Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

Dimensions of Team Effectiveness in Rural Health Services

Jean Ross
Centre for Rural Health
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PUBLISHER

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ABOUT THE CENTRE

The Centre for Rural Health was established late 1994. It was funded (initially by the Southern Regional Health Authority, then the Health Funding Authority and finally by the Ministry of Health) for a series of projects to support rural health services and community involvement. The Centre was under the directorship of Martin London and Jean Ross from, respectively, rural general practitioner and rural nurse backgrounds. It was also known as the National Centre for Rural Health. The Centre closed in late 2002, with final publications being completed in 2003. The resources and reports created under the auspices of the Centre were uploaded mid 2003 to be available indefinitely.

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Introduction

This research project about the dimensions of team effectiveness in rural health services in New Zealand has been divided into two main parts. The first part comprises a national overview based on health care teamwork in the rural setting and the particular influence rurality might have on the nature and effectiveness of teamwork. The second part comprises a more in-depth qualitative investigation about approaches to team building used by rural practitioners to build effective health care teams.

The two parts are linked together in this report and the recommendations made clear in the executive summary which complements the report.

The information contained in this document offers the aims, a detailed account of the process which was undertaken to obtain the data, the analysis, the discussion and the recommendations.

The Health Funding Authority (now the Ministry of Health) contracted the National Centre for Rural Health to undertake this project which links into a three year programme (1999-2002). The National Centre for Rural Health is situated within the Department of Public Health & General Practice, Christchurch School of Medicine, University of Otago, Christchurch, New Zealand.

Research Author

Jean Ross has been the lead member of the research team. Jean is Co-Director of the National Centre for Rural Health which was set up in 1994 (together with a GP colleague). Her role has been in the leadership and development of the role of rural nurses, both professionally and personally, on a national and political level and has a background in rural practice both in the UK and in New Zealand. She is the founder and coordinator of the Rural Nurse National Network and has a Master's thesis relating to teamwork and role identification of the core primary health care team.

Jean offers insights from her professional and personal opinions about teamwork. She believes rural teams comprise a diversity of personnel and need to be adaptable and to work in partnership to offer an effective health care service. This partnership should offer the community an increased set of skills and support, which is greater than that which can be provided by a person or single professional disciplines (Ross 1995). She believes the necessary tool to achieve this is for health practitioners to work within the boundaries of a team.

Given her professional identity as a registered nurse and situating herself as a researcher within this study has been a challenge. It has been essential to provide her views on teamwork as offered above. The reason for this has been to assist the reader to build up his or her own views and assumptions of her world view which may have been brought into this research. As a researcher she has respected the views and opinions of each of the participants. The participants have come from a number of disciplines and for the purpose of this project only rural health professionals were invited to contribute. This research arose from a series of linked studies previously undertaken. Jean has intended to extend her insight into these studies and explain and share how her commitment to this topic has progressed.

In 1995 Jean was invited by the then Core Services Committee (later to become the National Health Committee) of the Ministry of Health, New Zealand, to write and present a paper at a forum on the Delivery of Health Services to Smaller Communities (London & Ross 1995). The aim of this forum was to ensure a stable, content and energised rural health workforce. The paper Jean presented was titled "Professional Responsibilities Relating to Teamwork in Rural Practice". This invitation stemmed from her position as Co-Director of the Centre for Rural Health (London & Ross 1995).

Acknowledgements

The author wishes to acknowledge the time, energy and commitment of all participants who contributed to this project. Without their support this project would not have been completed. For ethical reasons the names of the participants and the organisations / communities they are associated with cannot be identified.

The participants are the primary writers of the report through comments given as responses both to the questionnaire survey and the focus group discussions. Some material has been given to this project on the proviso that it be used without identifying the writer. The data has been amalgamated as a whole and analysed by the author who has put forward her own opinion (this has been highlighted in the introduction).

Without the funding from the Health Funding Authority (now Ministry of Health) this research project would not have been undertaken. The Health Funding Authority is to be applauded for their support of and financial commitment to this project so practitioners, educators and the Ministry can have a deeper understanding of rural teamwork and educational requirements. Practitioners can therefore better meet the health needs of rural communities as a functional team.

Thanks also goes to all the participating organisations who distributed the questionnaire and for the opportunity to hold a focus group discussion at the WONCA (World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) Asia Pacific Conference in Christchurch in June 2000.

The author also wishes to personally acknowledge and thank:

Lyn Thompson, National Centre for Rural Health Secretary, for her dedication and effortless transcribing of the focus group discussions. In addition, for presentation and assistance in distributing the questionnaires and production of the work associated with these reports.

Ron Janes, New Zealand rural GP, for his views and guidance of the development of the questionnaire.

Alistair Penrose, Health Research Consultant, for his guidance in the adaptation of the questionnaire survey data entry, analysis of data and written commentary associated with the questionnaire.

Simon Bidwell, National Centre for Rural Health Research Assistant, for his tireless efforts in undertaking the international literature search on rural teams and teamwork and his written literature review of the sparse literature available.

The NZ Health Technology Assessment, especially Susan Bidwell (Information Specialist) for their diligent international review of all of the literature associated with rural teamwork and educational programmes.

Professor Les Toop, Head of Department of Primary Health & General Practice, Christchurch School of Medicine, for his oversight, guidance and support in the undertaking of this project.

Professor Michael West, Professor of Work & Organisational Psychology, Institute of Work Psychology, University of Sheffield, UK, for permission to adapt and use the "LOT Teamworking Questionnaire" (West 1996).

Pauline Barnett, Senior Lecturer, Department of Primary Health & General Practice, Christchurch School of Medicine, for her overview and critical appraisal of the final document.

Review of the Literature on Teams

> *"Teams which are more participative and collaborative are more likely to achieve a patient-centred service, to work together as a team and be more efficient."*
>
> (Poulton & West 1999, p.17)

The above quote provides a sense of wisdom, vision and direction implying that for the delivery of effective primary health care, health care practitioners need to work together and alongside the local community personnel. A number of recent New Zealand government reports: the Health Funding Authority's "The Next Five Years in General Practice" (1998); the Ministry of Health's Report of the "Ministerial Taskforce on Nursing - Redressing the Potential of Nursing" (1998), the Ministry of Health's :New Zealand Health Strategy" (2000) and, more recently, the "Primary Health Care Strategy" (2001), highlight the value of health professionals working together as a team. These documents emphasis that a team can provide effective and comprehensive health care. Despite this we need to be aware there is little evidence in the literature supporting the notion that teams in primary health care actually do adopt a collaborative model (Opie 1997).

Why Teams are Important

Although teams are being promoted as beneficial to the provision of health care, there is a limited amount of available research literature on the positive effects of teamwork. To assist a deeper understanding of teams it has been necessary to take an extended look at the international literature. The literature available about teamwork is generally from the primary health care setting based on urban experiences from Britain. International literature associated with rural teamwork is very limited, although to our knowledge there have been no systematic studies undertaken and published. However, there is some consensus in the literature, in particular the anecdotal literature which feature that there are particular characteristics associated with rural teams and teamwork. These will be highlighted within this review.

There is a general belief that a team of people can attend to the overall needs of a patient more effectively than individual health professionals. There are a number of aspects of health teams that give them an advantage over individual professionals working separately. A team has the potential to share the responsibility (Katzenbach & Smith 1993). These shared responsibilities offer some protection in a climate of increasing legal and ethical scrutiny and support for each member. Teams which function effectively and efficiently have the ability to improve health services and reduce fragmentation of care (Williams & Laungani 1999) especially when they work within a defined population (Toop 1998a). Many important aspects of health care such as the management of chronic health problems, maternity, and elderly care, to name but a few, require effective teamwork and shared responsibility for care (Pritchard & Pritchard 1994; Elwyn-Jones, Rapport & Kinnersley 1998).

There are a number of research projects which demonstrate that innovation in teamwork can be linked with effective team collaboration (West and Wallace 1991). Research undertaken on the requirements for team success could find no significant relationship between team structure and the four identified measures of team effectiveness: teamwork; organisational efficiency; health care practice and patient centred care (Poulton and West 1999). This research emphasised that team process which includes shared objectives such as participation, emphasis on quality and support for innovation, were the best elements for successful teamwork.

Teamwork encourages mutual respect and individual autonomy among professionals and support for each other. Through teamwork, professionals can develop a greater awareness and understanding of the contribution of other team members and their personal attributes. Evidence suggests that these elements of teamwork, together with agreed goals, lead to increased team effectiveness (Guzzo & Shea, cited in West & Poulton 1997) and team performance (Katzenbach and Smith 1993).

However, throughout the development of primary health care there has been continuing concern that there is a significant gap between the rhetoric and reality of teamwork (Poulton & West 1999). A number of examples of barriers to collaborative teamwork have been identified, including the time it takes to attend team meetings which conflicts with the valuable time that could be spent with patients: Ducanis & Golin (1979); Isles & Auluck (1990); Ovretveit (1990); Waine (1992); Katzenbach & Smith (1993); Poulton & West (1993); West & Slater (1996); Toop, Nuttall & Hodges (1996); Toop & Hodges (1996); Opie 1997 & Elwyn-Jones, Rapport & Kinnersley (1998). Poor relationships between health professionals, especially those caring for the same patient, can result in duplication and fragmentation in the provision of health care. This can lead to confusion for both the patient and health practitioners. There have been a number of professional barriers also identified. These include a variety of professional attitudes leading to conflict, professional rivalry, lack of professional respect and autonomy. It follows that for a team to work effectively and efficiently in primary health care, it is necessary to identify and address these barriers.

