care is a preventative wellness model to keep people well. The medical model can't be changed overnight, if you asking me if it's changing, yes I think that it is changing, so I gave you an example of a dietitian she had her professional opinion and I had mine but what really determines it as well where you have been and what your experiences have been. So am who would I align myself with I suppose that would have to be Occupational Therapists, we have similar kind of traits, but having said that you could have a dietitian in health promotion in comparison to a dietitian who works in a hospital, they are two completely different aspects of the professional with a different outlook. So that's where I kind of see the differences and then it's down to the person's perception, so then you see it's down to what your actually used to. If you're a dietitian and you've always worked in a hospital and then you are moved into a primary care setting or network, then you're going to replicate what you knowem.....so change for that to come about there, it's going to be more difficult, so I mean that's the first deterrent. I maybe getting off the point a bit but the word reconfiguration is the buzz word here in the HSE, that's thrown out a lot, so reconfiguring staff so if you move staff from one setting to a primary care setting and don't provide them with training as you were asking me earlier it would really help the PCT to put on a PCT hat, then the danger is that they

are going to replicate a sickness/medical model within a primary care setting. So that it's all about knowledge and training perhaps but it needs to be addressed.

Interviewer: So that the aspiration is that this shift will take place more thoroughly with help from training, knowledge sharing and so?"

Interviewee: "That is the hope, the fact is I mean you can't forget that you have to deal with the practicalities as well, these are that we do have medical intervention and it's needed people do fall and break their hips that they're are requirements of course that medical intervention is needed"

Interviewer: "So the medical model needs the social model in order to be an integrative service and to deliver the complete health care episode to patients to this end maybe could you describe one intervention or accomplishment to date that the team achieved?"

Interviewee: "The thing that really stood out is that a primary healthcare committee was formed where by all the heads of each discipline present on this PCT formed this committee. Because like there is only one of me on the team, but there maybe 4 or 5 nurses on the team so that head of discipline is on this committee and a representative from the GP side of things and so, and what is done then is we all meet to discuss what new initiatives can we do and feed back to the team. One of the things for me when Primary health care being roll out in Ireland that there was no public agenda in terms of educating the population, we are not educating people or communities what it actually is. In other countries where primary health care was rolled out this education was part of their primary health care agenda when they rolled this out. If i take New Zealand for example they rolled out primary health care model the very same time as Ireland did back in 2001. The differences were they

actually wrote down what they wanted to achieve and one of the things was an actual public educational campaign to the population in relation to what they were doing and what this will be. On a national level here that didn't happen for whatever reason. So one of things that the development committee decided upon and which was fed back to the group was to run a health day in the area. So a sub-committee was then formed to organise this”...

Interviewee goes on to describe a health day for the community that was organised on a Saturday, whereby members of the team displayed and promoted the services available to the community along with other services that are outside of the HSE such as the local leisure centre, the organisation GROW, local counselling services were involved

Interviewer: So out of the health day organised what were the results that came from that or looking into the future since the team was set up what changes have you seen and that you will continue to see in the future?”

Interviewee: “Well since that health day last year I have noticed the increase in self referrals as opposed to the referrals I was getting from a GP. So I take that as the public are becoming more aware of the services on offer.

Interview concluded at 11am

Appendix 7: Focus Group Participants of PCT 2 Focus Group

Transcript

Focus Group; 3 Participants Abbeyleix/Durrow - PCT 2

Date: April 28th 2009

Start Time: 10:30 am

Finish Time: 11:30 am

Participant1: Mgt/Admin

Participant 2: Allied Health Professional

Participant 3: Allied Health Professional

Participant 1: What's the difference between working in this environment -

Primary Care and Primary Care Team in comparison to other work places that you have all worked in prior to the formation of Primary Care teams?

