

Research paper

Practice managers' perceptions and experiences of protected learning time: a focus group study

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ABSTRACT

Background Protected learning time (PLT) has become an established method of learning for many primary care teams in the UK. Considerable resources are used to provide protected time for practice teams to enable them to learn. Members of the primary care team appear to value PLT differently, and the reasons for this are unclear. The aim of this research was to explore the perceptions of practice managers towards PLT.

Method A qualitative community based study using three focus groups of practice managers from semi-urban and rural general medical practices within three local healthcare co-operatives (LHCCs) in Ayrshire, Scotland was undertaken.

Results Managers perceived that PLT was of benefit to the team, and gave examples of how the team had learned from each other and from neighbouring teams. This learning was welcomed by managers. An emerging theme was the level of involvement of the pharmaceutical industry in the planning and provision of team-based learning. There was also some confusion over the responsibility for providing

learning for attached staff such as health visitors and district nurses. Managers wanted clearer guidance on how to develop educational events for their teams. They wanted to improve communication with the LHCC on evaluation feedback and developing a resource database. Managers also felt that they were working during the PLT sessions, rather than learning, and that they should have additional training to compensate.

Managers need more support with the planning and preparation of PLT sessions, which they undertake on behalf of the primary healthcare team. Improved communication with the managers of attached staff would encourage full attendance at meetings. Practice managers and LHCC managers need to build a stronger network to develop PLT further. Improved funding by primary care organisations would reduce the involvement of the pharmaceutical industry.

Keywords: primary healthcare, team-based learning

Introduction

In 1998 the Chief Medical Officer gave several recommendations in his report on general practice continuing professional development (CPD).¹ His recommendations included making learning a participative rather than passive process, and that learning should

be multi-professional when appropriate. He also recommended that learning should be centred on personal and practice development plans to improve patient care.

Protected learning time (PLT) has become an established method of delivering education to primary healthcare teams throughout parts of the UK. Resourcing PLT is important if it is to bring about team learning.² There is evidence that PLT can be a valuable way of learning, but that not every member of the team gains equally from this method, with clinicians gaining more than non-clinical team members.^{3–5} Change to patient care has been shown, with evidence that clinicians may alter prescribing behaviour as the result of PLT educational sessions.⁶ Benefits for the primary care team have been reported, but it can be difficult to provide learning that is relevant for all members of the primary care team. Research has stressed the importance of planning and preparing PLT to maximise its potential and to make it relevant for all team members. Practice managers are usually charged with the planning and preparation of PLT team-based educational events. However, there is limited research that has explored managers' perceptions of PLT as a concept and in practice.

In 2001, PLT started in one local healthcare cooperative (LHCC; now community health partnerships) before becoming adopted by all three LHCCs in 2002 in NHS Ayrshire and Arran. Initially, large central events were organised by LHCC educational steering committees to complement practice-based events. The large central events proved unpopular and the number of these events declined in subsequent years. As a result almost all PLT events in Ayrshire and Arran moved to become practice based, with most LHCCs having only one or two large events per year. An unpublished quantitative evaluation based on a questionnaire given to approximately 800 members of primary care teams in 2002 and 2003 in North and East Ayrshire showed that most clinicians welcomed and valued PLT. It also showed that non-clinicians, practice managers and practice administration and clerical staff valued it less. Free-text comments from the questionnaire showed that many managers found organising the events stressful and that they involved considerable time and resources.

After discussions between LHCC general managers, the primary care division medical director and the author, it was decided to examine the perceptions of practice managers from all three LHCCs. It was felt this research was needed to improve PLT locally, but also to add to the scant published evidence of PLT generally.

Method

A qualitative approach was chosen for this study, as such methods are useful when a relatively new topic is

being researched or when concepts regarding the area involved are unknown.⁷ It was felt that focus groups, with an independent moderator who was unknown to the managers, offered an effective way to ascertain the perceptions of managers. Focus groups allow faster collection of data than other methods, e.g. in-depth one-to-one interview, and they encourage discussion and debate allowing participants to express their thoughts about a topic.⁸

The study design consisted of a sampling stage, data collection stage, and finally analysis of the data by two researchers working independently. The study was approved by NHS Ayrshire and Arran Research Ethics Committee and NHS Research and Development Committee. The research team and their roles are described in Box 1.

Box 1 The research team

Chief investigator

Author of the paper and guarantor for ethical approval. The chief investigator was known to many of the managers as he was a local general medical practitioner. He read and analysed the anonymised transcripts and discussed and compared the analysis with the independent researcher. He did not listen to the focus group audiotapes as he may have recognised certain individuals by voice.

Independent researcher

The independent researcher was acquainted with a few of the practice managers. She listened to the audiotapes and read the transcripts. She analysed the generated data and compared the analysis with the chief investigator.