In addition, New Zealand health reforms over the past decade have changed the culture for the provision of health care from one of collaboration to competition (Blank, 1994; Hornblow 1997). Organisations and/or individual health professionals were at times put in a position of competition with each other to tender for the same health service contract. This approach is clearly not conducive to collaboration or teamwork. Additionally, providers of primary health care were no longer guaranteed traditional funding under the health reforms. Changing the system of funding to a competitive model (Hornblow 1997), allowed the then Health Funding Authority (HFA) to contract with a number of different providers. This, in turn, increased the potential for duplication and fragmentation of health services (Toop 1998).

The health reforms have, in effect, resulted in health professionals and health care groups being accountable to a number of different organisations with a variety of funding structures, each with their own goals and vision which is not conducive for effective teamwork. Although this competitive funding system has been revised in 2001 to incorporate a collaborative single funded approach, it will take time for health care personnel to work as a team in this new collaborative environment. Team member relationships built up over the past ten years have become strained and, to a certain degree, dysfunctional. Personal relationships built on trust and respect need to be re-established. As teams are currently promoted as a means of providing effective and efficient delivery of primary health care, it is timely to give this topic some attention.

The team approach is not a recent innovation. Teams have existed for a long time perhaps for hundreds of years in many countries (Katzenbach and Smith 1993). Over the years teams have been developed and been applied to a number of areas in the health sector. These include child abuse (Martin, cited in Duncanis & Golin 1979); chronic illness (Halsted, cited in Duncanis & Golin 1979); community mental health (Lastof cited in Duncanis & Golin 1979) and rehabilitation (Wilson, cited in Duncanis & Golin 1979). It is not possible to state precisely when the concept of a team in the primary health care setting became a reality

(Hasler 1992). However, the term "primary health care teams" emerged in the 1970s in Britain (Elwyn- Jones, Rapport & Kinnersley 1998). This emergence can be associated with the development of the practice nurses working alongside a general practitioner. Influenced by the British style, New Zealand also emerged with a similar delivery of general practice. The aim was that a team of different health professionals could provide many benefits for the provision of health care (Jefferys & Sachs 1983).

In the rural environment rural health care is provided in a variety of contexts including the home, school and farm as well as in the health centre or local hospital/ rest home. Rural primary health care is usually provided to geographically defined eligible populations which are easily identified by the providers. The delivery of health care takes on a relationship and knowledge of individual and family/whanau health issues relating to local geographical and rural issues.

Experienced rural practitioners will utilise every opportunity to provide health advice and care for the community people they serve. There are natural links between the delivery of rural health care, the providers and the community personnel because health care providers almost always live and work in the same community. This sharing allows health professionals to understand and respond to the health needs of the community. It is considered that in rural areas there is both a greater need and greater potential for teamwork. Collaboration necessarily extends beyond rural health professionals to include the rural community as a whole, uncovering an understanding, not only of other disciplines, but also the society and culture of rural areas.

The creation of a team of health professionals brings together different professions and, in the case of the rural environment, rural community personnel who can, in theory, provide a more complete health service. Teams are not a simple construct; they are often complicated, dynamic and may be potentially threatening to individual team members. Therefore, teams need to be understood and handled with care, respect and pride. It is the actual diversity of the various disciplines needed to provide effective and appropriate primary health care rather than their similarities which can cause unease between the team members. Equally, this diversity is necessary for teams to be functional. Teams have a lot of potential and perhaps the essential elements which make teams a success have not been fully explored.

> *"There is much more to the wisdom of teams than we ever expected."*
> (Katzenbach & Smith 1993 p.12)

The literature to date puts forward a number of definitions of teams, their structure and characteristics. It is the aim of this research to provide a more detailed concept of rural teamwork taking into consideration certain characteristics associated with rural teams. This will be highlighted in the discussion and recommendation section of this research.

Traditional Definitions of Teams

The Concise Oxford Dictionary Plus defines "team" as:

> *"Two or more beasts of burden harnessed together", or, "A set of persons working together."* (p.1337)

However, Pritchard and Pritchard (1994) suggests that a team is:

> *"A group of people who make different contributions towards the achievement of a common goal."* (p.13)

To summarise, it could be suggested that health teams are groups of health professionals from a variety of disciplines who understand and accept each other's complementary contributions to achieve common performance goals with shared responsibilities.

The Structure & Characteristics of a Team

Nine characteristics have been identified to make up a team (Ducanis & Golin 1979) and summarised into the following:
A team is comprised of at least two individuals;
Individuals may either meet face to face or not meet at all (but communicate by alternative mediums);

- A team leader is always identifiable;
- Teams function both within and between organisations;
- Team members' roles are defined;
- Collaboration is essential in teams;
- Team guidelines are operationalised;
- The team is patient centred
- The team is task orientated.

Additionally four main factors have been identified (West 1994) and named the four-factor theory. They are interrelated and make up the characteristics of an effective team. These are: team vision; participatory safety; support for innovation and task orientation which, when worked simultaneously, can lead to improved performance.

However, to date the model of a variety of disciplines working together in the form of a primary health care team has been slow to develop (Opie 1997). In addition, rural health care teams, for example, have not been developed and planned systematically. They have developed with an ad hoc approach which may have contributed to the lack of effective teams and teamwork.

Principles for Effective Teams - The Essential Ingredients

There is a basic recipe which includes a number of essential elements for effective teamwork (Katzenbach and Smith 1993). If followed, these may improve the performance as described in the following quote:

> *"Groups become teams through disciplined action. They shape a common purpose, agree on performance goals, define a common working approach, develop high levels of complementary skills, and hold themselves mutually accountable for results. And, as with any effective discipline, they never stop doing any of these things."* (p.24)

The essential ingredients, as agreed by a number of researchers mentioned previously, includes: team performance; team goals and tasks; collaboration and communication; understanding individual roles and function. These four ingredients will now be discussed in turn.

Team Performance

It has been suggested performance is the primary objective of teams and that no team arises without performance goals. Performance goals are an integral part of team development. To focus on performance requires the setting of clear team goals with built-in performance outcomes. Each team member must be clear about their own and each other's contributions. The tasks performed need to be interesting, engaging and challenging. Interesting tasks engender commitment, motivation and cooperation by team members (Guzzo & Shea 1992, cited in West & Poulton 1997). If a team takes on a task then the whole team must take the responsibility if things go wrong and likewise, take joint credit for successes. Measurement of a team's performance can be done in a number of ways. First, this can be achieved through peer review of the team's work. More recently, measurement of performance is being achieved through clinical audit, outcome measures and the development of standards and guidelines. Team performance influences team effectiveness which requires utilisation of the appropriate skills of all members of the team (Guzzo & Shea, cited in West & Poulton 1997).

Team Goals

Team goals give direction to the team's actions. Goals can be divided into two types; end goals and process goals (Katzenbach and Smith 1993). End goals are defined in terms of an external target whereas process goals are to be found within the process of teamwork. The team members can relate to the way they work and to their progress. It is worth setting both types of goals. As health professionals set and meet their process goals then it is probable they will also, if they are not too unlucky, reach their end goals. If, however, the focus is only on the end goal, and not on the small process steps and the end goal is never reached, failure and disappointment can be more devastating for team members (Katzenbach & Smith 1993). Teams who have clear goals and know how they are going to achieve those goals, define roles and have a plan to develop team focus and direction (West & Wallace 1991). The failure of a team to set clear goals often contributes to their lack of performance (Katzenbach & Smith 1993).

It is vital for effective team function that all team members understand and accept team purposes and goals (Clark (1984). Membership, participation and decision making regarding the function of a team will result in commitment to the identified goals. The criteria for effective goals should be positively framed, achievable, measurable and accepted by all team members. Shared aims of a team, no matter how important they are, will not occur without strategic planning, negotiation between team members and hard work. Goals should not be put into action before there is joint team member agreement (Katzenbach and Smith 1993). This aspect of teamwork is often missing because team members realise there could be disagreement and would rather not get into conflict situations with other colleagues. This may be one of the reasons they omit to discuss and negotiate goals. It is, however, better to discuss team goals prior to undertaking the tasks to avoid irretrievable conflict. This can be achieved by effective collaboration and communication (as described below), another essential ingredient for effective team and teamwork.

Collaboration & Communication of Team Members

Open communication cannot take place when there is pressure to conform to the majority decision. Differences of opinion are healthy and to be expected, while developing group strategies for conflict resolution. Conflict within a team is inevitable and a normal part of any team's process (Ross 1989). It is therefore necessary to acknowledge conflict and develop appropriate agreed ways of resolving it prior to the situation arising. If this is accepted it will encourage open effective communication which will assist in the team performance and in the necessary negotiation of roles and tasks.

Understanding roles within teams has been repeatedly identified in the literature as a prerequisite for effective teamwork (Isles & Auluck 1990; Poulton & West 1993; Toop, Nuttall & Hodges 1996; Toop & Hodges 1996). It has been suggested that if roles are not understood by team members this can be a barrier to effective teamwork.

Team Members' Roles & Functions

Gaining insights into role expectations is an important step towards achieving "role clarity", an essential ingredient for effective teamwork (Ducanis and Golin 1979; Meleis 1975). Role clarity includes understanding the goals of the role, developing the behaviour and attitude necessary for goal achievement and identifying role boundaries. For this to be successful there should be a high level of awareness among the team members who need to be sufficiently focused on their own and each others' roles and responsibilities (Williams & Laungani 1999).

In order for roles and functions to be effective, team members are required to recognise their own contribution and work as a collaborative team. If the members of the team do not do this the performance of the team may be reduced which ultimately may effect the delivery of primary health care services. Hence the importance of understanding ones own and each other's role and contribution for the setting of team goals. It is the belief of the author that the acceptance and understanding of roles is not as simple as suggested in the literature. It should be noted that the description of the social role has a major impact on individual and collective functioning, behaviour, beliefs and attitudes for teams and teamwork. However, there is not the scope and opportunity to discuss "role" and its implications to teamwork within this study. If the reader wishes to develop further insight in this topic refer to Ross (2001).

