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Research paper

Community nurses' perceptions and experiences of protected learning time: a focus group study

David E Cunningham BA MPhil FRCGP
Associate Advisor in Continuing Professional Development

Diane R Kelly MD FRCGP
Assistant Director in Continuing Professional Development

NHS Education for Scotland

ABSTRACT

Background Protected learning time (PLT) has spread quickly to primary healthcare teams in Scotland. Previous research has shown that PLT is generally well received, but that different professional and occupational groups have differing perceptions and experiences of PLT. Community nurses have low rates of attendance at practice-based PLT in NHS Ayrshire and Arran. It is not known why.

Aims To explore and understand the community nurses' perceptions and experiences of PLT, and to discover the barriers to their attendance at practice-based PLT.

Design Qualitative study involving four focus groups of 37 community nurses.

Setting Three community health partnerships in one NHS health board area in Scotland.

Methods Focus group interviews were conducted, audio-recorded and then transcribed. Transcriptions were analysed using a grounded theory approach to data analysis.

Results Community nurses often had separate learning events at PLT, and were not involved in the processes of learning with the general medical practice. Chosen topics were often irrelevant to them and their attendance was low. Learning was often uniprofessional. Community nurses perceived they did not have adequate protection from service delivery during PLT. They felt that practice managers had a key role in the delivery of PLT, and that team working and team learning were important, and useful if done well. They considered that the new contract had had a negative impact on PLT.

Discussion Community nurses need to be involved more in the learning process, if PLT is to be relevant and useful to them and the practice. Nursing managers may need to increase the service protection for community nurses in order to allow them to learn with the rest of the primary healthcare team. Those who organise PLT at primary care organisation level may have to consider using independent facilitators to effect changes.

Keywords: primary healthcare teams, protected learning time, team-based learning, teamwork

How this fits in with quality in primary care

What do we know?

Protected learning time (PLT) is an established resource for primary healthcare teams to enable learning that is protected from service delivery. Studies have shown that PLT is generally well received but that different professional and occupational groups have varying perceptions and experiences of PLT. One area in Scotland has shown that community nurses are infrequent attenders at practice-based PLT events, in contrast with other members of the primary healthcare team.

What does this paper add?
This qualitative study identified a range of issues that helped understand the perceptions and experiences of community nurses. Participants identified barriers that prevented them attending practice-based PLT events. These barriers included a lack of shared learning needs assessment, which resulted in irrelevant learning topics for community nurses. Nurses also identified that the atmosphere at practice-based events did not help learning, and that the new GP contract had unduly influenced learning topics. Some nurses perceived that they were not protected from service delivery as much as was needed.

Introduction

Protected learning time (PLT) is an established resource for primary healthcare teams (PHCTs) and primary healthcare organisations, to enable learning that is protected from service delivery. Starting in England in 1998, followed by Scotland in 1999, PLT has spread quickly throughout Scotland and is available in the majority of community health partnerships (CHPs).[1,2] CHPs are local primary healthcare organisations that aim to work closely with social work departments and other community agencies.

Research has shown that PLT is generally well received by PHCTs, but that different professional and occupational groups have varying perceptions and experiences of PLT.[1,3–8] PLT has been shown to improve patient care across a large locality.[9] PHCTs can use PLT to implement changes that bring about developments and new services for patients.[10]

PLT commenced in NHS Ayrshire and Arran in 2001. NHS Ayrshire and Arran has three CHPs; each organises a PLT scheme. CHPs arrange between six and eight PLT afternoons per year, the majority being practice-based PLT (PB-PLT), where teams plan and prepare their learning. Almost all general practices and community nurses are included in the schemes. A survey of practice managers in 2006 indicated that community nurses were infrequently attending PB-PLT, in stark contrast with other members of PHCTs.[11]

Community nurses in NHS Ayrshire and Arran are employed and managed by CHPs and are currently attached to specific general practices. New proposals by the Scottish Government's Department of Health may change this model of working to that of locality based teams.[12,13]

Set against this background, the aims of this study were to explore and understand the community nurses' perceptions and experiences of PLT, and to discover the barriers to their attendance at PB-PLT.

Method

Study sample

Community nursing managers estimated that their nursing teams consisted of over 200 individuals. A small number were attached to practices (two out of 57 practices) who did not take part in PLT. Some specialist community nurses did not attend PLT.

