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Interdisciplinary teamwork in the community rehabilitation of older adults: an example of flexible working in primary care

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This paper presents a section of the findings of a case study of a newly established community rehabilitation team (CRT) comprising physiotherapists, occupational therapists and nurses. The findings reported here address issues of interdisciplinary teamwork that arose during the project. All eight members of the team were interviewed as well as three ex-team members. The data were collected by semi-structured interviews and analysed using thematic content analysis (Strauss and Corbin, 1990). The findings suggest that when recognized barriers to teamwork are eradicated, such as geographical separation and different employers, teams such as the CRT can achieve high levels of teamwork. A problem that took longer for the CRT to resolve, however, was that of flexible working across traditional professional and hierarchical role boundaries. The paper concludes that the difficulties that need to be overcome when a new team and new service are established concurrently, should not be underestimated.

Key words: intermediate care; older people; primary health care; rehabilitation; teamwork

Introduction

Primary care led services

Over the past decade there has been a gradual change in the location in which the care of people takes place. Care that has traditionally been provided within the acute hospital sector can now often be provided in the home. The recent emphasis on healthcare in the community (Department of Health, 1990; 1996a; 1996b; National Health Service Executive, 1994) coupled with pressures on hospital beds, have contributed to this shift. Increasingly complex and technical services are being set up to provide healthcare in the home that at one time would only have been provided in hospital. There are many examples of this such as intermediate care teams, which are variously defined, but have essentially been established to allow earlier discharge home from hospital of patients who are physiologically stable or 'predictable' (Steiner *et al*., 1999), but who would benefit from intensive input from a team of professionals over a short period to increase both their independence and health status. The early discharge of patients who have undergone major surgery is an example of this, as is the rehabilitation of patients in the acute phase of their illness (Audit Commission, 2000), the subject of this paper.

Interdisciplinary teamwork in primary care

Teamwork in primary health care is generally considered to be the most efficient way of delivering services (Bond *et al*., 1985; Cant and Killoran, 1993; Department of Health, 1997; Field and West, 1995; Jones, 1992; Ovretveit, 1994; Pearson and Spencer, 1997; West and Field, 1995; West and Wallace, 1991; Wiles and Robison, 1994; Wood *et al*., 1994). Although as Pearson and Spencer (1997) note, we have little evidence of improved outcomes when professionals work collaboratively.

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There has been agreement in the literature about the basic tenets of successful teamwork for decades (Department of Health and Social Security, 1981; Elwyn and Smail, 1999; Hayes, 1997; Ovretveit, 1994; Ovretveit *et al*., 1997; Pearson and Spencer, 1997; Thomas and Corney, 1993; West and Slater, 1996). The prerequisites of teamwork are described as a common purpose and responsibility, a clear understanding of the professional's own function and those of others, the pooling of skills and knowledge, and facilitation or leadership.

The issue of pooling skills and knowledge is of particular interest as it is arguably something that is only slowly being recognized by practitioners, perhaps because they feel threatened by genericism (Booth and Hewison, 2002; Drennan and Williams, 2001; Furne *et al*., 2001; Goodman, 2000). Working across professional boundaries in order to pool knowledge and skills is an issue that is explored later in this paper.

Historically, however, establishing and maintaining teams in the primary care setting has been fraught with difficulties (West and Poulton, 1997). Although viewed as the ideal way of working, interdisciplinary teamwork remains highly problematic for many health professionals. A number of well rehearsed reasons for this are found in the literature and are summarized in Figure 1 (Department of Health and Social Security, 1981; Marsh and Kaim-Caudle 1976; Ovretveit, 1995; Thomas and Corney, 1993; West and Field, 1995; Wiles and Robison, 1994). These barriers to teamwork are based on the model of the primary health care team (PHCT) which, in theory, comprises a range of disciplines working together to meet the needs of a patient population. The existence of one large and potentially unwieldy primary health care team is now largely discredited however. Collaborative working in primary health care is likely to involve working in a number of different teams that are configured, and disbanded, according to the needs of individuals or populations (Elwyn and Smail, 1999).