Research Design

Purpose of the Project

The purpose of this research project has been to describe the dimensions of team effectiveness as it applies to rural health service teams. Additionally the research has aimed to identify ways in which teamwork can be improved for the delivery of rural health services. A further aim (still being worked on for completion in June 2002) is to develop a structured educational programme which may be used by rural health care teams to foster collaborative teamwork.

Some key questions include:

- What is the nature of health care teamwork in rural areas and how do rural teams differ from teams as traditionally described?
- Who are the members of rural health care teams amongst whom teamwork should be promoted?
- What facilitates successful health care teamwork in rural areas?
- What are some of the barriers to successful health care teamwork in rural areas?
- What educational or other interventions can help improve health care teamwork in rural areas?

In many respects, these are the same questions which motivate inquiries about health care teamwork in general. However, as rural health and health care are increasingly seen as unique, it is worth investigating health care teamwork within this specific context.

The project to date has consisted of:

- an in-depth literature search on the effectiveness of teamwork relating to the rural environment;
- an international focus group discussion on the characteristics and essential elements relating specifically to rural teamwork;
- a national questionnaire inviting rural practitioners from New Zealand to make suggestions as to what is the nature of teams; who are the members; what facilitates teams; what are the barriers and what educational needs practitioners have for rural teams and teamwork.

In-Depth Literature Search

An in-depth search of the national and international literature has been sourced. The search located databases of published literature and the Internet for material which made any mention of “interdisciplinary”, “multidisciplinary”, “interprofessional”, “collaboration”, “cooperation”, or “team” along with rural. For further information on the literature search and review of the literature, please refer to Bidwell & Ross (2001) or to Appendix 1.

Recruitment of Participants

Prior to recruitment of participants a discussion took place between the researcher and the administrator of the Canterbury Ethics Committee whether this research required ethical approval. A brief proposal outlining the aims, data retrieval methods and analysis of the research was sent to the chairperson of the committee. Ethical approval was not required for either the focus group discussion or distribution of the questionnaire.

Focus Group Participants

Focus group participants were sought from rural attendees at the WONCA 2000 Asia Pacific Conference held in Christchurch. Letters of invitation (Appendix 2) were distributed to these rural attendees who were identified from the list of conference delegates. The names of the rural attendees were obtained from the conference delegate attendee list. The letter introduced the researcher, gave a brief description of the purpose of the research aim, research process and the involvement required of the potential rural practitioner participants in the focus group discussion. This information was included in each of the rural attendees' conference satchels including the date, time and venue (Appendix 3). Interested respondents were invited to post the reply slip at the reception desk at the WONCA conference, indicating their interest in participating. Additionally if any potential participant wished to speak to the researcher they were invited to leave their names and a message at the reception desk for the researcher to follow up. A one page information sheet relating to the research was printed in the WONCA daily newspaper and all delegates were informed about the focus group discussion through the plenary conference housekeeping session. Information of the focus group session was printed in both the WONCA conference abstract and programme section of the delegates' conference information manual.

The participants met at the allotted time on the scheduled day with the understanding that the focus group could comprise a number of international rural practitioners from a number of different disciplines. The participants were also aware they were required to volunteer their time which was anticipated to be one and a half hours. This time would allow for a preliminary meeting which provided a fuller explanation of the purpose of the study and consideration was given to the written details of the research. The participants were invited to read the focus group core ground rules (Appendix 4) and add additional rules if they required. They were also asked to sign individual consent forms to participate (Appendix 5). The remaining time was allotted to the focused discussion.

Demographic Details of Participants

Demographic details of the participants were obtained from each of the participants by inviting them to complete a brief questionnaire (Appendix 6). In total, seventeen participants attended the focus group meeting of which eight were females and nine were male. Out of nine general practitioners, one held an educational position and two out of the six rural nurses were managers. There was one educator, a Professor of Rural Health Care and one participant was a psychotherapist and councillor. Thirteen of the participants were New Zealand residents and the remaining four were from Australia and South Africa.

Focus Group Meetings - Setting the Scene

The Focus Group Format

The venue for the focus group meetings was a convenient place for the participants, who were attending the WONCA conference 2000 in Christchurch. The seating arrangement was comprised of chairs placed in a circle to encourage all participants to see and talk to one another with ease. Refreshments were provided throughout the meeting. Individual name badges were provided for the participants to wear. The intention of using name badges was to assist the participants to get to know each other by addressing each other using first names. The participants sat randomly in the room. The participants were aware that the discussion would be tape recorded and subsequently transcribed. The participants were encouraged to announce their name prior to speaking, for transcription purposes.

At the commencement of the focus group meeting the participants were invited to introduce themselves, explain where they worked and how long they had been working in rural practice. They were also reminded of the confidentiality of the discussions and that all the taped and paper material that was generated from the focus group meeting would be securely stored. This material (raw data) would only be available to the researcher and transcriber. The quotes used from the focus group meeting would appear in the themed transcripts after being coded. All evidence which could link particular participants to a quote, or annotations from the themed transcripts, would be removed and coded using random letters of the alphabet.

The coding of the participants' quotes and the protection of the full transcripts was undertaken to protect the participants, not only to respect their contribution but also to allow them the freedom to speak. Each participant had been informed, both verbally and in writing, about the purpose of the study, the procedure, their rights in participating in the research and of the importance of adhering to the agreed core written ground rules. No additional ground rules were suggested by any of the participants at the focus group meeting.

At the completion of the focus group meeting the participants were thanked for attending and contributing to the discussion. They were invited to complete demographic details and a consent form and informed that they would receive a completed copy of the final research report when it was available.

Focus Group Data

Topics for Discussion at Focus Group Meetings

A series of open-ended questions relating to the objectives of the research included:

- What is your understanding of rural teamwork?
- What are the essential elements of rural teamwork?
- What are the necessary educational requirements to build effective rural teams?

The participants generated further questions which were then discussed by the group. General themes occurred throughout which provided insight into the motives for participants' beliefs and opinions on the topic. The discussion was audiotaped and subsequently transcribed. A number of themes were drawn from the transcripts.

Analysis of Focus Group Data

A "cut and paste" technique involved reading through the transcripts then cutting and pasting the relevant quotes (Krueger 1994). This assisted in generating the themes and helped make sense of the discussion. The themes become an important link to the discussions by using the most useful quotes to highlight why the themes were chosen. It was then possible to highlight descriptions of rural teams including the characteristics, membership, functions, purpose and constraining and driving factors associated with rural teams.

Utilisation of the Data

The data generated from the focus group discussion gave insight into the characteristics of rural teams and the essential elements necessary for effective rural teamwork. This data was subsequently used to adapt, with permission, a valid teamwork/education questionnaire (LOT Teamworking Questionnaire by West ,1996) which had previously been used by the LOT team in Britain. The aim was to make it as relevant as possible for the rural New Zealand scene.

Rural Teamwork Questionnaire

The source was a questionnaire constructed originally by Professor Michael West from the Local Organising Teams (LOT) of the Health Education Authority's Multidisciplinary Team Workshop Programme to support teambuilding within primary health care in Britain. The original questionnaire was designed to gather information about teamworking and teambuilding (Appendix 7) .

The adapted questionnaire (Appendix 8) aimed to survey the views and opinions on multidisciplinary teamworking in rural primary health care in New Zealand. The intention was that the amalgamated data would inform the National Centre for Rural Health's projects about the extent and success of rural teamwork and teambuilding. The questionnaire was divided into four sections. The first section related to the demographic details of the participants. The second section asked for a description(s) of a rural team(s). The third section sought participants' views on teamworking in their own area. The fourth section invited participants to highlight the content and teambuilding education sessions they had attended or used with their own teams.

The questionnaire was distributed to all rural health practitioners throughout New Zealand on the National Centre for Rural Health's database. From a total of 1,250 questionnaires, 450 were sent to general practitioners and the remainder to rural nurses who worked in rural hospitals, the community and isolated rural areas. All health practitioners were invited to participate, firstly to inform them about the aims of the research and, secondly, offer rural practitioners the opportunity to participate in the research. Additionally, the researcher was aware that there could be a number of unopened questionnaires returned due to practitioners having either moved away or retired. For this reason a representative sample was not used.

There were 126 responses. 10 questionnaires were returned with the practitioner indicating they preferred not to complete it as it would take too much time and therefore would require payment to complete it. 40 questionnaires were returned because either the practitioner had moved away or the person no longer held a position at the premises. 12 questionnaires were returned following the cut off date and were not analysed. The 126 completed responses comprised 74 general practitioners who had been in their profession an average of 21 years; 46 rural nurses who had been in their profession an average of 24 years and six others. 64% of all respondents worked in a rural situation; 22% semi rural; 4% remote and 10% in a variety of locations. 90% of the respondents were of European ethnic background and 3% were Maori.

The poor response rate was not surprising given that the topic is one which is of limited interest to the majority of health professionals. A similar situation occurred when the author undertook a study on teamwork in 1999. This previous study also had difficulty recruiting health care practitioners from the general practice environment in the Canterbury region of New Zealand. This study also researched health care practitioners' understanding of teamwork. It is believed these are the minority. However, the ones interested in this topic could therefore be representative of practitioners who wished to contribute their thoughts on the topic.

The questionnaire was distributed over the New Zealand Christmas/summer holiday period of December/January 2000/02 which could also have resulted in the poor response rate. However, this was unavoidable as it was necessary to wait for ethical approval and the questionnaire needed to be distributed as soon as this was granted due to the timeline set by

the National Centre for Rural Health's contract, requiring the project to be completed by mid 2001 in order for the third stage of the project to progress. It is also for this reason that a reminder to those participants who did not respond was not pursued.