Participant 1 (Mgt/Admin): Well very different, because I am a qualified mental health nurse and was based in a hospital setting and not the old community care what's now the primary care, with regard to working in that form of hospital team. I chose to change career as I have a small family, so I completed a computer course the admin job arose on the team and I went for it and got it, I suppose because I had a nursing background and would have had some sort of an idea what they were looking for. I enjoy working here as it's completely different working here,.....yes very different because you get to see what the physio's do and to work with nurses and the GP and things like that so it's good to see how all the different disciplines work together"

Participant 2 (Allied Health professional): "I suppose this is my first time working within primary care and I suppose in a true team setting so em.....where I have worked before for many years it was quiet in isolation in the physio department working through waiting lists, our communication was mainly through a phone call, or written letter so now it's much easier from my point of view when you have a problem case ...you know discuss it at a team meeting ...am and working here is great in this building because all the different disciplines are coming in and out, so if you did have a problem you'd know that the OT will be coming in or a social worker is going to be coming in to have a chat and sometimes you can get an awful lot more information that way than say through a letter, email or phone call so things can happen quicker to solve a particular problem that you may be having with client, things can happen quicker in that way, you also informed about things that are going on in an area as well....you know ...it might be relevant to you, it might not, so it's nice to keep in touch with what other disciplines doing as well,...so you know ...am so yeah I'm finding the team work great and makes my job an awful lot easier"

Interviewer: so in essence you worked in a more hospital setting where this interaction with other disciplines didn't occur?"

Participant 2 (Health Professional): "Yes I actually worked in a district hospital before this in an outpatient department, em.....it wasn't in a acute setting but it was a clinic but basically we were in isolation but the thing about it was that we were separate to the primary care or community care physio's as it was known then and they were in a different building about a hundred yards away from us but we had actually zero contact with them apart from a phone call....you know so we were linked in with a service but both groups were out serving the community but from different aspects of it, not so much working together"

Participant 3 (Health Professional): "Yes similar situation also I was here before the team was sort of set up...am...and from a community point of view from the domiciliary visits that I would do it does make a huge difference ...am...you can prioritise much easier just from meeting the other team members face to face and you just have much more support ...am...you know any question you have any worry that you have about a client that you're seeing is answered much quicker face to face it's much easier rather than trying to track the person down that you want to talk to. It's definitely improved the quality of the service that you can deliver."

Participant 1 (Mgt/Admin): "Yes I would agree in that it's much quicker and its different because you would know it that there's is going to be every second week there's going to be a meeting so straight after the meeting I will get the minutes off the person that chaired the meeting, and you can read immediately after the meeting what's after being discussed and decided upon and it's interesting when you see what input from the different discipline has decided upon whereas before coming from my nursing background in looking a case write ups it was very much the consultant decides this or the physio decides that. After I write up the recommendations as it's so quick that the decisions that have been made through the meeting need to be written up and updates or what has been carried out needs to be documented for the next meeting so in that sense it's much quicker and you can see that from an admin point of view how the service delivery is carried out almost instantaneously. So you know....it's not left or left up in the air, there's clear referrals to each discipline on what needs to be done so as the team can be updated by the time the next meeting comes about two weeks later."

Interviewer to Participant 1 (Mgt/Admin): That's a very different background indeed, what with coming from a nursing background from hospital setting. What kind of challenges do you see or have found?"

Participant 1 (Mgt/Admin): Yes it is different, but the challenge just to get it started and off the ground, primary care seems to be working very well from day one in Abbeyleix and Durrow so there haven't or there hasn't been too many problems even with people attending meetings every two weeks and that I think it's a brilliant way to target and service the community in a different way, as before in my previous job as a nurse it was very much GP focused and everyone worked individually within their own remit of nursing, physio, OT, GP and so on, whether as here and as a Primary Car Team there's a lot of communication between the different people on the team as a multidisciplinary team, I think its brilliant

Interviewer: "So you organise the team meetings?"

Participant 1 (Mgt/Admin): " Yes I just remind the team am....the meeting is coming up as I know everybody at the moment is very busy, with schedules and that...and just organising and if minutes have to be given out I will give out the minutes and I organise separate case conference meetings that might come up, which can come up quite a lot"

Interviewer: "Is there difficulty in organising the meetings with busy schedules?"

Participant 1 (Mgt/Admin): No...the primary care seems to be fine from here, but areas where a case conference that would lead from discussion in primary care meeting, because then you are dealing with different areas from the different primary

care teams maybe from Offaly team and you're dealing with maybe consultant psychiatrists that are very busy, getting the time from them to meet like confirming a dates to meet, but overall it does work out.