Although discussion about the ideal of teamwork in primary health care has been around for many years, certain recent developments have placed renewed emphasis on the importance of co-ordinated working practices.

Working across role boundaries

Integrated nursing teams (INTs) are being promoted in community nursing as the ideal model for co-ordinating the working practices of the many community nursing disciplines that have traditionally worked alongside, but independently of one another. In practice, INTs mainly involve district nurses, health visitors and practice nurses whose unco-ordinated working practices have lead to gaps and duplication in the services provided. Many integrated nursing teams are self-managed, i.e. they hold their own budget (Black and Hagel, 1996; Gerrish, 1999; Young, 1997).

The emphasis of the integrated team is on the skills available within that team, and flexibility across traditional role boundaries in order that the needs of the population served are met as far as possible. Traditional professional roles are subordinated to the needs of the local patient population, whatever they may be. Although lip service has been paid to skill mix in community nursing for at least a decade, in reality, skill mix has been translated as grade mix, i.e., the introduction of different (cheaper) grades of staff to nursing teams. District nursing, for example, has been reconfigured in response to the 'skill mix' review carried out by the value for money team in the early 1990s (National Health Service Management Executive, 1992). As calculations of the community nursing establishment have been based more on historical precedent than the needs of practice populations (Audit Commission, 1999; Lightfoot *et al*., 1992), the resulting mix of staff may have little to do with the skills they can offer (Hallett and Pateman, 2000; McIntosh, 2000). Skills of nurses in the community, district nursing in particular, have been neglected in intractable discussions about what different grades of nurse should be able to do (Audit Commission, 1999). Integrated nursing teams offer solutions to this inflexibility both within and between community nursing disciplines.

Therefore, community nurses are becoming more aware of the importance of flexible working, which may involve handing over aspects of their work to other personnel, and becoming skilled in areas which do not fit within traditional perceptions of their role. In theory, population need defines the nature of the nursing team's work, and the person best suited to the work carries it out, irrespective of previous constraints of professional labels.

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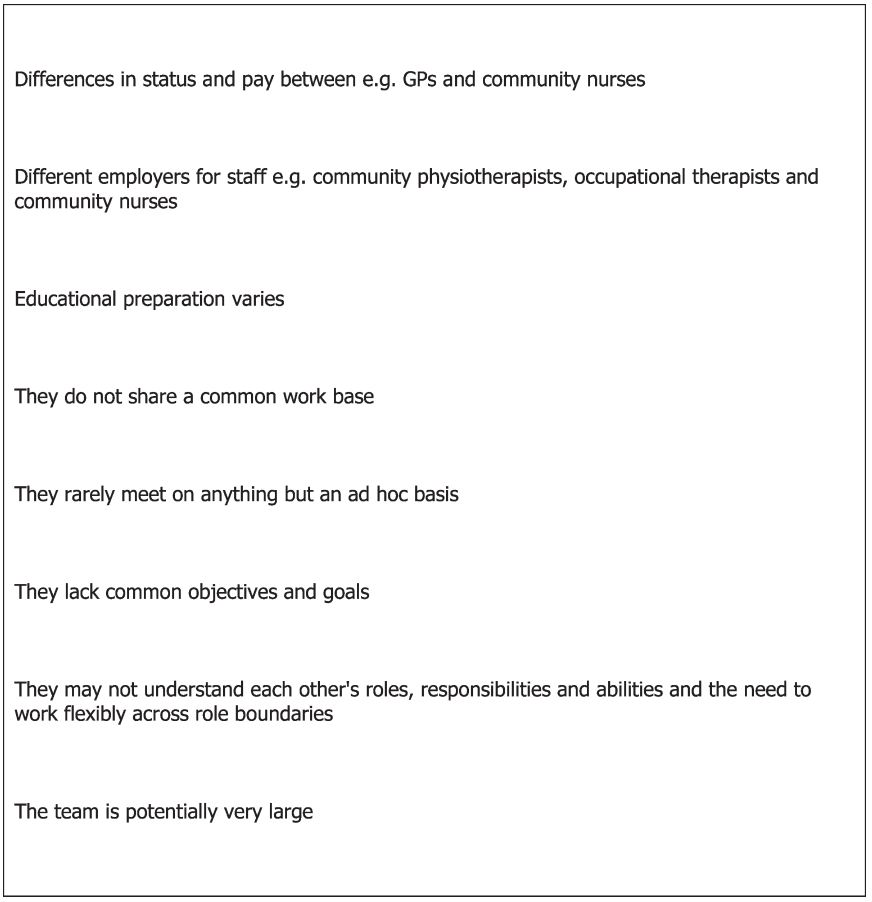