The participants who did respond were an interesting sample. Their responses form the basis of the analysis but cannot be used as a generalisation of the majority of the views of rural practitioners. Generalised results were never the intention of the research. The questionnaire has been only one method of generating data on the topic. Previously, an in-depth international literature search had been undertaken in addition to holding an international focus group. All had generated related data/information on the topic. The available information and data will help lead the research into the next stage.

As there was a poor response rate, a further aim is to develop a simple brief questionnaire to distribute to all rural practitioners on the National Centre for Rural Health database. The questionnaire will invite them to contribute their thoughts on specific information obtained from the previous focus groups and the national teamwork questionnaire in relation to the characteristics of rural teamwork, which are of concern to the rural practitioners. Both quantitative and qualitative data has been generated and is available for analysis. It is hoped that a good response rate will be achieved and the data and analysis can then be generally attributed to rural New Zealand. Participants will also be invited to contribute to a third stage.

Quantitative Analysis

Respondents

There were 126 respondents to the survey. For the purposes of analysis by occupation, three groups were defined: "GPs", "Nurses" and "Other" which included the small numbers of managers, midwives and occupational therapists. In some cases it was appropriate to exclude the "Other" group for appropriate interpretation of statistical results. Table 1 below shows all respondents by sex and occupation. The mean age of respondents was 46 years. There was no difference in the mean age of respondents by either main occupation or sex.

Table 1: Respondents by sex and occupation

Main Job	Male	Female	No response	Total
GP	47	22	5	**74**
Nurse	0	42	4	**46**
Manager	0	1	0	**1**
Midwife	0	1	0	**1**
OCC Therapist	0	1	0	**1**
Total	**47**	**70**	**9**	**126**

One respondent declined to indicate their ethnicity. Table 2 shows all responses. Overall, nearly 90% indicated a broad European ethnic background. Interestingly, of the four respondents indicating Maori descent, only two indicated they identified as Maori, yet a total of ten respondents indicated they knew the name of their hapu/iwi.

Table 2: Respondents by ethnicity

	Frequency	Percent
NZ European/Pakeha	88	69.8
Other European	17	13.5
NZ European/NZ Maori	5	4.0
South African	4	3.2
Canadian	2	1.6
Chinese	1	0.8
Dutch	1	0.8
Indian	1	0.8
New Zealander	1	0.8
NZ European/Samoan	1	0.8
Niuean	1	0.8
North American	1	0.8
Other ethnic group	2	1.6
Total	**125**	**99.2**
Missing	1	.8
Total	**126**	**100.0**

Respondents were asked to indicate whether their main location of work was remote, rural, semi-rural or urban. Some respondents also indicated they worked in a variety of locations. To aid readability respondents were classified as being either a GP or nurse. Two respondents could not be classified according to these categories. There was no difference between GP and nurse responses summarised in Table 3. Of the twelve responses indicating mixed work locations, eleven indicated a component of rural work.

Table 3: Main location of work by occupation

	GP	Nurse	Total
Rural	51	28	79
	69.9%	54.9%	63.7%
Remote	3	2	5
	4.1%	3.9%	4.0%
Semi-rural	12	15	27
	16.4%	29.4%	21.8%
Urban	1		1
	1.4%		.8%
Mix	6	6	12
	8.2%	11.8%	9.7%
Total	**73**	**51**	**124**

Respondents indicated whether they worked regular or on call hours as shown in Table 4, it was not unexpected that nurses were more likely to work regular hours than GPs. Nurses were more likely to work part time than GPs (40% vs 15%) and 80% of GPs worked full time compared to 56% of nurses.

Table 4: Hours of work by occupation

	GP	Nurse	Total
Regular hours	8	30	38
	11.0%	60.0%	30.9%
On call	4	3	7
	5.5%	6.0%	5.7%
Regular hours on call	61	17	78
	83.6%	34.0%	63.4%
Total	**73**	**50**	**123**

GPs had been in their current position for an average of 11 years while nurses had been in their current position for 7.5 years; a significant difference. However, GPs had been in their profession for a mean 21 years, compared with nurses at 24 years which was not a significant difference.

Working With Others

Respondents were asked whether they worked with other health professionals and 97% indicated they did; 4 respondents indicated they did not. We then asked who exactly they worked with, the headings being: General Practitioners; Practice Nurses; Public Health Nurses; Physiotherapists; Pharmacists; Counsellors; Plunket Nurses; Midwives; Dentists; Social Workers; District Nurses. Respondents were also asked to indicate how many were in each category and were also given the opportunity to provide further detail about others they work with.

Responses were difficult to analyse by number of other health professionals as some respondents provided only ticks rather than numbers and others provided a range of responses. Accordingly, rather than using numbers we have simply used whether respondents indicated they worked with any number of health professionals under each heading as our reporting mechanism.

The "team" size varied from working with no others under the heading provided, to the maximum of 11 headings. The man number of headings indicated was 5.6. Analysis by occupation and by location of work showed no differences.

Table 5: Professionals worked with:

	GPs N=74		Nurses N=52		Total N=126	
	Count	%	Count	%	Count	%
General Practitioners	53	71.6	43	82.7	96	76.2
Practice Nurses	67	90.5	34	65.4	101	80.1
Public Health Nurses	26	35.1	24	46.2	50	39.7
Physiotherapists	41	55.4	29	55.8	70	55.6
Pharmacists	35	47.3	27	51.9	62	49.2
Counsellors	25	33.8	20	38.5	45	35.7
Plunket Nurses	27	36.5	17	32.7	44	34.9
Midwives	29	39.2	20	38.5	49	38.9
Dentists	25	33.8	12	23.1	37	29.4
Social Workers	11	14.9	22	42.3	33	26.2
District Nurses	40	54.1	28	53.8	68	54.0

There were 62 respondents who identified people they commonly worked with who did not come under the main headings given in Table 5 above. There were 31 core categories identified. The most common being those identified by 10 or more respondents were: Ambulance workers (16); Mental/Psych workers (12); Occupational Therapists (12).

The other categories identified by less than 10 respondents were: Hospital staff (9); Podiatrists (9); Dieticians (6); Diabetes Nurses (6); Laboratory staff (6); Osteopaths (5); Geriatricians (4); Community health/support workers (4); Police (4); Radiology staff (3); Respiratory Nurse (3); Optometrist (3); Fire Service (3); Audiologists (3); Chiropractors (3); Receptionists (2); Health volunteers (2); Maori Health Providers (2); Maori Mental Health Team (1); Sexual Health Nurse (1); OSH (1); Volunteer groups (1); Practice Manager (1); O & G Specialist (1); Support links (1); Paramedics (1); School staff (1); Speech Therapist (1).

Team Type and Team Members

Respondents were asked to define which sort of team they associated themselves with. They were not restricted to association with only one team. The teams defined were:

Rural Community Team

Rural community teams are comprised of people who live in rural areas. Members of the team have often lived, for a number of years, in the same community. A community team can be comprised of local people, police, fire brigade and health care volunteers.

Rural Health Professional Team

Rural health professional teams are comprised of a number of health professionals who work together either from the same premises or within the same rural community.

Expanded (Secondary Team)

A secondary team is comprised of some team members who are based out of the district but contribute to the health care of the rural community.

There were 122 (97%) of respondents providing a valid reply to this question. Just over two thirds (69%) associated themselves with only one type of team. The remaining 31% were associated with several teams. There was no statistical difference in the percentage of GPs and nurses associating with different teams, nor was there a difference between occupations according to whether they associated with single or multiple teams. Table 6 shows the breakdown. Overall, 86% of respondents associated either solely or in combination with a rural professional team; 35% with a rural community team and 25% associated with an expanded team.

Table 6: Association with different team types

	GP	Nurse	Total
Rural Community Team	6	3	9
	8.3%	6.0%	7.4%
Rural Professional Team	41	28	69
	56.9%	56.0%	56.6%
Expanded Team	2	4	6
	2.8%	8.0%	4.9%
Community + Professional	7	7	14
	9.7%	14.0%	11.5%
Community + Expanded	2	0	2
	2.8%		1.6%
Community + Expanded	2	2	4
	2.8%	4.0%	3.3%
All Types	12	6	18
	16.7%	12.0%	14.8%
Total	**72**	**50**	**122**
	100.0%	100.0%	100.0%

Respondents were then asked to describe their teams under the following headings: Team Members; Clinical Environment (including on call commitment); Rural Environment.

Section 1 of Questionnaire – Responses

Respondents were asked, "To what extent do you think that multidisciplinary teamworking in your area has contributed to the effectiveness of rural primary care in the following dimensions:"… They were offered a 6 point scale indicating the following classifications:

1. Very little contribution
2. Little contribution
3. Moderate contribution
4. Good contribution
5. Very great contribution
6. Don't know

Chi squared tests were performed to test for differences in responses between GPs and nurses. The "Other" group was excluded from this test as were "Don't Know" and "Non Responses". All questions in this section were examined for correlation with team size described in Table 5. No correlation was evident. Complete analysis of all responses is provided in Appendix 9. Table 7 below summarises the responses according to three categories: Negative %, showing the percentage of respondents indicating very little or little contribution; Moderate %, shows the percentage of respondents indicating moderate contribution; Positive %, shows the percentage of respondents indicating good or very great contribution. Invalid, missing and don't know responses were excluded from this table. However, there was a good response rate so this is of little effect. Percentages do not always sum to 100 as they were rounded to 0 decimal places. Responses are sorted in descending order by the Positive % column.