Participant 2 (Health Professional): "Our main thing now in the climate current is I suppose is resources...ah...you know...even space and working with other team members their resources are limited as well especially again in the current climate. Maybe in areas where the other disciplines haven't the same time to give us for example, in the areas of health promotion initiatives which in the first year when we joined the team and started we were all pretty good in this sense and we are still trying to continue on with that but sometimes it's difficult for other disciplines to play a part in that because their resources are elsewhere now so that's a challenge"

Participant 3 (Health Professional) : "And I suppose time is of the essence it's a huge challenge as we are very busy here, waiting lists are increasing and we can't put enough time in the areas that we would like to so again time is the big team"

Interviewer: "So time is certainly of the essence"

Participant 1, 2, 3,: Laughter

Participant 3 (Health Professional): "There aren't enough hours in the day",...Laughter. "It is creating a problem I suppose the time aspect, we are just finding that it's getting much busier, are waiting lists have grown even though there's slightly more staff here than we were used to...am...then with the primary care idea we would like to do more health promotion activities and it all takes time and that"

Interviewer: " Ok so in essence the primary care reform is all about proactive rather than reactive?"

Participants 1 & 2 (Mgt Admin & Health Professional): "Exactly"

Participant 3 (Health Professional): "For sure, certainly and just talking about this we ran a few physio classes here and we just found that we were really caught for space. The groups that we could handle even at that was difficult"

Interviewer: "Actually just getting back to the team meetings, are these effective, what is discussed and decided upon in terms of is the primary focus the cases that are to be discussed, or is there an opportunity to address other areas such as health promotion or population health?"

Participant 2 (Health Professional): "I suppose at an earlier stage it was looking at how we were working and health promotion and that sort of thing, Carol facilitates the meetings and she's steering us in the right direction. We completed questionnaires in the earlier stages of the team by Carol on how the team was functioning, but in general what is brought up is client cases that might concern more than two disciplines so that's how it's run really so the clients that you want discussed get discussed or if we have any concerns"

Participant 3 (Health Professional): "And as well when things are quiet when we don't have patients to discuss...you know...and there's times when we have the time discuss and chat about what's going on what's new"

Participant 1 (Mgt /Admin): "Yes the GP talks as well at meetings"

Participant 3 (Health Professional): "Yes, the GP's give talks on something new in a new research that they may have done and feed it back to the group....and ...you know...things like that that are going on, that would happen as well. So it's great that way to know what is going on in the area"

Participant 2 (Health Professional): "And we have fed back on things on some of the initiatives that we have done such as bone health classes that we done at the team meeting so we have, so it gives us the forum at the meeting to say what we have done, what we are currently doing and what we plan to do in the future"

Interviewer: "Are you aware of the TBPM model, or have you participated in the programme"

Participants 1 (Mgt/Admin): "No I haven't participated in this"

Participant 2 (Health Professional): "I have heard about it but I haven't participated in this"

Participant 3 (Health Professional): "No I haven't participated in this either, but I am aware of this"

Interviewer: "Ok, What type of training would you have received to date since your membership of PCT, in terms of team building skills, effective meetings training"

Participant 2 (Health Professional): "Purely practical training as opposed to formal training"

Participant 1 (Mgt/Admin): "On-the-job training"

Participant 3 (Health Professional): "On the Job and practical training"

Interviewer: "All hands on deck so to speak"

Participants 1, 2, & 3: Laughter

Participant 2 (Health Professional): Yes it's very much practical but we did attend effective team meetings training that was some time ago"

Interviewer: "Does the team get much outside influence or information into the group, do you interact with other teams outside of this particular area?"

Participant 2 (Health Professional): "Yes I would have gone to teams in other areas to see how they were working, just to see if they had some initiatives that we might be able to roll out and vice versa, we'd link in with them, the same with even regions outside of the DML area as well such as Kilkenny, where you would make contact to see what's being done and take some ideas out of this or likewise a problem or issue that may have arose in this area that we would have dealt with effectively other teams might contact us to see how it was carried out and that sort of thing. It's a case of us learning off each other"

Participant 3 (Health Professional): "Yes that's really it, just enquiring to other areas on certain initiatives that we here are thinking of doing and basically researching it in terms of what other areas have done, if they had completed such activities and the success rate of it"

Interviewer: "If a new team member is to join the team what can you contribute or what do you think could be done in order to settle in that new team member?"