Recruitment

Initially, recruitment was purposive but later became theoretical, in keeping with a grounded theory approach.[14,15] Stratification was used to include different roles within community nursing teams, e.g. district nurse, health visitor and staff nurses. Stratification involved the three CHP areas of North, South and East Ayrshire. Community nurses were identified and recruited by nursing administrative staff. The process was independent of nursing managers. Recruitment stopped when focus groups had reached a limit of ten participants per group. Auxiliary nurses were included laterally, to expand theory generation.

Focus group interviews

The focus groups were moderated by the first author, who was unknown to the majority of participants. He had received training in focus group moderation. An interview guide was used to structure the discussion, but groups were free to discuss any topic they considered relevant. The guide (see Box 1) was drawn up after discussion with a convenience sample of community nurses, and as a result of previous studies of PLT.[5,6] The guide was iterative; the discussion of earlier groups resulted in changes to the guide for subsequent groups.

Anonymity and confidentiality were assured, and participants were encouraged to be frank and honest

Box 1 Interview guide

- What are your experiences of protected learning time?
- What can prevent attendance at PB-PLT?
- What are the barriers for learning at these events?
- Has the new general medical services (GMS) contract affected what happens at PLT?
- How could PB-PLT be improved?

in the discussion. This was helped by most participants being well known to each other. Three out of four groups were held at area team meetings. Contemporaneous field notes were taken at each group by the first author.

The meetings each lasted approximately 60 minutes, and were audio-taped, with permission, using a digital machine. The audio files were sent to an independent transcriber and subsequent transcripts returned to the first author. Transcripts were checked against the original audio-recordings and corrections made.

Data analysis

Data analysis followed a grounded theory process. Transcripts were analysed before further focus groups were held.[14,15] Transcripts were read and re-read by the first author, and line-by-line codes were developed. Codes were compared with earlier ones, and comparisons made with codes from other groups, following the constant comparative method. Memos were written to help analysis and expand categories, and field notes were studied to consider the atmosphere at focus groups and to recall non-verbal communication of participants. Recordings were also replayed to listen to participants' tone of voice and pauses.

The results of the study were sent to all participants for verification.

Results

Four focus groups, involving 37 individuals, were held from March to July 2007. Three groups were uniprofessional, two were of district nurses and one of health visitors. The fourth group was mixed and included auxiliary staff. Groups ranged from seven to 11 participants. Each CHP held at least one focus group. Recruitment for further groups was halted after the fourth group when data saturation was achieved.

Six main themes emerged from the data (see Box 2).

Box 2 Emergent themes

- Varying levels of inclusion of community nurses in the process of learning
- Fragmented uniprofessional learning
- Lack of protection from service delivery
- Important role of the practice manager
- Team working and team learning
- The impact of the new GMS contract on PB-PLT

Varying levels of inclusion of community nurses in the process of learning

It seemed common for community nurses to learn separately from the rest of the PHCT at PB-PLT. There were numerous barriers that they felt prevented them from engaging in shared learning with the PHCT. Community nurses often felt excluded from the process of identifying learning needs, and some felt distant from the PHCT when they did attend PB-PLT, usually in the practices' premises.

It was perceived that in the early days of PLT the learning topics had seemed relevant, but this had decreased as PLT progressed. Community nurses felt they were consulted less and less by practice managers about what their learning needs were. There was little evidence of any systematic process of gathering learning needs for all members of the PHCT. Attendance by community nurses at PB-PLT events had fallen off as a result.

> 'I would say it's a lot of the time, it [PB-PLT events] is not aimed at our group, the district nursing group, and a lot of it is either aimed at, well, different disciplines. Some of the ones that we went to were mainly aimed at sort of GPs. So there was no relevance at all to the district nurses, so you sat there for about an hour and a half not really understanding what was getting discussed. So as far as I was concerned that was a bit of a waste of time.' (Group 2, participant 4)

> 'We have a very pro-active practice manager, but she sees that [PB-PLT] as an afternoon for her staff. And sometimes we are her staff and sometimes we are not. So she takes the majority, how useful it would be for the majority. If it suits us then we tag along, and if it doesn't, you're left, you are kind of out on a limb. Apart from a few of us who have been asked by line management, I have never been asked what I would like to learn and give my ideas.' (Group 2, participant 9)

Participants alluded to the atmosphere at PB-PLT events. They considered it was very important to feel welcomed by general practitioners (GPs) and the practice manager, especially when events were held in practice premises. Some felt that when they attended PB-PLT they were not truly integrated

members of the PHCT but were visiting the practice solely for PLT.