Focus group moderator

The focus group moderator was unknown to all the managers. She had previous experience of qualitative research by undertaking in-depth interviews. She received training on focus group moderation. She recruited the participants and arranged the focus groups. She facilitated the focus groups and made contemporaneous field notes. She listened to the audiotapes and read the transcripts. She contributed to the discussion and the iterative process of the research.

Study sample

Practice managers from all three LHCCs were identified, and those from teams not taking part in PLT were excluded. A purposive sampling strategy was adopted aiming to achieve maximum variation of opinions and experiences. Practices were identified within NHS Ayrshire and Arran from areas of varying

deprivation (using the Carstairs index). It was also decided to stratify practices into size, so that managers from large and small practices would be invited to participate. It was felt by the research team that size of practice may be one factor that influenced the role of the practice manager in planning and preparing for PLT. The moderator contacted the managers of selected practices by telephone, and invited them to attend the focus groups. Invitations stopped when the three groups reached a maximum size of nine participants. It was felt that this number was appropriate to achieve the optimum discussion in each focus group.

Focus group interviews

Managers were given an information sheet with details of the aim of the project and the guarantee that their discussion would be anonymised. Consent was sought, and each participant signed a consent form whose format was agreed by the local ethics committee. Managers were reimbursed for the time spent in the focus group. Managers from each LHCC met together, as it was felt this would encourage the discussion more as they would be more familiar with other group participants. Venues were chosen that would be private and confidential, but also independent of the LHCCs and of NHS Education for Scotland. Each meeting lasted between 60–90 minutes, and the conversations were recorded using an audiotape recorder. Prior to the discussion, the moderator reiterated the aims of the study and the nature of the participants' input to it. Data collection followed an iterative process in that topics that emerged from one group influenced questions posed to future groups, and this iterative process was maintained throughout subsequent data analyses. A topic guide used for focus group discussions is shown in Box 2.

Box 2 Topic guide for focus group discussions

- 1 Experience of PLT
- 2 The perceived value of PLT to primary care teams
- 3 The impact on practice managers of planning and preparing PLT in-house educational events
- 4 The effect of PLT on administration and clerical staff
- 5 The use of time for education versus time spent on normal working activities

Validation

The tapes were transcribed by National Health Service Education for Scotland (NES) staff who were unfamiliar

with the participants. Participants' names were replaced with a number, and place names which would have identified group members were anonymised. Copies of the relevant focus group transcript were then sent to all practice managers for their comments and approval for subsequent interpretation. Three managers made comments about the transcripts; the most common topic fed back was on change of grammar.

Analysis

The chief investigator read through the transcripts of all three focus groups, whereas the independent researcher listened to the audiotapes and read the transcripts. It was felt this would increase the amount of information gained from the recorded voices and enable assessment of tone of voice, hesitation and humour and so on. The moderator's field notes provided further information on non-linguistic communication and group interactions.

The chief investigator, independent researcher and moderator met on three occasions during the course of the study, and after the completion of the focus groups, to analyse transcripts. Thematic analysis was used as a method of qualitative analysis.⁹ Transcripts were studied and data sorted into issues, categories and, finally, themes. Having two researchers analyse and interpret the data independently helped to identify the maximum number of themes.¹⁰

Results

Three focus groups were held at mutually agreed times convenient for managers. Group sizes ranged from five to nine with the total number of managers attending all three groups being 21(36%). Only one manager attended from each practice. There are 58 practices in the Ayrshire and Arran health board area. Six main themes emerged from the analysis of the three focus groups (see Box 3).

The benefits of PLT in aiding team's development

Practice managers valued PLT. They felt it encouraged education and teamwork within their practice and as a result they did not want the scheme to end.

'It's something that we have really wanted for years and we have never had, the luxury of protected time.' (Group 1, participant 6)

Managers reported that the time given was valuable, but that they wanted to improve the quality of the learning experience for all of the team members.

Box 3 Key themes that emerged from focus groups

- 1 The benefits of PLT in aiding the team's development
- 2 The opportunities to learn from other practices and teams
- 3 Difficulties in organising PLT educational events for the attached members of the primary care team
- 4 The influence of the pharmaceutical industry in the provision of educational resources
- 5 The lack of co-ordination and feedback to the LHCC, and the lack of development of PLT
- 6 Workload issues for practice managers in the planning and preparation of in-house educational events

'Now we've got it we want it better.' (Group 1, participant 6)

'I think the most important thing is in spite of all the negative stuff we don't lose it we just want it better.' (Group 2, participant 3)

The opportunities to learn from other practices and teams

Managers considered meeting staff from other practices a very useful and relevant way to learn, and some gave examples of sharing organisational materials and discussing everyday common topics. They also found it beneficial when team members brought back information about organisational systems from other practices. Managers from smaller practices also thought it was cost-effective to undertake relevant training together, for example resuscitation training or health and safety training.