Figure 1 Potential barriers to effective teamwork in primary health care

Something that is less common however, yet clearly necessary (Audit Commission, 2000; Booth and Hewison, 2002; Department of Health, 1996a; 1996b), is this level of integrated working between disciplines within primary care. While, for example, we know that practice nurses and nurse practitioners in primary health care settings take on aspects of the traditional work of the general practitioner (GP) (Jenkins-Clarke and Carr-Hill, 1998; 2001), and there is role overlap between health and social services (Hudson, 2002) other examples are rare. If we are serious about providing cost-effective services that are defined by patient need rather than current resources, flexible working within existing services is clearly necessary.

Rehabilitation in the community

The subject of this paper is the home rehabilitation of patients in the acute stage of their illness. There are many potential benefits of rehabilitation in the home as the patient is in a familiar environment rather than the artificial environment of the hospital, and can set individually tailored, realistic goals that meet his or her specific needs (Sinclair and Dickinson, 1998).

Traditionally, however, the rehabilitation of elderly (65 plus) patients immediately after admission to hospital following an acute episode such as a fractured limb or stroke has taken place in hospital. Rehabilitation then continues post discharge, via the outpatients department. After this, continued rehabilitation in the community is usually

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provided by separate services rather than by an integrated team. Several disciplines may be visiting the patient to provide rehabilitation, but they may be unaware of each other's roles and responsibilities, or where overlap or potential gaps in the service exist. For example, physiotherapists and occupational therapists may visit a patient in their own home after discharge from hospital following a stroke, but they tend to work independently of one another. Community nurses, such as district nurses, may also visit the same patient to carry out nursing care, but it is unlikely that they are involved in rehabilitation (Gibbon, 1994).

This paper reports on selected findings of a case study of a newly established community rehabilitation team comprising physiotherapists, occupational therapists, nurses and support workers working flexibly across role boundaries to help patients to become maximally independent.

The community rehabilitation team

The community rehabilitation team (CRT) pilot project was established as one of a series of initiatives by an acute trust, community trust and health authority to allow early discharge home of patients from two large teaching hospitals in northwest England. Some of the impetus for developing services to support patients at home following an inpatient episode, came from the average length of stay in hospital of 90 days for elderly patients requiring rehabilitation following, for example, a stroke, or a fractured limb. Apart from the financial implications of this, there were considerable costs to the patient who spent a great deal of time waiting for rehabilitation sessions with physiotherapists and occupational therapists. These may have been scheduled for as little as half an hour, two or three times a week. As the therapists did not work at weekends the patient could wait for more than four days with no therapeutic input. A team of professionals visiting the home intensively over a seven day period seemed to be a sensible, cost-effective alternative. The patients had the option to stay in hospital for their rehabilitation if they preferred. The criteria that were used to decide whether patients requiring rehabilitation could be transferred from hospital to the CRT are presented in Figure 2.

At the beginning of the study, the community rehabilitation team (CRT) comprised the following 11 staff:

- Four co-ordinators;
- Three key workers;
- Four associate key workers (formerly known as support workers).

The roles of the staff were as follows. The CRT co-ordinators identified and assessed patients in hospital before their care was transferred to the team. They were also responsible for the discharge of the patient at the end of the period of rehabilitation. Each patient was allocated a key worker who planned the programme of rehabilitation. Within three days of their discharge from hospital, a physiotherapist, an occupational therapist and a nurse, all key workers, assessed the patient and agreed the aims of the rehabilitation and the patient's individual goals. The role of the associate key worker was to support the key workers in the ongoing care of patients following initial assessment.