> 'I think there is still that chasm between ... [pause] I can talk from [name of practice], yes we know each other but because we're not on the same premises it can be quite difficult because you're signing in [signing the visitor's register at practice reception]. I'm bringing my team in, the last small event I actually spoke to the girls in the practice about the role of the district nurse and they were asking me questions about why we did what we did, and it was a really good session. We just actually started just asking me questions, and good interaction but my team were sitting back quiet. They look at it sometimes as a chore and they feel a bit uncomfortable; going into the practice.' (Group 4, participant 11)

These perceptions and experiences raised the concept that community nurses did not always feel they belonged in some practices, and that being in the practice was not a common occurrence.

For some, there were feelings of intimidation when they attended PB-PLT, and this was felt mostly by junior members and reported back to senior nurses. Most of these perceptions concerned their interactions with GPs.

> 'What I find sometimes though is for those of us who are well used, if you like, to dealing with GPs it's [PB-PLT] fine. For some grades of staff who perhaps are less so, then I think it can be quite difficult because I think it can be quite intimidating and I don't always see a great camaraderie there [at PB-PLT], and I think that's very intimidating. I think it's alright probably for most of us round this table, who are fairly senior, but for some of the junior members of staff I think they are extremely hesitant and I have seen people taking annual leave because they feel intimidated by them. You're not really welcomed by other disciplines if you like.' (Group 4, participant 3)

Team leaders reported that junior members felt considerable pressure from nursing managers to attend PB-PLT. It became preferable for them to use annual leave to avoid attending PB-PLT because of their perceptions of intimidation.

Participants raised concerns that there was not enough recognition of the diversity of staff roles within the community nursing team. Auxiliary members felt that much that was discussed at PB-PLT did not match their needs.

> 'I feel it personally, as being, as what you're talking about [group participant], as being an auxiliary nurse and the general feeling of the nursing auxiliaries well most of us are part-time workers, we're not full-time workers so you know it's always in the afternoons and a lot of us have our own personal things that we have to do in the afternoon. So therefore that's why quite a few of the girls don't come. But also I think I agree with you 100% that we feel that a lot of it is just totally irrelevant to our job and we feel that a lot of what's been going on is over our heads.' (Group 4, participant 8)

When topics were selected on the basis of others' needs (often the GPs, or the need to prepare for the new contract), community nurses felt neglected and isolated from the team and decided that attendance at PB-PLT was not a good use of their time. They were keen that if PB-PLT was to continue it should return to being multiprofessional in style, and reflect the learning needs of all the PHCT.

> 'I think that I have got a good team, and I think that if something was organised, like another team event that we were at, like the one that we were at, at the end of last year, that would have been a good protected learning. When we are all together as a practice, whereas it has all fallen away by the wayside.' (Group 1, participant 6)

There was a degree of passivity in the community nurses' thoughts on who was responsible for planning and preparing their learning at PB-PLT. Some thought that topics would be identified by others, usually the practice manager, and that an educational event would be delivered in consequence.

> 'And we used to have things organised for us, ideas would come up and someone would fix it, but last year mostly I noticed that if I didn't find something for us to do then there was nothing. I had to find something for my own staff to be involved in. Because there wasn't always something else that was of interest or useful.' (Group 1, participant 7)

Other community nurses saw the importance of being active in their learning, and especially appreciated events where they interacted with other members of the PHCT. They preferred this method of learning to didactic lectures from specialists.

> 'But incorporated in that are workshops, as far as I am concerned, for us all to learn, and this idea that you are getting spoken to all of the time, and not interacting with other people in the group. There are things that I would learn, that I would find more useful. There are ones there but they are not always appropriate to our needs. And a lot of the times that I find that there are not as many GPs that go, that there are nurses, so for each of the groups there should be GPs. There should be a proper mix of GPs, nurses and clerical staff, making it clear that they are all getting protected time.' (Group 1, participant 8)

That PB-PLT offered poor learning was not the experience of all community nurses. Participants perceived that when learning met their needs and was interactive, particularly with the rest of the PHCT, then it proved to be useful for them.