'I think for the first time we have opened a lot of dialogue [between administration and clerical workers], we have actually joined with one other practice and we've got that feeling of intermixing with another practice and learning things from them.' (Group 3, participant 1)

Managers appreciated the network of contacts that were built up between administration and clerical staff as a result.

'It's not the training they remember, it is the communication between different practices.' (Group 3, participant 7)

Large centrally organised meetings were usually not favoured by managers as a learning method, but one redeeming feature was the ability for staff from different primary care teams to meet and learn from each other.

'It's a way of sharing, and a way of learning from each other, that's what it is all about. There are good systems in

other practices that you don't even think about.' (Group 1, participant 6)

Managers also reported that topics such as significant event analysis and risk reduction were well received by administrative and clerical staff at both large events and in-house events, and that these educational methods were popular since the topic was seen as relevant to those involved. Managers argued that it was essential to have small-group learning rather than large lectures. They perceived that staff benefited from the interaction and discussion that was possible with small-group learning.

Difficulties in organising PLT for educational events for the attached members of the primary care team

Some managers found planning and preparing educational events for PLT at in-house events was more difficult when it included attached health visitors and district nurses. There was a degree of confusion between the two components of the team involved. Managers felt that attached staff were part of the primary health-care team, but also part of a greater team of district nurses and health visitors within the locality, and were not sure who was responsible for organising their training. Defining who is in the team and who is not was also difficult for some managers. Managers also expressed regret that they did not know the learning needs identified by appraisal for attached staff, and as a result could not incorporate these needs into the planning of in-house PLT sessions.

'You organise training around your staff's appraisals, but you don't appraise the nurses so you have no idea what their training needs are.' (Group 1, participant 4)

This led to difficulties in planning relevant in-house education for attached staff. Managers reported that some attached staff did not attend in-house meetings or attended infrequently as a result. This caused managers difficulty as it was not known whether they would attend or not.

'I have community staff tell me they're coming and then they don't turn up or they leave because they finish at 3 pm.' (Group 1, participant 5)

Some managers recalled that attached staff did not attend at all, and that training had evolved into split sites:

'Well we've reached an agreement that the district nurses do their own thing on protected time afternoons and it is up to them.' (Group 3, participant 4)

Others agreed to keep the attached team informed of what was planned, but there seemed to be little

communication between managers and the attached staff to find mutually useful topics:

'I tell them what the doctors are doing, and if they are interested in it then they are welcome and if not they have got their own PDPs [personal development plans] to do.' (Group 3, participant 3)

The influence of the pharmaceutical industry in the provision of educational resources

Managers reported increasing use of pharmaceutical representatives as a resource for PLT. They felt representatives had seen a lack of provision in the area and had moved quickly to fill that gap.

'I don't think there are a lot of people to tap into for training and you end up getting reps to sponsor your day in doing things like that, whereas if someone from the trust could provide this training you would take them but you end up getting reps who provide training for this, that and the next thing.' (Group 1, participant 5)

Managers reported that representatives were seen not only as important resources for education but that they also acted as informal reference points. For example, they often knew who provided quality education and were acting as a database of what was available locally.

'I think sometimes reps are coming in and they are suggesting something and they are now building up experience of what has been successful for the practice.' (Group 3, participant 1)

An alternative opinion was that pharmaceutical company representatives solved the problem of filling up the in-house sessions.

'I mean as soon as you have got the dates [of PLT] you have got the reps banging on your door saying – "I can give you this and I can give you that" – and you think "great", so you fill that in and stop worrying about it.' (Group 3, participant 5)

No mention was made in the focus groups as to whether the education provided by pharmaceutical companies was informed by an educational needs assessment, or what evaluation was undertaken to see whether the education was worthwhile or not. Managers did report that it was difficult to gain from this resource unless doctors were available to see the representative. In some cases this had been made explicit by company representatives.

'If you ask them to come out just to speak to admin and clerical staff and there are no GPs [general practitioners] on site they are not interested, and that's a problem.' (Group 3, participant 4)

'You are not going to be able to get sponsorship if you have not got any GPs involved.' (Group 3, participant 6)

Managers raised the suggestion that independent funding of education would have made the need to approach the pharmaceutical industry unnecessary. Managers commented that several colleagues had approached the LHCCs for funding for in-house educational events, but had been informed that there was little money available, and that they should approach pharmaceutical representatives.