In addition to these personnel, there was a project manager with overall responsibility for the development of the team, an administrative support worker with clerical and administrative responsibilities, and a medical consultant who provided medical back-up for the patients on a sessional and consultancy basis.

The findings presented in this paper concern the development of the community rehabilitation team. They form part of a one year evaluation of the pilot project which employed an intrinsic case study design (Stake, 1994). The case being studied was the introduction of an organizational change, which was a community-based alternative to the hospital rehabilitation of patients. Multiple methods were used to collect data about the context of the work of the team, the perceptions of patients and carers about the team, the cost-effectiveness of the service and the functioning of the team itself.

Method

The methods of data collection for this part of the case study were exclusively qualitative. They comprised fieldwork in the form of participant observation with the researcher taking the role of complete observer (Gold, 1958); and semi-structured interviews. Fieldwork was conducted throughout the one-year evaluation study. The researcher attended the weekly meetings of the team through-

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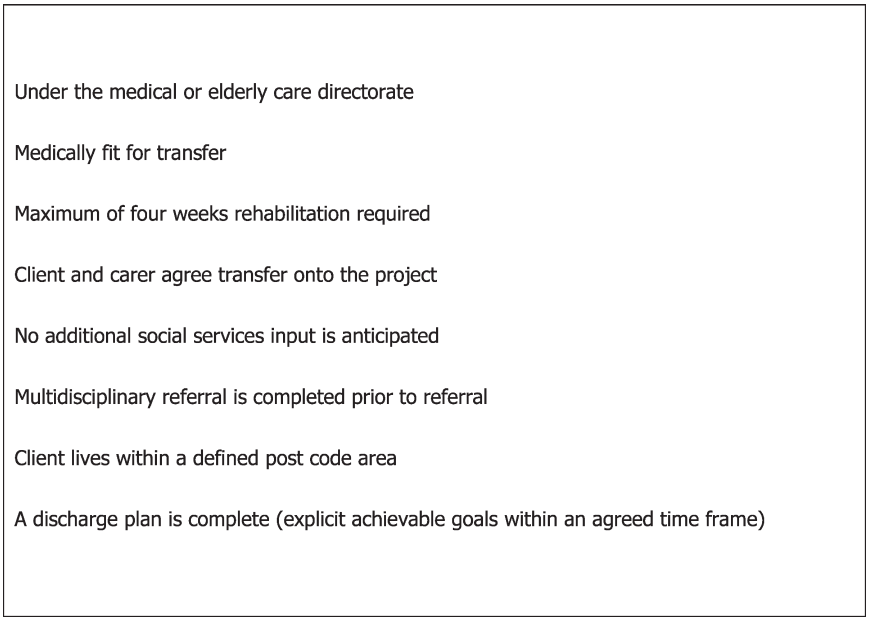

Figure 2 Criteria for transfer of patients requiring rehabilitation from hospital to the CRT

out the evaluation, and used other opportunities as they presented, for example, when collecting the patient data. Observations were recorded as field notes (Schatzman and Strauss, 1973) and, drawing on principles from grounded theory, they were annotated with methodological and theoretical notes (Strauss and Corbin, 1990). The observations were used to inform the development of the interview schedule used with CRT members.

Semi-structured interviews were carried out with the 11 original members of the CRT using a semi-structured interview schedule. The interview schedule asked team members for background details, such as previous experience of working in the community, about their role within the team, their interventions with clients, about gauging the success of interventions and about establishing a new service. Eight of these interviewees were working with the CRT at the time of interview:

- Two co-ordinators (one physiotherapist, one nurse);
- Three key workers (one physiotherapist, one occupational therapist, one nurse);
- Three associate key workers (support workers).

The three interviewees that had left the team since its inception were:

- Two co-ordinators (one physiotherapist, one occupational therapist);
- One key worker (a nurse).

The project manager was also interviewed. The interviews were conducted at the staff's place of work, including those who had left the team, and lasted between 45 minutes and two hours. With the staff's verbal consent, all interviews were tape-recorded.