> 'It is good [PLT] and I have always thought that it should be good, and a lot of them are, because the topic is good, the subject is really useful to us as district nurses, and we get to meet, at the bigger ones we get to meet other people. And as it is, even now, we did a small one separate from the big one that was on yesterday, and it was really useful.' (Group 1, participant 8)

Fragmented uniprofessional learning

As PLT evolved, the community nurses learned that PB-PLT was unlikely to be relevant to them. As a consequence, more of their PB-PLT events became uniprofessional in nature, organised by the nursing managers and detached from the PHCT. Subsequently practice managers became aware that community nurses would not be attending PB-PLT, and events were planned that were unlikely to be relevant or valuable to community nurses. Thus, PB-PLT fragmented into several distinct events. This was not always what the community nurses would have preferred and was not what they perceived PLT was designed for.

> 'So I think that it must be very difficult, but initially they [PB-PLT] were very good because they were new and the topics were interesting. Then I think that the practices lost the kind of role where they were bringing everybody together to have these in the practice. The [district] nurses would be doing something, the CHP would put on something for health visitors, so they went away to that, and it was all very fragmented and disjointed, and that is what has happened in the last year or two, that is what has happened to protected time. Everybody has been able to do something on their own or not. Or join up at a big event that's on, or there are two events on. The one yesterday was not a central event it was actually just organised by the CHP laterally, practices had already organised things. So none of our GPs were at the thing yesterday.' (Group 2, participant 8)

A minority of community nurses were not attached to any particular practice, and for them attending PB-PLT was very difficult. They did not feel they belonged to any specific practice or welcome to attend any practice's PB-PLT.

> 'The problem that I have got with the practice-based PLT is that I am not allocated to an actual GP practice. I kind of work geographically. The bulk of my work is done with one practice but they are within an another area.' (Group 2, participant 7)

When community nurses got together for uniprofessional learning, which had replaced PB-PLT, their learning needs were often difficult to identify and collate. Health visitors were able to make suggestions to nursing managers, but often these were not transformed into learning events.

> 'Well we were asked a couple of months ago, one of the line managers asked us to go to a peer group meeting and pick topics. So we chose topics and we handed it in, but they wanted more broad topics, and we thought ''No! This is what we want'', which would help us. But they don't seem to be listening. They want a broader subject matter and we are thinking ''No! We want court skills'', we want pertinent things that actually on the ground affect us.' (Group 1, participant 3)

Lack of protection from service delivery

Community nurses felt aggrieved at the lack of protection from service delivery they perceived they had for PLT afternoons. Participants felt that the out-of-hours service and NHS 24 (the equivalent of NHS Direct in Scotland) covered emergency calls for the practice, but that there were not enough resources available or arranged to adequately protect them. There was variation in this cover between CHPs. One CHP focus group felt that the arrangements for them were quite satisfactory, in contrast with the other two CHPs.

Health visitors were infrequently called back from PLT events to see patients, but district nurses regularly reported the need to return to attend to patients, especially those with a terminal illness, or on nurse-administered insulin.

Some community nurses alluded to the difficulties of not knowing if there would be any cover for them until shortly before PLT was due to start. District nurses felt that in order for them to cope with this uncertainty, and in order to attend PLT, they had to condense the day's workload into the morning session before PLT began.

> 'Because there is no staff to cover, so the protected element of it, it is fine if you are a GP, because ADOC [out-of-hours provider] will take over your calls and your visits, full stop. Your nursing service, if you do not have a nurse to cover, then you are picking up your diabetics, and your terminals and you have no one to cover your afternoon.' (Group 2, participant 5)

> 'Well, I think the idea [of having PLT] is a good one, however I don't think protected is the right term because finding time in practice, protected time to escape from practices is not honoured locally. It's a struggle because you need to think about staffing, staff cover and that's not easy and I think it's a bit of a struggle to find the bank cover. And so it's quite a stressful event because you run around like a headless chicken in the morning trying to get everything done, just to escape for the afternoon.' (Group 3, participant 7)

District nurses considered that they arrived at PLT events tired and worn out by the increased workload of the morning, and not in an appropriate mood to concentrate and focus on learning.