Table 7: The contribution of multidisciplinary teamworking in respondent's rural area

Question: *"To what extent do you think that multidisciplinary teamworking in your area has contributed to the effectiveness of rural primary care in the following dimensions?"*	**Positive %**	**Moderate %**	**Negative %**
Patient care generally	75	17	8
Relationships with patients/community	69	17	14
Quality of care	64	23	14
Enhancing mutual respect and trust between professional disciplines	62	22	17
Increased knowledge of other members' professional skills	62	21	17
Sense of belonging to rural community based on individual local situations and circumstances	60	20	21
Maturity of team	60	21	20
Provision of out of hours emergency care	59	8	33
Appropriate skill use	59	26	16
Information sharing*[2]	58	25	17
Increased knowledge of other members' personalities	58	28	14
Role understanding across professional disciplines	58	27	14
Sense of belonging to team	58	22	21
Meet other team members at least once a year	58	19	22
Greater understanding of community needs	57	21	22
Support for team members	56	25	20
Effective communication and use of language between members	52	28	21
Growth and development of health professionals themselves	51	26	24
Flexibility and adaptability for team members to work effectively in diverse situations	47	23	30
Organisational efficiency	43	29	27
Decisionmaking	43	22	35
Constructive debate	41	25	35
Support for new ideas	41	27	32
Disease prevention	39	36	25
Build relationships with expanded (secondary) and community teams	39	30	31
Understanding of cultural diversity and adaptability	36	27	37
Setting objectives*[1]	32	23	45
Protocol development	29	18	53
Monitoring of individual and team performance	28	23	49
Practice planning	26	26	48
Activity audit	25	19	55
Has allocated protected time set aside for meeting, planning and evaluation of teamwork	23	15	62

*** Notes:**

1. Nurses were much more likely to respond in the very great contribution category than GPs
2. Nurses were much more likely to respond in the very great contribution category.

Section 2 of Questionnaire – Rural Teambuilding Education

Question 9: ***"Have you ever attended or used/read information on teambuilding approaches/educational resources?"***

	Frequency	Percent	Valid Percent
Yes	48	38.1	38.4
No	77	61.1	61.6
Total	**125**	**99.2**	**100.0**
Missing	1	.8	
Total	**126**	**100.0**	

The 125 valid responses to this question are shown by main job classification below. Significantly more nurses responded affirmatively to this question than GPs ($p<0.001$).

	Used/read information on teambuilding Yes	Total No	Total
GP	16	58	74
	21.6%	78.4%	100.0%
Nurse	29	16	45
	64.4%	35.6%	100.0%
Other	3	3	6
	50.0%	50.0%	100.0%
Total	**48**	**77**	**125**
	38.4%	61.6%	100.0%

Question 10: ***Have you attended any teambuilding workshops?***

	Frequency	Percent
Yes	35	27.8
No	91	72.2
Total	**126**	**100.0**

The 126 valid responses to this question are shown by main job classification below. Significantly more nurses responded affirmatively to this question than GPs ($p<0.001$).

	Attended teambuilding workshops Yes	Total No	Total
GP	10	64	74
	13.5%	86.5%	100.0%
Nurse	22	24	46
	47.8%	52.2%	100.0%
Other	3	3	6
	50.0%	50.0%	100.0%
Total	**35**	**91**	**126**
	27.8%	72.2%	100.0%

Respondents answering "yes" to question 10 were asked to complete the remainder of Section 2 while those answering "no" were directed to the final question (26) asking for comments. Accordingly all subsequent questions are analysed on the basis of N=35. As there were only 3 "Other" job categories and two of these respondents appeared to have come from a nursing background, these three have been bundled with nurses for analyses by job classification.

Question 13: To what extend have the following areas been covered in your teambuilding workshops/educational sessions?

Respondents were offered a 6 point scale indicating the following classifications:
1. Not at all
2. A little
3. Moderately
4. Quite substantially
5. Very substantially
6. Don't know

Because of the small number of valid responses to these questions it was not appropriate to use chi squared tests. Monte Carlo tests were performed with a sample size of 10,000 and a confidence level of 99%. There was no significant difference in responses between GPs and nurses. Complete analysis of all responses is provided in the Appendix. To aid interpretation of this data, responses have been classified according to three categories: "Not at all" and "A little" responses grouped under the heading "Minimal"; "Moderate" responses grouped under "Moderate"; "Quite substantially" and "Very substantially" grouped under the heading "Substantial". Occupations have not been included in the summary table as it has been shown that there is no significant difference between GP and nurse responses. Percentages have been rounded to zero decimal places.

Question: *"To what extent have the following areas been covered in your teambuilding workshops/educational sessions?*	**Minimal %**	**Moderate %**	**Substantial %**
Relationships between professionals	4	22	74
Communication	15	11	74
Team collaboration	11	19	70
Shared decisionmaking	11	22	67
Building cohesion	11	22	67
Team objectives	4	33	63
Developing mutual role understanding	26	11	63
Role clarification	11	30	59
Getting to know one another as people	19	22	59
Conflict resolution	18	26	56
Innovations in practice	26	26	48
How to use time effectively	33	19	48
Team meetings	18	33	48
Relationships with patients	31	27	41
Commitment, i.e. time/resources	30	30	40
Audit of activities	38	25	38
Protocol development	35	27	38
Practice planning	35	27	38
Health needs assessment	48	16	36
Disease prevention	44	22	33
Computerisation	63	19	18

Question 14

Respondents were asked to indicate if they had ever been part of: i) syndicate or small group exercises for teambuilding; ii) lecturers; iii) other [teambuilding exercises].

There were no differences between GP and nurse responses to any part of this question. 61% of respondents indicated they had been part of syndicate or small group exercises for teambuilding; 58% indicated they had attended lecturers; 33% indicated other attendances although there were only 12 valid responses to this question meaning only 4 affirmative responses. Responses in the other category included: practice member discussions; Outward Bound activities; fortnightly team meetings; Covey 360 degree workshop; Myers Briggs workshop. A full analysis of responses is in Appendix 9.

Question 15

Respondents were asked who typically attends workshops. Respondents were able to tick as many categories as applied so the columns below should not be summed as the rows are not mutually exclusive. Of the 27 who provided a valid response, 17 (63%) provided only one answer; 8 (30%) provided two responses; 1 provided three responses; 1 provided four responses. It was most common for some members of the practice team to attend workshops.

	Yes	No	Total
The whole practice team	7 29%	17 71%	24
The whole practice team plus other community professionals	4 17%	19 83%	23
The whole practice team plus a range of others	2 9%	21 91%	23
Some members of the practice team	16 62%	10 38%	26
Some members of the practice team plus other community professionals	6 26%	17 74%	23
Some members of the practice team plus a range of others	5 21%	19 79%	

Question 16

Respondents were asked whether the teambuilding programme/educational session was spread over a number of occasions or completed in one session. There was no difference between GP and nurse responses. Note that these questions are not mutually exclusive as some respondents indicated that they had attended workshops that were completed in one session and spread over a number of sessions. This is to be expected as some respondents had attended a variety of workshops. Overall, 48% indicated the workshop was spread over a number of occasions while 56% indicated that it was completed in one session. Full analysis of responses is provided in Appendix 9.

Question 17

Respondents were asked when the sessions typically took place; on weekdays or during the weekends. 79% indicated that they took place on weekdays, however, only 33% of GPs indicated this to be the case compared with 94% of nurses. This was a statistically significant result. Conversely, 25% indicated they took place on the weekends, however, GPs were much more likely to attend weekend events than nurses (67% vs 11%). Again, a statistically significant result. Full analysis of responses is provided in Appendix 9.

Question 18

Respondents were asked where the events typically took place; within the practices, in hotels, in an educational establishment or in some other place. 44% indicated they typically took place within the practices; 16% indicated hotels; 36% indicated an educational establishment. There was no difference between GP and nurse responses. There were six respondents indicating that the events took place in other locations: "In practices other than ours"; "meeting room and conference room"; "Community Centre and motel"; "local fire brigade rooms"; "church hall"; "hired rooms" or "St Johns". Full analysis of responses is provided in Appendix 9.

Question 19

Respondents were asked if there were any follow up events after the workshop. There were 25 (71.4%) valid responses to this question with 52% of those indicating there were follow up events after the workshop. There was no significant difference between GPs and nurses (p=1.00).

	Yes	**No**	**Total**
GP	3	3	6
	50.0%	50.0%	100.0%
Nurse	10	9	19
	52.6%	47.4%	100.0%
Total	**13**	**12**	**25**
	52.0%	48.0%	100.0%

Question 24: Overall, to what extent do you feel that investment in teambuilding/educational sessions provides results in terms of efficient and effective health services?

There were 23 (65.7%) valid responses to this question. Interpreting the Table below, 57% of respondents rated teambuilding/educational sessions as providing quite good results or better while 43% thought the results were very limited or moderate. The low number of respondents means that there is very limited statistical power. The Fisher's exact test showed no difference between GP and Nurse responses (p=0.128). However, it is interesting that only one out of the five responding GPs indicated a response as quite good results or better compared with twelve out of eighteen nurses.

	Very limited results	**Moderate results**	**Quite good results**	**Very good results**	**Outstanding results**	**Total**
GP	2	2			1	5
	40.0%	40.0%			20.0%	100.0%
Nurse	3	3	3	8	1	18
	16.7%	16.7%	16.7%	44.4%	5.6%	100.0%
Total	**5**	**5**	**3**	**8**	**2**	**23**
	21.7%	21.7%	13.0%	34.8%	8.7%	100.0%

Question 25: Do you use, or have you used, other methods of teambuilding?

There were 25 (71.4%) valid responses to this question with no significant difference between GPs and nurses (p=0.615). Again the low number of GP responses to this question severely limits statistical power.