The interviews with the CRT were carried out in two stages. Three interviews took place in December 1998 (one co-ordinator, one key worker and one associate key worker). The remainder were carried out in April 1999, including the three ex-team members who were able to give a perspective on the earlier development of the team and the service. The interviews were used to explore the role of the team, the difficulties encountered in establishing this new service and issues about teamwork.

Analysis

The interview data were fully transcribed and subjected to thematic content analysis (Strauss and Corbin, 1990), which involved colour coding recurring themes and categories within the data. This was done by hand, with illustrative excerpts

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of data transposed on to postcards pertaining to the identified themes. When reporting the findings no differentiation is made between team members and ex-team members, or between different personnel within the existing team. This is partly for reasons of confidentiality as team members could be very easily identified, but mainly because the philosophy of the team was to eradicate any sense of hierarchy amongst team members or notion that the work of the team was determined by professional labels attached to staff rather than patient need.

Findings

The findings are presented under three subheadings. First, the barriers encountered when establishing the community rehabilitation service are discussed; secondly, factors facilitating teamwork; and thirdly, the challenges of working across role boundaries.

Barriers to establishing the service

The CRT encountered a number of barriers to successful teamwork that were attributable to the newness of the service. This caused friction between team members. There were certain difficulties in the early stages of setting up the community rehabilitation service, for example, initially the length of time that patients were visited by the team for rehabilitation was four weeks, which was considered to be too short by the majority of staff, but was later extended to eight weeks if required. Stroke patients in particular were thought to require this longer period of rehabilitation to make a noticeable difference to their health status. Another problem was one of recruitment. The project manager found it particularly difficult to recruit physiotherapists which delayed the start of the project, and she eventually had to advertise and recruit from another acute trust. She speculated that a reason for this may have been that the CRT was an intensive seven day service, and as previously mentioned therapists tend not to work at weekends.

Another barrier to establishing the service was that, to start with, the team received very few referrals from the two hospitals (hospitals A and B). Various reasons were given for this ranging from anxiety of hospital staff about change and the ability of the team to care for these patients, to the politics of who had been appointed as project manager:

> I think it's change really. I don't think people like change particularly . . . It's hard not to get paranoid . . . you hear so many different rumours and things but I think on the wards there's such a high turnover of staff it's difficult to have any sort of continuity, knowing what's going on with just the day to day care of the patients never mind us you know. But I think there has been some bad feeling and some not wanting the team to work . . . it's hard to prove it because I'm not in the hospital seeing it but I can't believe that especially with (hospital A) that there's not patients who could benefit from us. No I mean I think people have a tendency not to want to risk you know sending people out. I don't know whether they feel they'd be blamed if anything happened in the home but they don't seem to be able to hand over and I don't know what it is really (3t).

> It's the political issues between (hospital A) and (hospital B) because they wanted this community rehab team for themselves and because an outsider became the project manager there've been stumbling blocks you know from day one which are obviously much better now and it's just the problems seemed to go on and on and on and we felt [there was] like a jealousy type thing . . . (4t).

This member then describes a new rehabilitation assessment that was introduced to the hospital wards at the early stages of the pilot project. Initially the CRT co-ordinators were able to visit the ward to assess patients for the service. A short way into the project, however, another layer of bureaucracy was introduced in the form of a rehabilitation assessment team (RAT), who carried out an initial assessment of potential patients before they could be referred to the CRT. Although ward staff were now much more aware of the new procedure for referral, initially it caused problems:

> We think it's all to do with jealousy from the outside and they weren't referring. They started up this rehab assessment thing that we couldn't get the patients out until they had had a full rehab assessment on the wards and so initially the wards could ring us up and

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> say we've got a patient for you and then that all stopped and the numbers dropped and dropped and dropped (4t).

> So there was an enduring sense that the team were not receiving referrals from all the patients who met their criteria for rehabilitation in the home. Equally, patients were being accepted by the team – particularly in the early stages of the project – who may not have strictly met their criteria. This was partly because the team had the resources to accept such patients although as one team member pointed out the 'smallest thing you may have done' could have made all the difference to that person's rehabilitation (3t).