District nurses in particular, expressed their perceptions about the inequality of resources used to provide the protection from service delivery during PLT. This, they felt, contrasted strongly when compared to the protection they perceived was arranged for GPs. This resentment compounded the upset caused by their lack of significant involvement in PB-PLT. They concluded that PB-PLT was centred

on the needs of the practice, and in particular the needs of the GPs. This made them feel at the periphery of the practice and the team, and they felt included in PB-PLT not as a necessity, but as an afterthought. Their attendance was perceived as being considered neither crucial nor needed by the remainder of the PHCT. Thus, various factors acted in concert to discourage their attendance at PB-PLT. Some feelings were also vented towards community nursing managers, as community nurses felt they could have done more when attempting to organise protection for their attendance.

> 'Initially management took responsibility for, they had set staff that would do it and that seems to have gone because they have jobs in other places and things and then the next thing it's down to individuals to arrange cover.' (Group 3, participant 2)

In contrast, health visitors had accepted their inability to attend, more so than their district nurses colleagues had:

> 'Well I have just kind of accepted it, that that is the way that it is. If the work has to be done, then I just feel that it has to come before protected learning. I probably feel that we get enough opportunity for study days and various things in practice, and things that you need to know, and I probably don't feel that deprived by it really.' (Group 1, participant 4)

Health visitors expressed various reasons to explain this acceptance of not being able to take part in PB-PLT regularly. Some felt that they had good opportunities to learn on their own or with their health visiting team. They considered that their nursing managers were very supportive of their individual and health visiting team's learning needs. Others felt that they were not missing anything of value. They considered it preferable to carry on with their normal workload.

Their previous experiences of learning, where they had learned in an environment away from work, had caused some difficulties for health visitors when they attended PB-PLT. They often found the practice setting distracting, and although they were not actually working, they could not divorce themselves from being at work.

> 'But I don't think that in the practice you can relax. It is your workplace. I don't know if anyone else feels that way, but it is not really like you can. As if you can relax because there are still parts of the surgery open, so you have got people coming in and out. And if you happen to go out of the room and you have a patient speaking to you. It is quite distracting.' (Group 1, participant 3)

> 'Yes, but there is always that element that you are still at work, and they are saying: ''Oh! Remember to see such and such!''. And you get your diary out and you start to write things down. And you still feel that you are really not there [in a learning environment].' (Group 1, participant 10)

Important role of the practice manager

Community nurses felt that the practice manager was the key individual in the planning and preparing of PB-PLT. The practice manager was important in gaining their involvement, not just by arranging PB-PLT which included them, but in the development of an organisation that valued and fostered team work and the roles of the different individuals in the PHCT. He or she was instrumental in setting the tone and atmosphere for the PB-PLT event. This encouragement could range from a simple invitation to attend, or to informal discussions with them to find common learning needs.

Community nurses recognised that the GPs would have an important influence on the practice manager's behaviours, but that ultimately it was the practice manager who nurtured team working.

> 'Because likewise there are practice managers who will say: ''Well you are more than welcome to come along to what we have got on, or is there something else that you have got to do? Has the CHP done something else?''. And then there are other ones who will not let you know what is going on.' (Group 2, participant 6)

Some participants were quite specific when describing desirable behaviours of practice managers in order to have quality PB-PLT.

> 'She asks. She asks people, what they need to learn. What she does is speak to people. She'll speak to the health visitors, speak to the district nursing team. She'll speak to the practice nurse, she'll speak to the clinical and admin. Speak to the GPs, what are we needing, what do we need to work with?' (Group 4, participant 6)

Relationships between community nurses and practice managers varied. Community nurses appreciated practice managers who strove to include them in the learning needs assessment and also in the PB-PLT events themselves. Participants were realistic about the burden of planning and preparing PB-PLT for the entire PHCT, and there was a feeling that on occasions practice managers felt exhausted by this task.

> 'We discussed what would be relevant for nursing, health visitors, your admin. support staff, and they seemed to have done all of that, not that you are going to get to the point that you know everything. But then it is down to the practice managers, who were, I think the ones that were organising it, and they said, ''Well we have done that, *so* it is up to each discipline now to say what they need'', and they will then try and slot you in. That is what is happening.' (Group 2, participant 6)

Participants had insights into the roles and responsibility of practice managers, and were aware that they were employed by GPs and had to take this into consideration when planning and preparing events at PB-PLT.