	Yes	No	Total
GP	4	1	5
	80.0%	20.0%	100.0%
Nurse	11	9	20
	55.0%	45.0%	100.0%
Total	**15**	**10**	**25**
	60.0%	40.0%	100.0%

Qualitative Analysis

Two stages of the qualitative data have been analysed. The first stage was to analyse the written contributions from the participants and theme them into two main areas. The areas consist of the characteristics of rural teams, indicating both the contributing and hindering factors associated with rural teamwork. The second stage is associated with the factors necessary for effective rural team building education. The data has been themed into the following areas which the participants indicated were important:

- Characteristics of rural teamwork)
- Contributing factors for effective rural teamwork) *(relate to section 1 of questionnaire)*
- Constraining factors impeding rural teamwork)
- Rural team building education *(relates to section 2 of questionnaire)*

Characteristics of Rural Teamwork

The particular elements associated with the characteristics of rural teamwork include:

- Local services are responsive to the rural setting
- Understanding rural people and how rural communities work
- Iwi participation and involvement fully at all levels

> *"Strong committed people in leadership positions in provider organisations, ability to engage grass roots providers and community participation. Strong, effective, equitable and honest links with iwi. Iwi involved fully at all levels."* (Rural Nurse)

- Engaging grass roots people and gaining community participation and involvement
- "Community ownership" of the service would facilitate cooperation and effectiveness rather than regional services".

> *"Community ownership of the service would facilitate cooperation and effectiveness. Regional services have caused inappropriate services, reduced responsiveness to need and inappropriate services which waste resources. Savings, e.g. Voluntary hospital clinics or St John's Ambulance workers are changed to funding agencies and the fees charged are not returned to the rural area."*
>
> (Rural General Practitioner)

- Responsive to community need to build better health care
- Get the health model right then build the health care team
- Providing effective rural leadership and coordinating care
- The more geographically isolated the more rural teamwork is effective

Contributing Factors for Effective Rural Teamwork

The contributing factors for effective rural teamwork were identified by the respondents and have been amalgamated under a number of headings which include team membership, teamwork, team planning, team education and quality outcomes.

Team Members

Team members need to be in a position to play multiple, flexible roles. A rural team is comprised of a number of different health professionals and community members. There are a number of contributing factors which need to be accommodated for teamwork to be effective.

Team members need to:

- have mutual respect and support of all team members including those that are "on call", team membership needs to be small, and members need to have regular contact with each other.
- learn about each other's roles which are equitable and negotiable
- define/know their own boundaries and skills which are acknowledged by one another
- have their individual contributions valued
- have reciprocal open and effective communication
- have buy in from the medical profession
- respect that iwi, are key community people, in the rural team
- understand personalities of team members and the way individuals work
- have competence and experience for the provision of health care
- work within an environment which is cooperative not competitive
- share patient notes
- have clarification of private general practitioner funding roles in the team

Teamwork

Effective teamwork offers a more responsive health service at a local level and a stable team of health professionals. Rural nurse practitioners need to be accepted by GPs as complementary and not working in opposition. Rural nurse practitioners work with doctors and not for them.

Team Planning

Team planning requires team members to*:*

- use appropriate models of health delivery for the community's needs, e.g. use rural nurse practitioners
- be involved in the planning process, setting goals and organisation
- be well informed with a shared vision for success
- have shared goals and seek ways to achieve access to these
- take into consideration client needs
- have regular constructive face to face multidisciplinary team meetings to air matters of concern and encourage methods to improve both professional and patient issues, invite expert advisers to assist in team meetings if necessary.

Quality Outcomes
Quality outcomes require:
- a functional team
- integrated services

Teambuilding Education
Teambuilding education needs to:
- empower all team members
- provide for all team members with mutual trust and respect
- strengthen the relationship and effectiveness of the team (use appropriate team exercises)

Constraining Factors Impeding Rural Teamwork

The particular elements associated with the constraining factors which impede rural teamwork have been amalgamated under a number of headings which were identified by the respondents and include:

Teamwork
- Competition between providers
- No culture of primary health care teams - no long term planning or team effort
- Instability of general practitioners in the team
- General practitioners not moving with the times and continue to hold onto team power
- Lack of formal education
- Lack of uninterrupted time
- Lack of locums to relieve for time off
- Stress
- Overwork
- Competition

Team Members
Team members tend to experience burn out, lack of time being "on call" and shift work. There is too much paper work and difficulty in keeping up with the workload. There is competition amongst providers and little acceptance and willingness to make change of new roles such as the nurse practitioner role. There is a lack of full time GPs for back up of rural nurses advanced roles, there is a lack of full time nurses. There are no incentives for team building, there is a lack of cooperation and too much patch protection.

Team Meetings
Team meetings are a chore there is difficulty to get all members to the same meeting. There is no time set aside for meetings when they do occur there is usually conflict between the members. Team members tend to have different agendas and GPs traditionally hold onto the power and leadership. There is no long term health care planning nationally, regionally or locally while decisions tend to be made regionally not taking into consideration the local situation and requirements.

Rural Teambuilding Education

The number of respondents who answered section 2 was poor with only 38% of them indicating they had attended or used/read information on team building approaches/educational resources. Significantly more nurses (64%) had done so compared with GPs (22%). Of the 38% of respondents who answered this section 28% indicated they had attended team building workshops. Again significantly more nurses (48%) had done so compared with GPs (14%).

Team Education Why Have It?

- To improve knowledge of other people's roles and skills
- Improvements gained from using a professional health care team most effectively; sharing care and skills to the betterment of patients and the management of practice
- Improve knowledge and skills of team members
- Gives individuals an opportunity to understand and respect other colleagues (members)
- Increases tolerance between individuals, improves communication and better use of resources

Content of Teambuilding Workshops

Of the 35 respondents indicating they had attended team building workshops, over 50% indicated that the following areas had been covered quite or very substantially: relationships between professionals; communication; team collaboration; shared decisionmaking; building cohesion; team objectives; developing mutual role understanding; role clarification; getting to know one another as people; conflict resolution.

Of the 35 respondents indicating they had attended team building workshops, over 40% indicated that the following areas had been covered only a little or not at all: health needs assessment; disease prevention; computerisation.

How and Where Teambuilding Workshops Carried Out?

Of the respondents to this question, 61% indicated they had been part of syndicate or small group exercises for team building while 58% indicated they had attended lectures. Of the nurses who responded to this section 94% of them had attended teambuilding sessions on weekdays compared with 33% of GPs. While 67% of GPs attended teambuilding sessions on weekends compared with 11% of Nurses.

Who Attended Teambuilding Workshops?

It was more common for some members of the practice team to attend workshops rather than the whole practice team.

Evaluation of Teambuilding Workshops

Of the respondents to this question, 52% indicated there were follow up events after the workshop. While 80% of GPs indicated that investment in teambuilding/educational sessions provided very limited or moderate results in terms of efficient and effective health services, compared with 43% of nurses. Low response numbers mean this should be interpreted with caution. However, 44% of Nurses indicated that investment in teambuilding/educational sessions provided quite good or outstanding results in terms of efficient and effective health services, compared with 20% of GP's. Again low response numbers mean this should be interpreted with caution.

Rural Team Building Education

Team building exercises the respondents attended	• While in Britain • Healthlink south internal courses • Royal NZ College of GPs • Auckland Medical School - seminars • Church camps • University papers - Diploma of Primary Rural Health Care (HASC:407) • Part of Bachelor of Nursing • "Shelley Jones" leadership workshop • Team building day • Outdoor activities - exercises at Outward Bound; team building with tasks beyond the individual • Independent Practitioner Associations • Continuing professional education • Little and often - meetings
What rural participants want in the way of teambuilding education	• Professional development • Leadership • Understanding each other's roles • Communication • Conflict resolution • PRIME (Primary Response in Medical Emergencies) • Refresher courses - Trauma • Practical exercises Understanding of teams and how they work
Teambuilding education should consist of:	• Socialising • Being culturally appropriate • Kaizen principle • Myers-Briggs personality training as a team • Rich Allen / Eric Jensen - staffing: a discovery • Building personal self esteem • Brain friendly workshops • Understanding teams and how they work • Steven Covey - 360^0 • Communication skills • Decisionmaking skills • Conflict resolution • Planning and setting objectives • Listening to each team member's contribution • Active participation • Leadership skills • Team building exercises - total immersion for weekend in retreat with all team members • Exercises are relevant to practice • Practice management skills • Cooperation of group members followed by intense debate and modifications • Facilitate team members to use or develop skills in key areas • Having fun

Teambuilding education needs to ensure the participants are introduced to understanding of the following themes:	A number of themes have been identified and include: ***Team Members*** • Build on strengths of team members • Acknowledge diversity of team members • Encourage friendship and interaction • Encourage mutual respect • Getting to know each other • Getting to know roles - break down barriers • Active participation of members • Treat all members as equals • Acknowledge issues and feelings • Gain understanding of members' perspective ***"The Team"*** • Team integral to decisionmaking ***Measure / Evaluation*** • Set and measure outcomes • Actively encourage team participation in audit • Debrief following exercises • Self education - gives clearer direction • Further evaluation 3-6 months later • Written evaluation after session ***Performance*** • Recognise and reward good performance • Manage poor performance • Feedback ***Education*** • Allow for problems to be brought to the group • Increase understanding of teams and how they work • Be facilitative not directive • Shared leadership
Team education for teambuilding	***What Works?*** • Team meetings with exercises and offer prizes • Organised by local health authority - all team • Members attend - different scenarios discussed and people's roles • Effective facilitation • Group exercises - physical and mental to solve problems • Social time - activities (informal) • Role model - video feedback • Free speech • Effective educator • Effective programme • Regular programme • Encouraged to attend and be paid • Practice techniques for improving communication • Project to be completed after the session so application of principles can be practised • Meeting other health professionals - recognise mutual problems: role ***Why it Doesn't Work*** • Can't get a locum • Protected time • Workshops not always acceptable to individual need • Travel to educational courses • Fragmentation

Discussion

The Dimensions of Team Effectiveness in Rural Health Services

This discussion revolves around the concept that primary health care teams when performing to their full potential can offer effective high quality health care (Pritchard & Pritchard 1994, Elwyn Jones, Rapport & Kimersley 1998, Williams & Laungani 1999). However, there is very little evidence to this effect which relates to the provision of rural primary health care and rural health care teams. It has been the aim of this research to take note of the limited understanding of rural teamwork and to study and describe the dimensions of team effectiveness. The longer term aim has been to put forward a number of recommendations to the Ministry of Health concerning ways in which rural team work can be improved to provide appropriate rural health care by effective rural teams.