> I think it's still true now [taking patients who do not meet the criteria] although we're busier much busier we're still getting some of the vascular patients home, they're mobile on the ward and they can look after themselves on the ward and really all they needed was district nursing but we accepted them (6t).

It was often the case, particularly at the beginning of the project, that patients were referred to the team too late. The team was treated as a discharge service for patients who had effectively finished their rehabilitation: 'too late to really get stuck into' (3t). Staff frequently referred to the service as 'the cherry on top of the cake' in these circumstances. Referrals such as this would often come at very short notice. There was consensus that on the whole patients could have been referred to the team a lot earlier. The physiotherapists expressed concern about becoming professionally deskilled, firstly because most of the intensive work with patients had already been completed, but also because they were not receiving many referrals to visit 'meaty patients' (11t) such as those with strokes.

Another issue that has been previously alluded to was that the CRT was one of a series of initiatives to encourage the early discharge home of patients. An intermediate care team (ICT) with which ward staff were more familiar had also been established, so many potential referrals to the CRT went to the ICT:

> Confusion all the time with ICT but again over the past oh gosh six months I suppose it has got better (4t).

So there were potential barriers to successful teamwork caused by unfamiliarity with the service. As one interviewee commented:

> One of the major issues is really that there are two things going on . . . the team setting up is one thing, and that is a whole big thing in itself, forget the project because the project is another thing entirely. What I think has happened is that they have tried to do the two big things together and really you have got to get one right before you start the other . . . where as if you have got a ready made team, no team is ready made, but a functioning team that had gone through its process of norming, storming and performing, then you have got a working unit, the unit can do the project. You can evaluate the project in isolation of all the other things that are going on (10t).

The team did however have an induction period of six weeks during which the project manager involved all staff in intensive team building activities to break down professional boundaries and hierarchies, and skilled staff in, for example, literature searching techniques, IT skills and basic tasks such as duty rostering. It would appear however that establishing this new service in a climate that was perceived to be rather hostile at times, was potentially disruptive to teamwork.

Factors facilitating teamwork

So at the same time as establishing a new service, the project manager and staff were building a team. Teambuilding is a significant task in itself. By the end of the evaluation the team appeared to be working well together, evidenced by the highly positive comments from patients (Luker *et al.*, 1999, personal communication), but it had taken much effort – and determination – to get there. Staff were asked what had helped to establish the team. One member of staff suggested, slightly pessimistically, that:

> I think . . . the thing that made us gel very much together at first was because everyone hated us! The hospital couldn't stand us, the community services couldn't, so if we didn't stay together I don't know what would have happened really so that was important (8t).

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There were, however, many contributory factors to the successful development of the team. An important strength of the team was that they shared a similar definition of rehabilitation and were therefore aiming for the same broad goal for clients, for example:

> Optimal independence is my definition of rehabilitation (8t).
>
> To me it's re-educating a person to be as independent as they possibly can (7t).
>
> Rehab to me is making them back independent how they was managing before (5t).

The team was providing a relatively narrowly defined service. This may have made it easier to arrive at commonly agreed goals.

Another strength of the team was that the team-building exercises that had been facilitated by the project manager had resulted in a marked lack of hierarchy within the team when making decisions about clients, for example:

> When we've all gone in and seen what the person's capable of doing then we feedback [to the team] and say 'they don't really need OT . . . they're fine, they can do all the things that they need to do to function'. They listen to the support workers you know so we're not pooh poohed, we don't know what we're talking about type of thing. So here I think the support workers have quite a bit of say, probably more so than they would in a hospital environment (7t).
>
> Everyone was open to any discussion you know. There wasn't that, well, I am and I think. You know anything could be thrashed out which is what you need (5t).

Hierarchical role boundaries had been eradicated where possible so, for example, the support workers had link roles with organizations in the community, they would complete the duty roster, or use library databases to seek out information to underpin practice. An important contributing factor to the lack of hierarchy was that the team wore identical uniforms irrespective of profession or role within the team (red polo shirts and navy trousers). During the induction week the project manager had sent them to a large department store to select their uniform. The project manager is convinced that the decision to dress the same as one another had a considerable impact on eliminating status differences within the team.