> 'But I think as you say, the lead person within most of the practices is the practice manager, and his wages are paid by GPs. He is not really responsible for your students, your health visitors, your district nurses, and all of these clinical support workers and all of the rest that comes along with the title of nursing. So it is not that they are looking after their own, they are meeting the agenda that they need to achieve for their specific [practice].' (Group 3, participant 2)

Team working and team learning

Community nurses were clear about what they thought were useful and relevant topics for all members of the PHCT at PB-PLT events. There were considerable descriptions of what good events had happened in the past. Highly valued events tended to regard 'the team' as the study topic, in contrast to learning about a common clinical or non-clinical topic together. Team-building events were perceived as being very useful and relevant to all of the PHCT.

> 'I think there was a team building one, at the [local hotel and conference centre], towards the end of last year, and those are the best ones because they are facilitated and they have workshops, and a mixture from admin right up to your senior partner, and such a lot is achieved there, and that's a really good day. The working of the practice and what the problems are, and I think that that is what it was about. Not just hearing about multiple sclerosis but how you function as a practice, what are your problems, how you gel together and things like that.
>
> But someone did say; ''Well I think that it is a waste of government money, your whole practice going along to this hotel, and staying all of that time'', but it was really, really good. Because everyone in the practice was there, and they were all involved and you got to hear about the things that upset other people, or are good for other people.' (Group 3, participant 1)

Participants regarded independent facilitation as being very important for team-building and team-working events, particularly when delicate analysis of team working was to be done. They viewed independent facilitators as working for the team in general, in contrast to practice managers who they viewed as not being completely independent of a key component of the team – the GPs.

Good team relationships were so important that some would consider asking their nursing manager if they could move out of a practice if they had a poor relationship with the rest of the PHCT.

> 'I definitely wouldn't stay in a practice where I did not feel part of the team. And you could say that about a lot of GP practices. But I like where I am, and you get the best out of a person if ... [pause]. I would hate to be, I wouldn't stay in a practice that I didn't feel part of it.' (Group 1, participant 2)

There was disappointment when team-building events did not result in persisting change in attitudes and behaviours in the practice. Some alluded to confidential significant event analyses (SEA) where participants shared personal thoughts on important events which had caused, or had the potential to cause, significant problems for the PHCT, and for patient care. Their hopes of more intimate and closer ways of working with their GP colleagues were dashed by their perceptions of some of the GPs' attitudes.

> 'It is very sad, and then when everything is all rosy, and everything else, then we do a significant event and everything is just hunky-dory, and then the next day they [GPs] just walk past you and you think, ''what is this all about?''. And I think that is just human nature, and I don't think that protected learning time will remove that.' (Group 1, participant 8)

Opinions were expressed that this example of an SEA was not true learning that benefited the team or improved team working in the long term. Community nurses felt that some practices regarded taking part in an SEA as being a 'tick box exercise', that is, something that was undertaken to increase performance for the new GMS contract, and that any motivation to improve team working and patient care was secondary to this. Participants perceived it was unlikely that PLT by itself could create a team-working spirit within a PHCT. PLT may strengthen teams, but there must be some degree of existing team working for PB-PLT to be a success.

A prominent subtheme was the need that participants had to be recognised by the rest of the team. Some health visitors felt distant from the practice and could be angry and upset if their work was not visible or known to the others, in particular the GPs. This seemed pertinent to PLT, as participants considered that if there was little known about their roles, there would also be little known about their learning needs. Some participants were angered by their perceptions that others held about their work:

> 'Because it is obvious what I do. It really is, I have worked in a practice for a few years and they must know what I do. I do an immunisation clinic for them, I do a weight-wise clinic for them, I do a smoking-cessation clinic for them, I also do a developmental session with them.
>
> And then they tell me that they don't know what I do! They are not that thick! [laughter from the group]. No! I find it quite disgusting because I honestly heard years ago that GPs do not know what health visitors do, we have got to make ourselves more upfront and all of the rest of it.

> But I really thought that these days were long gone.' (Group 1, participant 2)

Paradoxically, some community nurses wanted to learn more about other team members, and their job roles. Health visitors considered that they were not clear what practice managers' roles and responsibilities were. Some participants felt that this topic of exploring each others' roles and responsibilities was an ideal learning subject for PLT and that this may foster closer working. Participants reflected on previous PB-PLT events when team members had informed each other about what their key job roles and responsibilities were.