This research has asked a variety of questions which provided a number of themes such as the characteristics of rural teams, rural team membership, and contributing and constraining factors relating to rural teams and teamwork. This research has also studied as to what are the basic requirements for rural teambuilding and the types of team interventions and educational content recommended for effective rural practice.

To date this research has achieved a number of its aims, which relate specifically to an improved understanding of rural teams and teamwork in New Zealand. The data has been generated taking both a quantitative and qualitative approach. Data has been generated by undertaking a questionnaire and focus group discussion. The analysis from the data comprises first, the dimensions of team effectiveness in rural health services, indicating the characteristics of rural teamwork. In addition, the contributing and hindering factors associated with rural teamwork have been highlighted. The second area has themed the contributing and hindering factors which may affect rural teambuilding and associated teambuilding educational resources which respondents have used. The qualitative data has been further analysed with a view of differentiating between themes and the occupation of the participants. However, it has not been the intention of this research to differentiate between the occupation of participants and the themes they have identified. This would be too pointed highlighting the attributes, beliefs and assumptions different occupations hold about each other. Highlighting these differences could have a number of negative effects on this research. Additionally, as highlighted previously, the number of participants who contributed to these questions was small and can not be generalised. However, it is important to note that there is a corresponding resemblance of the data generated between the questions asked and the participants' responses at the focus group discussion and from the questionnaire responses.

A list of these findings are organised in the following five sections and will form the basis of the research discussion:

- Rural health team membership
- Characteristics of rural health teams
- Contributing factors for successful rural health teamwork
- Constraining factors which impede successful rural health teamwork
- Rural health teambuilding and interventions recommended for practice

Rural Health Team Membership

The majority of the respondents (97%) indicated they worked simultaneously with other health professionals, there was no difference between GPs and Nurses responses. There were eleven core health professions provided in the table (table 5 found in the questionnaire Appendix 8) for the respondents to choose from. However, half of the respondents indicated their "team" comprised a number of members who had not been identified in the given list. The most common being identified were: ambulance workers, mental health workers and occupational therapists. It is important to note that a rural team may comprise a variety of diverse members dependent on the rural community, the requirements of that area and the availability of specific people to meet the health needs of the particular community. This highlights the need to have a description of "different" rural types of health teams with a varied and diverse membership. A rural health team is not a traditional team as described in the literature on teams (Pritchard & Pritchard 1994). Rural health teams may consist of community personnel, health professionals or a mixture of both. In addition, team membership may comprise a relationship of team members who are a mixture of both kith and kin who have been associated with the local community over generations.

Three rural health teams have been identified and are described as follows:

Rural Community Health Team

Rural community teams are comprised of people who live in rural areas. Members of the team have often lived for a number of years in the same or similar communities. A community team may be comprised of, for example, local community people, police, fire brigade, ambulance personnel, school personnel, health care volunteers and health professionals. It is essential to respect and listen to the community's ideas, visions and knowledge as they tend to stay in the area and understand its complexities, whereas professional team members tend to be more transient. Additionally, informal networks may already be in place within the rural community prior to the involvement of the health professionals.

Rural Health Professional Team

Rural health professional teams are comprised of a number of health professionals who work together either from the same premises or within the same rural community. Individual team members tend to have a variety of goals which may or may not be consistent with each other and the community's goals while the personalities of individual health professionals may restrict effective teamwork.

Expanded (Secondary Team) Rural Health Team

An expanded or secondary rural health team is comprised of some team members who are based out of the immediate area but contribute to the health care of the local rural community. The restriction of face-to-face interactions, collegiality and the development of formal teams require the need to develop a trusting relationship with the "voice" at the end of the telephone. Attempts need to be made by these team members to meet together at least once a year or to introduce themselves to each other at meetings or other events.

These three different descriptions of rural health teams are a starting point to further our understanding of rural team membership and assist in future discussions and planning rural health care.

The majority of the respondents associated themselves with a rural professional health team (86%). However, they were less inclined to associate themselves with a rural community health team (35%) and even less an expanded team or secondary health team (25%). Generally, the respondents who were more isolated or being associated as a solo practitioner (the minority who responded to this questionnaire) appeared to be aware of and include the support of the members of the expanded team. These respondents were also aware that teamwork was more effective when isolated. This may be because people are more dependent on each other for success and could highlight whether other rural health professionals are aware and associate the members of the community in which they work as part of the rural health team.

Mature Teams

The ultimate goal of a rural team is to develop what the focus group respondents called “a mature team”. A mature rural health team understands and respects the dynamics of the rural community and the complexities of rural team members. This team is flexible and makes allowances and acknowledges that conflict may occur and attempts to work within a "win win" situation. A mature team with this kind of an approach has the ability to achieve success when they take into consideration the characteristics of a rural health team as described below.

Characteristics of Rural Health Teams

For a rural health team to be effective it relies on a number of characteristics that are specific for the provision of rural health care. A rural health team has some particular elements associated with its membership (as described above) and includes the:

- flexibility that each rural team may comprise a diverse and unique membership;
- involvement and consultation with local community people about their health needs;
- planning and delivering of health care having taken into consideration the local community knowledge, and history;
- geographical and demographic context of the rural environment;
- team members sense of belonging to the team and community;
- team members being driven by a purpose, commitment and direction (sometimes known as a crisis) in association with the local community's health or health care delivery.

The above elements require health professionals, planners and funders to get to know the local community and listen to the local people/iwi so they can work in partnership. This in turn can assist with the successful delivery of rural health care by an effective health care team. Effectiveness refers to how well a team undertakes and accomplishes its purpose (West & Slater 1996). It relates to a team’s performance and provision of effective health care while remaining vital and has the wellbeing of its members at heart. West & Pillinger (1996) indicate that “before attempting to enhance the effectiveness of interventions, four dimensions should be met.” (p.5)

- First the use of teams must be appropriate. If there is no interdependence between team members to achieve a goal and if one person alone could achieve the goal successfully then there is no need to involve a team of people (Ovretveit 2001).

- Second, there needs to be adequate support from mangers, GPs, Community Trusts or whoever has authority over the team.

- Third, the team requires adequate resources to ensure it can function effectively. Suggested resources a team needs include, time, information, funding and sufficient personal support.

- Fourth, teams need to have a correct diagnosis of their composition, stage of development and their specific issues or concerns. This implies that there does not necessarily mean there is one intervention which can be used by all teams. Team intervention needs to be tailored to meet the needs of individual teams. Team facilitators require to be informed of different innovative options to advice, plan and assist teams to become effective while working alongside individual teams.

Contributing Factors for Successful Rural Teamwork

It was encouraging that over 50% of the respondents indicated that multidisciplinary teamworking made either a good or very great contribution to rural primary health care for the following dimensions: patient care generally; relationships with patients/community; quality of care; enhancing mutual respect and trust between professional disciplines; increased knowledge of other members' professional skills; sense of belonging to rural community based on individual local situations and circumstances; maturity of team; provision of out of hours emergency care; appropriate skill use; information sharing; increased knowledge of other members' personalities; role understanding across professional disciplines; sense of belonging to team; meet other team members at least once a year; greater understanding of community needs; support for team members; effective communication and use of language between members and growth and development of health professionals themselves. West & Pillinger (1996) imply there is research evidence indicating that the organisational context in which the team is placed can have a significant influence on team effectiveness. The areas which should be considered include the provision of education for teamwork, clear team goals, rewarding team performance and giving constructive feedback. There should also be adequate resources and support for teams as this assists their development.

Constraining Factors Which Impede Successful Rural Teamwork

A large proportion (over 40%) of the respondents indicated that multidisciplinary teamworking made either a little or very little contribution to rural primary health care in the following dimensions: setting objectives; protocol development; monitoring of individual and team performance; practice planning; activity audit; allocated protected time set aside for meeting, planning and evaluation of teamwork. These areas have been well researched as being essential elements for effective teamwork and if they are not attended to, could be detrimental for the team's success.

Participants of these workshops tend to prefer teambuilding activities associated with relationships between team members rather than addressing task issues related to health or illness. Team meetings, conflict resolutions and shared decisionmaking were part of the educational content in team building workshops, areas which are again relevant for effective teamwork. This pattern of responses reveals a consistent approach in the context of team building workshops internationally (West & Pillinger 1996). Additionally the current New Zealand health system poses concerns for effective teamwork. One area is the funding of general practice services which requires nurses to be employed by GPs which can have detrimental affects on the team relationship.

Context and structural issues need to be changed to encourage effective teamwork to:

- create a consistent and single line of organisation of the team;
- ensure there is appropriate training for teamwork;
- enable teams to develop clear strategies for meeting health care needs of their local populations;
- determine who will be the leader of the team;
- create collaboration, not competition, with simple funding for health services.

Effective Rural Team Building Education

The overall aim of this research (to be completed in stage 3 during 2001/2002) is to develop an appropriate educational rural team building resource. It is the intention that this resource will be used with rural health care teams within New Zealand. There could therefore be an advantage to take a deeper look at the educational needs of different occupational groups who contributed to the research questionnaire. The aim is to identify the educational needs of rural practitioners. This area has the potential for developing a suitable education package relevant to the needs of rural practitioners while taking into consideration, research pertaining to evaluations of teambuilding educational courses (West and Pillinger 1996) and the findings from international studies.