Finally, several of the staff mentioned the empowering management style of the project manager as important to the team's development. There was no hierarchical difference between the project manager and the staff:

> It's a long time ago (that the team was set up). I think what it was, was a different style of management than we've ever had I mean I've ever had in the hospital, much more honest style of management . . . when we all first started here we were given ownership of it really which is important you know we were sort of set out with just a desk and we devised our own documentation philosophies and all the rest of it really . . . We were also given a lot of information about health service politics which is very rare I mean in hospital you don't get to hear about something until it's happened because you know nobody feels it's your business anyway . . . A more honest style of leadership (8t).
>
> I think we've had good management from [project manager]. I think she's had a lot of faith in us as practitioners and yeah sort of instilled confidence in us when you know we're being knocked by the rest of the world. Yeah I think she's been really good (3t).

New services need product champions and staff need support. The project manager provided both and in doing so, empowered the staff.

Working across professional role boundaries

An issue that took much longer to resolve was that of working flexibly across professional role boundaries. The project manager was very clear that patient need would drive the service rather than professional role boundaries, and used a variety of techniques during team meetings to establish this principle. The issue of multiskilling was, however, a source of tension during the early development of the team. Letting go of certain parts of a role involved trust, which the team agreed takes time to build:

> Well first of all we had to trust each other and I don't think that was there for a long time . . . People were actually very protective

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> of their role . . . that person would be very upset if [a colleague] had gone about it incorrectly then hot words would be exchanged. What you do looks quite simple to other people doesn't it? Doing a figure of 8 bandage looks quite easy . . . Even sitting to standing is quite complicated . . . (11t).

By the end of the pilot project the team seemed to be committed to working in an integrated way and, in using patient need to define the service, most of the staff were able to use their full range of skills and had developed new ones:

> Well we all agreed in the beginning when it was said that we were all going to be more like generic workers we decided that we . . . need to hold on to our like key core role and skills but we could share various tasks so that if I'd done a kitchen assessment with somebody them someone else could practice what I'd recommended with that person. It wouldn't have to be me so long as it was left to me to interpret what had happened from that and assess for future things. And with nursing and physio things we could perhaps carry out an exercise with somebody so long as we fed back all the information and weren't trying to interpret how it had gone on . . . I think there's very good opportunities to use what skills you've got and to develop new ones (3t).

Another example of skills development of a multidisciplinary kind follows:

> At the moment it's kind of a dual role really. One of them is nursing assessments and . . . well nursing problems really. The other part of the role is going in as a sort of pseudo OT and physio really, going over whatever plan of care they've decided after their assessment, going in and helping people rehab . . . making cups of tea, making themselves meals, getting them used to walking outside with a frame, with a stick so yeah, find it very much an extended role really . . . Certainly it's affected the way I assess now, certainly my nursing assessment's been affected from it yeah (8t).

When a group of people are first brought together, irrespective of any difficulties associated with the work they are undertaking, a certain amount of tension is to be expected. As stated, however, staff were eager to convey to the interviewer that the team was now established and working well.

Discussion

In spite of the considerable problems reported in the literature with developing teamwork in the primary care setting (e.g., West and Poulton, 1997), it would appear from the data reported here, that the community rehabilitation team had overcome potential barriers and were working cohesively to meet patients' rehabilitation needs in the home. Returning to the commonly recognized barriers to teamwork there are many possible suggestions for why this might be. The problem of having separate employers that exists for most workers in primary health care did not exist for this team as they had the same manager. They were also housed in one office, under one roof, which is rarely if ever the case with other 'teams' in primary health care, so the communication difficulties encountered through geographical separation were not an issue. They were also a small team (eight members) which is recognized to facilitate teamwork (Poulton and West, 1999).

There were no marked differences in status and pay between the three professions of nursing, occupational therapy and physiotherapy, so this was another potential barrier that did not exist for the team. Also, for this group, their educational preparation was not dramatically different in either length or level as is arguably the case between, for example, general practitioners and their colleagues in primary health care. The team also had a relatively narrowly defined remit that may have made setting objectives and goals relatively straightforward (West, 1994). But the success of the team was not simply due to a lack of barriers teamwork. They had worked hard to overcome problems that either existed, or were potentially there.