> 'But no it was a good idea, because it did give you an insight into what all the members were doing, and you didn't really appreciate that before. It was quite good.' (Group 1, participant 7)

> 'And you can see the difference it makes, you know, it's definitely a closer primary care team. Yeah, you know what *you* do, they suddenly realise what a district nurse does with no disrespect to them, but they ... [pause] so there is a completely different sort of way that you work. It's definitely more of a team.' (Group 3, participant 1)

The impact of the new GMS contract on PB-PLT

Community nurses perceived that the introduction of the new GMS contract had a major impact on what happened at PB-PLT. For some practices, this had dominated the learning agenda at PB-PLT, and made community nurses less likely to attend. Participants felt that some PB-PLT was used by practices to put the new contract into operation and to plan in detail what team members would be doing to improve the practice's performance. Some community nurses felt that practice managers had changed; they had lost their focus on the PHCT, and had become business managers under the new contract.

There were perceptions that the new contract had changed relationships between the practice and community nurses, and that they were being asked to do new work purely to improve the earnings of GPs.

> 'I think it [new GMS contract] has certainly had an effect. Because it is all down to how many points, and they make prizes, and then that gets them money so yes it does [affect PLT].' (Group 2, participant 7)

> 'Because as [group participant] said earlier, protected time to begin with was really good, and it was useful. There was a lot of interesting and varied topics, but then when you come to the end of that, and they get hit with contract work and they think: ''Well, we will use that time to get the contract work sorted out''. And it has just sort of fallen by the wayside since then.' (Group 2, participant 9)

This change particularly affected work relating to health promotion and chronic disease management. Health visitors recalled that practice managers had made requests to them to start or increase the number of these clinics within the practice, with the aim of increasing the practice's performance with the new contract. There was a degree of suspicion among the community nurses that attending PB-PLT would result in them being allocated further roles for the new contract.

> 'I think we would be wary of that certainly [attending PB-PLT if the learning agenda included the new contract]. That our agenda might not necessarily be the same as the GPs', it's more about service provision but it's not necessarily about ticking boxes for financial incentives.' (Group 3, participant 9)

Although some health visitors agreed this new work was within their job role, they had concerns about how other parts of their workload would be affected. In particular they were anxious about issues relating to child protection work, and the statutory duties that that included. They considered child protection work was relatively unseen by practices but was high on their own agenda. Increased contributions to the workload of the new contract often left them feeling stretched when their colleagues were absent. Some of the health visitors described feeling coerced and pressurised to conform to practices' requests.

> 'It is what it is all about really, and where they want us to ... Instead of just emailing us the part that involves you: ''we want you to set up this clinic'', almost to the point where it is bullying to set up a clinic. So if it is a stop smoking clinic, and you know that might be the health visitor's role, but do you have the resources? And once the clinic is established it is set in tablets of stone within a surgery, if you try to withdraw that service, if you have got lack of staff, and you will find it very, very difficult. So we wouldn't put the service in, in the first place because of staffing and because of the ratio of staff and things like that, but you have to fight your corner really.' (Group 1, participant 1)

Participants felt isolated and exposed at PB-PLT and when visiting the practice in general. Health visitors could feel, because of their relatively small numbers per practice, vulnerable to the practice's demands. There were expressions of feeling unprotected by colleagues and nursing managers.

> 'You find yourself saying, ''Whoa! Slow down! Let's have a discussion about this''. That is the time to discuss our responsibilities for the whole. Our line managers are sitting down here [CHP offices]. And we're based in a practice up there. But when they [practice managers] see us every day, they think, ''Could you do this, could you do that?''. And that then impinges on everything else. But as you say that is where we need to discuss our roles and our responsibilities.' (Group 1, participant 3)

Alternative views about the impact of the new contract were expressed by participants. Some recognised that practices were tasked with the delivery of quality care,

especially when that involved the workload of chronic disease management. Participants felt they needed to know more about the new contract and what impact it had on practices and patient care. For a minority of participants, helping with the new contract was welcomed and they argued it strengthened their role and links with practices.

> 'I think it's just interesting to hear, you know to actually get it from somebody actually saying "this is what the GP contract is. This is how it affects practice income". I'm already asked "can you help out?". Well, we already do that, we already do that which means that they have gone and consolidated what we did and strengthened that bond a bit more with the practice.' (Group 4, participant 8)

Box 3 Recommendations for the future of PB-PLT

- Integrating community nurses into the processes of learning may improve their attendance at PB-PLT.
- Nursing managers may need to increase the level of service protection for community nurses, especially district nurses.
- Primary healthcare teams should spend time on team building, and understanding and appreciating each other's roles.
- CHPs should consider developing a team of facilitators to enable team building and learning together.
- Policy makers should consider the reorganisation of community staff into localities, and the effect this will have on collective learning.