Participant 1 (Mgt/Admin): "We have a folder that has been documented what the primary care team is, so if anyone came it either from an admin area or a health and social care area, a day was given going through the documentation to show what the primary care team is all about, introducing to the rest of the primary care team

anyway, Carol McCann is usually always there anyway to informally train in the new member”

Participant 2 (Health Professional): “We’ve been here from day one when the team since the team has been set up”

Participant 3 (Health Professional): “Likewise I have been here since this team started, actually I was here before in this area before the team was formed as this was my base but as part of the district hospital setting and not classified as a primary care team member as it hadn’t come about”

Interviewer: “Ok great so how in your opinion can you induct a new team member into the team, to show them the ropes if you like, in terms of how much quicker things are done now due to the different way in which things are being done?”

Participant 2 (Health Professional): “I suppose it depends, like from a physiotherapist point of view, you know, you would probably go through an informal induction procedure you know going through the policies and procedures and all the rest, but like if it’s another discipline I suppose to introduce ourselves and having close links with Carol McCann who is the team co-ordinator who is very good at inducting people in making sure that they are familiar with the policies and procedures within the primary care setting, contacts and internet information relating to information that would be of use to the new team member, such as new initiatives and the like or the development of such within primary care”

Interviewer: “So do you make many visits out to clients on a day-to-day basis, how practical is it for you to show them the ropes if you like”

Participant 3 (Health Professional): " I suppose I would do a lot of call outs to clients, we were all here from day one when the team was brought together but I suppose I would have done that with (Participant 2) as I as I said I was actually based here as it turned out so I just introduced her to the area, locations and so on, and shadowing me really"

Interviewer: "Ok great, just to finish up, are you all enjoying working within the Primary Care Team?"

Participant 1 (Mgt/Admin): "Yes It's great to see all the different disciplines working together as before as I mentioned I came from mental health nursing background and it was very much everyone had their job to do, but now it's seeing these different disciplines working before who may have not done so closely before"

Participant 2 (Health Professional): "Yes, it's good for the community and being a part of this, also to work with other disciplines and not in isolation. Having said this there is an awful of change and sometimes the things that you would like to be doing can't be addressed straight away, but the structure is now there with PCT's to achieve this"

Participant 3 (Health Professional): "I would agree with this also, It's great to be able to really make a difference in the community but it's the level in which it is achieved can be frustrating however I will agree that the structure and foundation is now there to do this"

Appendix 8 – Targeted Participants

Breakdown illustration

Appendix 8: Target Participants Breakdown Illustration

Interviewee /Participant	Role	Job Category	Pillar	Team	Team Location	Length of time in Situ
Interviewee 1	Team Leader/Coordinator	Management/Admin	PCCC ¹	PCT ² PCT1 PCT2 PCT3 PCT4	PCT 1 – Portarlinton PCT 2 – Abbeyleix/Durrow PCT 3 – Birr PCT 4 - Banagher	PCT 1 – 5years PCT 2 – 2years PCT 3 – 2years PCT 4 – 2years
Interviewee 2	Team Trainer TBPM/Team Development	Management/Admin	Corporate	All teams within Dublin Mid-Leinster	N/A	N/A
Interviewee 3	Social Worker	Allied Health and Social Care	PCCC	PCT1 & PCT2	PCT 1 – Portarlinton PCT 2 – Abbeyleix/D	PCT 1 – 1.5 years PCT 2 – 2 years

¹ Primary Continuing Community Care

² Primary Care Team

Interviewee /Participant	Role	Job Category	Pillar	Team	Team Location	Length of time in Situ
Interviewee 4	Social Worker	Allied Health and Social Care	PCCC	PCT1	Portarlinton	2 years
FG ³ Participant 1	Administrator	Management/ Administratio n	PCCC	PCT 2	Abbeyleix/Durrow	2 years
FG Participant 2	Physiotherapist	Allied Health can Social Care	PCCC	PCT 2	Abbeyleix/Durrow	2 years
FG	Physiotherapist	Allied Health	PCCC	PCT 2	Abbeyleix/Durrow	2 years

³ FG: Focus Group

Participant 2		can Social Care				
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Appendix 9: PCCC Transformation

Implementation Structure

PCCC TRANSFORMATION IMPLEMENTATION STRUCTURE