The lack of co-ordination and feedback to the LHCC, and the lack of development of PLT

Managers raised issues relating to the development of PLT. Some commented that they were not sure what the aim and objectives of the scheme were, and wanted further clarification and involvement from the LHCC. They said that the LHCC had taken for granted that practice managers were able and willing to provide education for the majority of the PLT sessions. Other managers reported that they had concerns about what happened to the feedback and evaluations of meetings submitted by them to the LHCC, and what impact, if any, this had on the future development of PLT. Managers also identified that some members of their primary healthcare team were not honest when completing evaluation forms, particularly at large centrally organised meetings:

'Well, they all fill in the forms but they [admin and clerical staff] have admitted to not being totally honest.' (Group 2, participant 3)

'The thing is they are desperate to tick anything, you have not got time to be totally right with what you want to say.' (Group 2, participant 1)

Workload issues for practice managers in the planning and preparation of in-house educational events

This was an important consideration for managers. There was a feeling strongly held that they were given the responsibility for arranging education for the primary healthcare team, and that this was a substantial amount of work. It was clear why some resorted to pharmaceutical representatives for help. Managers also claimed that PLT was usually of little personal benefit, as few of the educational activities were linked to their own learning needs. A further opinion was that managers reported that they felt they worked on the PLT afternoon instead of learning with their team. Perhaps this is because they arranged the educational

activities and felt responsible for ensuring the smooth running of the event:

'... we are generally running them. Introducing them and thanking them. Making sure it's going okay, doing the dishes when they leave.' (Group 1, participant 6)

'I think with the managers, they're not supported in it at all, they're the ones that are seen to be the organisers, they have to do it, you know, and no one has actually said it's for PLT and it is your job to do so. It is just assumed that you will do it.' (Group 1, participant 6)

Discussion

This study aimed to explore some of the perceptions of practice managers with regard to PLT, and this has been achieved. This study adds to the sparse body of knowledge regarding PLT. The qualitative design of this study has generated valuable data from practice managers about their perceptions of PLT, and in particular, it has uncovered useful information about primary care team-based education.

There are other strengths of the study. The use of an independent moderator for the focus groups allowed participants to be honest and forthcoming about their views on PLT. This is in contrast to a previous study which raised concerns that interviewees were reluctant to criticise the PLT scheme in case they could be identified.³

The PLT schemes had run for at least three years in all areas, and four years in the pilot area. Practice managers in Ayrshire have considerable experience of PLT, and focus group participants gave their views based on this. The sampling method used to recruit participants tried to achieve a wide range of opinions and covered all three LHCCs within the Ayrshire and Arran Health Board area. The sampling strategy used was independent of the primary care trust and LHCCs, thus avoiding participants who were selected by bodies who have an interest in the results.

Using two different researchers to analyse the data resulted in a greater breadth of themes identified, without compromising the anonymity of the focus group members.

One weakness of the study is that it may not include those managers who felt so negatively about PLT that they did not take up the invitation to participate in the focus groups. The study also did not invite managers whose practices had left the scheme or had never joined at the start up. Thus the focus groups cannot be assumed to represent all the perceptions of practice managers in Ayrshire and Arran.

Previous studies have used semi-structured interviews to gain information about practice managers and their perceptions on PLT.³⁻⁵ This study has focused solely on managers, rather than the primary care team, and the interactive nature of focus groups may have provided different and deeper information than individual interviews.

Conclusions

Practice managers have a key role in the planning and delivery of in-house education sessions for primary care teams within PLT. This focus group study has uncovered a number of difficulties and unforeseen themes which merit attention from those who commission and organise primary care learning. Managers have expressed the need for more help with these activities both from within the primary care team and from the LHCCs. Managers need support with adequate resources for team-based education, or some will resort to the use of pharmaceutical companies to fill that gap. Previous research has shown that this method of provision may provide education that is not based on learning needs, and may have a promotional element.¹¹ It may be worth primary care organisations considering employing or resourcing independent educational support for primary care teams if PLT is to become a success and create useful changes based on educational needs. Primary care teams may also need to reflect on the planning and preparing of in-house PLT events and to support managers more in this task.

Primary care organisations may want to consider providing education for managers that is separate from PLT sessions, in order to compensate them for the time spent at PLT in-house events. Some of these sessions could include learning about education for teams in an effort to improve team learning further. Managers may also need to consider delegating some of the duties of organising PLT to others in the team.

This research into PLT has highlighted whether primary care teams really are fully integrated teams who work and learn together. Government publications have encouraged primary care teams to learn together.¹² Attached staff have two managers to respond to: the practice manager and also their own nursing managerial structure. This duplication of management has led to attached staff falling between the two systems, resulting in fragmented and often separate education as a consequence. This needs to be improved before primary care teams are able to learn and work effectively together.

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ETHICAL APPROVAL

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CONFLICTS OF INTEREST

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