Discussion

This study aimed to explore and understand the perceptions and experiences of community nurses, and to discover some of the barriers that prevented attendance at PB-PLT. These aims were achieved. Data generated were rich and descriptive, and add to the depth of understanding of what is known about PLT.

There were a number of strengths to the study. Participants had considerable experience of PLT. They were attached to many different PHCTs in three separate CHPs, and thus were able to give diverse insights of PB-PLT. A range of community nurses gave their opinions, from team leaders to auxiliaries. The moderator of the focus groups (the first author) was known to only a few of the participants and this may have encouraged frankness and honesty. We were satisfied as a result of what was said, that participants spoke freely and without fear, about many sensitive and difficult issues.

Participants were asked to verify if the key themes that emerged from the data were representative of their discussions. Seven out of the 37 participants responded, and all agreed that they were. Participants were able to consider PLT for the years before and after the introduction of the new GMS contract.[16]

There were limitations to the study. The data were analysed by the first author only; using two or more analysts may have resulted in different or further themes being identified. The research covered only one health board area in Scotland. PLT may be different in other areas but these findings should still be of general interest.

The study has identified various recomendations for the future of PLT (see Box 3).

PB-PLT worked best in PHCTs where community nurses were involved in the various processes of team learning. If community nurses can be involved when teams identify learning needs, and plan and prepare in collaboration for PB-PLT, then this should increase the learning potential for community nurses and also for the PHCT.

Community nurses have highlighted the need for independent facilitation at learning events that focus on the workings of the team. They considered it greatly improved the quality of learning at these events. This finding is in keeping with other work which highlighted the importance of independent facilitation at practice development meetings that produced improvements in practice.[10]

Community nurses had some reservations about the independence of practice managers at PB-PLT events. CHPs may need to consider using resources to train PHCT members to become facilitators, who may then work for their own or for other teams in a reciprocal manner.

There are implications for policy makers in considering the findings of this study. Community nurses placed considerable value on being attached to PHCTs, and valued working in a team where there was mutual respect and good communication between professions. They also appreciated when their work was visible to practices and when they were genuinely involved in making changes to practice working.

Policy makers may need to rethink their proposed changes in organisation of community nurses from their current attachment to practices, to that of geographically based teams.[12,13] Moving to nursing teams that are based on localities may further weaken the links between community nurses and practices. This would have a negative affect on PLT; participants in this study who were not attached to any PHCT rarely felt able to attend PB-PLT. Research from the 1980s emphasised the importance of communication between clinicians within the PHCT, and stressed the importance of interprofessional meetings.[17] This study

has shown that for some teams, learning together at practice-based meetings may not be a regular occurrence, implying that, for some, little has progressed in 20 years.

Other issues have been raised by the introduction of the new contract. Recent quantitative research has examined the factors that may influence a practice's performance in the new contract.[18–20] Edwards and Langley have raised some concerns about how the new contract has affected the relationship between general practices and community nurses.[21] This study adds further evidence to their conclusions that the new contract has created strains between the professions in primary care.

Boudioni has brought attention to the impact of the small business nature of general practice on lifelong and team learning, and this study corroborates some of their findings. Although Boudioni has argued for the need for teams to have PLT, it may be that time alone is not enough for all PHCTs to make full use of it.[22] Rushmer and colleagues have argued that leadership from nursing managers and GPs is needed to make practice learning successful.[23] This study suggests that leadership from practice managers is important to make the most effective use of PLT.

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ETHICS COMMITTEE

This research project was submitted to and approved by NHS Ayrshire and Arran Research Ethics Committee on 22 December 2006, protocol No 06/S0201/60. It was also approved by NHS Ayrshire and Arran Research and Development Governance committee.

CONFLICTS OF INTEREST

The first author is the chairman of North Ayrshire CHP PLT steering committee and is a member of East Ayrshire CHP PLT steering committee. He is also a GP in North Ayrshire. The second author has no declared conflicts of interest.

ADDRESS FOR CORRESPONDENCE

David E Cunningham, NHS Education for Scotland, 2 Central Quay, 89 Hydepark Street, Glasgow G3 8BW, Scotland, UK. Tel: +44 (0)141 223 1400; fax: +44 (0)141 223 1403; email: davidecunningham@wightcablenorth.net

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