The project manager had helped the team to break down any sense of hierarchy amongst themselves. This was reinforced by the fact that staff wore identical uniforms irrespective of profession or status within the team. The project manager used various techniques to ensure that all eight members of the current team felt equally valued

(Hayes, 1997; West 1994), that they had a voice and their opinions counted. So for example where there was no reason why a support worker should not be carrying out a role traditionally associated with someone of higher status, that person would be supported in doing so (West, 1994).

Perhaps the most difficult issue to resolve for the team was working across professional role boundaries. This is a recurring theme in the literature (e.g. Booth and Hewison, 2002; Furne *et al*., 2001; Molyneux, 2001), and was a considerable problem at the beginning of the project. Health care professionals are becoming increasingly used to unqualified – but nonetheless 'skilled' – colleagues taking on aspects of their work if adequately supervised. Nursing auxiliaries have been working in community settings for decades, and assistants to physiotherapists and occupational therapists are commonplace in acute hospital settings. Straddling professional boundaries is still a comparatively new concept however.

Recognizing the abilities of colleagues, potential or realized, and matching the skills of staff to the needs of the client/patient group is essential to teamwork in primary health care (West, 1994). It is arguably rarely achieved, with a few emerging exceptions such as integrated community nursing teams, some of which have managed to address the skills of team members and to break down traditional role boundaries (Black and Hagel, 1996; Furne *et al*., 2001; Gerrish, 1999). If individuals from the same profession find it difficult to work this flexibly then it is perhaps not surprising that those from different professions will find it challenging. The CRT appeared to be making considerable progress, however, in spite of initial difficulties.

For the community rehabilitation team, the problems they experienced seemed to be compounded by the fact that they were setting up a new service, and were still working out what they should be doing within their traditional roles. To paraphrase one of the interviewees (11t), it takes trust to allow staff who are either unqualified or qualified in different disciplines to take on aspects of your role. This, she considered, took a long time to build. It has been argued (Gibbon, 1994) that community nurses have rarely if ever been involved in rehabilitation in the past. If this is the case, a completely new way of working is required, which will not happen overnight.

Conclusion

So what can be learned from the community rehabilitation team about teamwork in the primary care setting? A potentially generalizable lesson is that in circumstances where the majority of barriers to teamwork such as geographical distance from one another and separate employers can be eradicated, in spite of the current emphasis on flexible working practices in primary health care (Department of Health, 1996a; 1996b) working across professional boundaries takes longer to achieve. Yet mixing and matching skills to meet the needs of the client group is a vitally important component of teamwork. Flexible working in most of primary health care remains in its infancy.

Another slightly contentious interpretation of the data concerns the differences in status that arguably exist in primary health care. The medical profession continues to dominate primary health care (with the term 'primary care' often used synonymously with 'general practice'). This has been perpetuated in the past by GP fundholding, and continues to be, by the underrepresentation of nonmedical health care professionals on primary care group/trust boards. Teams such as the CRT who are led by nonmedical personnel and who draw on medical opinion when necessary begin to address this imbalance of power. Similar claims can be made for the Primary Care Act pilots where GPs are salaried and some employed by nurses. In relation to integrated community nursing teams Gerrish (1999: 374) draws similar conclusions:

> Integrated nursing teams may provide a means whereby nurses can assume a more prominent role. The sense of empowerment engendered through establishing a collective voice on nursing issues and acting with greater autonomy may provide nursing with the opportunity to realize its potential contribution to the future development of primary care. Paradoxically, by stepping aside from the traditional hierarchy inherent in the PHCT, integrated nursing teams may provide community nurses with the opportunity to be more influential.

A final important message for other newly established services delivered by teams of health care professionals, is about the potential difficulties

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associated with setting up a new service and a new team concurrently. Although it would be a luxury in the current economic climate to spend much time building a team before setting the task, this may well be the ideal. Failing that, the importance of teambuilding activities during the early stages of the development of the service should not be underestimated.

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