The educational content identified by rural practitioners which could benefit rural teambuilding can be grouped into three areas. The educational content identified by both rural general practitioners and rural nurses. The educational content identified by rural nurses only and those identified by rural general practitioners.

The educational content identified by both rural nurses and general practitioners includes learning how to communicate together effectively and to understand each other's roles. They both identified aspects of what teamwork education should consist of and include; communication, role definition, having fun and that all the team members should be present at the educational sessions. They both expressed the need for regular team meetings but that there was pressure on time to achieve this. In addition the exercises used for team building needed to be relevant to rural teams, not waste time and should be local. Funding of the sessions generally by the government was also an important consideration including time off work. They also indicated that community participation was of value to team working and needed to be included in education. Funding of health services seemed to crop up a great deal implying that it was difficult to have effective, equal understanding and delivery of teamwork because of the employer/employee relationship general practitioners have with nurses. General practitioners indicated that they had difficulty in devolving responsibility to nurses, whereas nurses where aware of the hierarchy and patch protection put up by general practitioners.

The educational content identified solely by rural nurses expressed that, routinely, nurses did not take a leading role in teamwork and that if teamwork was to be effective then it would be necessary to rectify this. Rural nurses also highlighted the disparity of power, and decision-making in a team and that there needed to be mutual respect amongst team members. They also required conflict resolution, professional development and acknowledgment of different team members' perspectives. Rural nurses felt controlled and exploited by general practitioners and that their role was misunderstood and was not used to its full potential.

The rural general practitioners solely identified educational content, including gaining locum cover and financial assistance to cover costs in order to attend education sessions, as issues of concern. They were also concerned that their own personal time was protected time for family life. They were very aware of the financial implications to their business and required government assistance and that the recent competition to provide health services was detrimental to teambuilding. General practitioners were more sceptical with regard to teamwork education than the nurses. They wished to get the structure right first and then develop an education structure and team membership around that.

Potential Rural Teambuilding Educational Resource

The literature indicates that there are six main areas which need to be made available as a teamwork educational resource (West & Pillinger 1996) and include individual:

- team diagnosis
- team building
- team training
- leadership training
- team work re design
- appropriate organisation context

The findings from this research indicate that the content of a teambuilding resource requires, but is not limited to, the following:

- Understanding teams, in particular, rural teams, and how they work
- Understanding the historical development of profession and role
- Trust, respect and acknowledgment of other team members ability to perform
- Communication/ Listening skills
- Conflict resolution
- Team planning
- Leadership skills
- Being culturally appropriate
- Active and equal participation and attendance by all team members
- Team building exercises - total immersion for weekend in retreat with all team members - exercises are relevant to practice
- Cooperation of group members followed by intense debate and modifications
- Facilitate team members to use or develop skills in key areas
- Follow up and evaluation of teambuilding
- Socialising
- Having fun

The development of an appropriate educational resource for the development of rural teams needs to take into consideration that rural teams are not traditional teams as described in the literature (Pritchard & Pritchard 1996, p.13):

> *"A group of people who make different contributions towards the achievement of a common goal."* (p.13)

Rural teams are composed of a diverse membership and need to be adaptable, flexible, multiskilled, mature in their outlook and have respect for and trust in one another.

The Purpose of this Research

For the purposes of this research the intention was to study rural health professionals, namely rural nurses and GPs only. However, further work is required to study rural community non health professionals and their views, experience and knowledge on teamwork. This information together with the data generated from this research could assist in the understanding of all members of rural teams who are associated with the provision of health care. The overall intention would be to develop and pilot a teambuilding educational resource suitable for community and expanded rural health teams.

We can be assured that teambuilding education is not necessarily a waste of time or resources if researched and provided appropriately. There have been a lot of lessons learned through work on teambuilding by West and Pillinger (1996). They indicate that by exposing health professionals to teambuilding educational sessions is a very helpful way of developing primary health care professionals awareness of teamwork. They put forward a number of recommendations to ensure there are adequate resources and that teambuilding facilitators are knowledgeable in teambuilding, and team development. For the needs of rural teamwork, facilitators would also need to be knowledgeable in rural community development.

In Conclusion

West and Pillinger (1996) imply there is research evidence indicating that the organisational context in which the team is placed can have an significant influence on team effectiveness. The areas which should be considered include the provision of education for teamwork, clear team goals, rewarding team performance and giving constructive feedback. There also needs to be available adequate resources and support for teams to achieve success. For this to occur we need to consider the following:

- Take into consideration rural community expectations
- There is a need to change and focus on the direction of rural health care
- Knowledge and understanding to manage change
- Involving other health providers and community personnel
- Availability of a conducive health funding service system to accommodate effective teamwork
- The need to develop practice and rural community profiles
- The sharing of responsibility by rural health teams and organisations

There can be a number of teams within a rural community. There can be a community team that was formed before a professional enters and will be there when the professional leaves. There is a professional team and there is a coming together of community and professionals and there can also be sub teams. Team membership can be small, medium or large. If we are going to have a functional and effective team then we need to take into consideration the personal attributes of people. We need to understand there is conflict of power and that things won't work all the time, that people do have the expectations they should and we should actually bring in effective people, such as facilitators, to help us to develop teams. We need to be organised to meet with our teams at least once a year; the teams that are present and the teams that we utilise apart from those. We need to take into consideration that culture plays a major part, especially in New Zealand and we need to look to the other teams to assist in the delivery of health care and for setting goals and working alongside them. We need to work collaboratively.

Summary

To summarise, for successful rural teamwork it is necessary for rural people, community personnel, rural health professionals, the funders, District Health Boards and the Ministry, to be aware there have been a number of identified characteristics associated with rural teamwork relevant to New Zealand. This includes the variety and diversity of rural team membership and the specific context in which the team works and delivers health services.

Rural health teams are not traditional teams as described in the international literature which tends to be based on the urban composition of team members and characteristics. However, there is a comparison between the data from this research and international research, of the beliefs held by health professionals, that a functional primary health care team can offer an improved health care service of higher quality than a non-functioning team or single discipline.

The majority of team building workshops offer relationship sessions and tend to limit the more organisational / planning sessions which are just as important for effective team building. These areas need further consideration by rural health practitioners, team developers and educators. This will be highlighted in stage 3 of this project to be completed in June 2002.

Recommendations

Recommendation 1
To describe and establish a national/international understanding of the membership of a rural health team using one of the three definitions described in this research: Rural Community Health Team, Rural Professional Health Team and Expanded (Secondary) Health Team.

Recommendation 2
There are sufficient funds available to continue to study the various membership of rural teams. This will ensure health professionals, communities, funders and the Ministry are in a position to understand and describe the diversity of rural health teams. It will also add to the international literature on rural team membership.

Recommendation 3
To further survey (with additional resources) non health professional rural health team members' understanding, knowledge, experience and interpretation of rural teams.

Recommendation 4
To ensure that rural health teams are identified with the relevant characteristics which are specific to their context.

Recommendation 5
To ensure attention is given to reduce the constraining factors which may impede effective teamwork such as:

- the funding of health services;
- the private contract for GP health services is adapted to accommodate teamwork and the sharing of leadership and responsibility of the team;
- the acknowledgment and utilisation of the versatility of team members' skills;
- the availability of more resources and support to assist team members to attend educational team building workshops;
- the organisational context is conducive to teamwork.

Recommendation 6
To establish a relationship with local communities and health professionals to plan, develop, deliver and evaluate their health care and services.

Recommendation 7
To ensure all rural team members have a sense of belonging to the team and there is effective communication amongst members.

Recommendation 8
To establish and make available, resources for team meetings to become a normal and routine part of the delivery of health care. Team meetings need to be face-to-face at least once a year with expanded teams and at least monthly with rural community and rural professional health teams.

Recommendation 9
To define an educational team building resource tool/s to support and enhance effective teamwork by rural health care teams by:

- completing stage 3 of this project and having available a well researched and appropriate draft team building resource/s;
- establishing a small number of rural health teams in New Zealand who are willing to pilot the draft team building resource/s;
- the National Centre for Rural Health securing additional funds for the year 2002 and beyond, to pilot this draft team building resource with the consenting rural health teams;
- evaluating and adopting this draft team building resource to ensure it is suitable for rural New Zealand.

Recommendation 10
To resource a sufficient number of experienced team building facilitators / educators to provide the services described in recommendation 11. It will be essential to secure additional funds for the year 2002 and beyond for experienced team facilitator/s to work alongside rural teams.

Recommendation 11
To make known to all rural health teams the availability and resources to engage with an experienced team building facilitator who can work alongside the team with the aim of assisting the team to become more effective by:

- undertaking a team diagnosis;
- developing tailor made educational team building resources based on the researched evidence and New Zealand's piloted team building resource/s;
- working alongside the whole rural team at their own pace and at their suggested venue;
- regular feedback and evaluation of the team's performance.

Appendices

Not available in web-based version, please contact author.
See www.moh.govt.nz/crh for contact details.

1 BIDWELL Simon & ROSS Jean (2001) **An International Literature Search and Review of Rural Teamwork and Teambuilding** Centre for Rural Health : Christchurch, New Zealand

Accessible from www.moh.govt.nz/crh

2 Focus Group Letters of Invitation

3 Focus Group Research Information

4 Focus Group Core Ground Rules

5 Focus Group Consent Form

6 Focus Group Demographic Form

7 LOT Teamwork Questionnaire

8 Adapted LOT Rural Teamwork Questionnaire

9 Quantitative Data

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