Evaluation of protected learning time in a primary care trust

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ABSTRACT
Charnwood and North West Leicestershire Primary Care Trust (PCT) was established in April 2002 following the merger of three primary care groups (PCGs). An evaluation of protected learning time (PLT) was undertaken to enable the PCT to ‘take stock’ of the three former schemes before embark- ing upon a PCT-wide programme. This paper will share the findings from part of this evaluation, the semi-structured interviews. Nineteen staff participated in a semi-structured interview, which incorporated administration, a general practitioner (GP), practice nurse, practice manager, manager and community nursing staff. Key findings included PLT being viewed as an in-house general practice-based learning and as a multipractice event, access was generally good as practices were supportive of PLT. The relevance of PLT was mixed with clinical staff viewing the sessions in a more positive light than administration staff. The successes of PLT were seen to be information giving, networking opportunities in particular cohesion among similar staff groups, i.e. practice managers. Staff identified specific examples of things they were able to take away and implement into practice. Suggestions for future PLT sessions were identified which included the arrangements, the functioning of the PLT committee and wider issues for the PCT/trust board to consider. The semi-structured interviews formed part of an evaluation to reflect upon PLT in the former PCGs. They have proven to be informative and will enable the PCT to make an informed choice as to the future planning and delivery of PLT.

Keywords: delivery, planning, protected learning time

Introduction
Charnwood and North West Leicestershire Primary Care Trust (PCT) was established in April 2002 following the merger of three primary care groups (PCGs) (North and South Charnwood and North West Leicestershire). An evaluation of protected learning time (PLT) was commissioned by the PCT to enable them to ‘take stock’ of the three PCG schemes before embarking upon a PCT-wide programme. This paper will share the findings from part of this evaluation, the semi-structured interviews.

Literature review

Clinical governance
The clinical governance agenda has introduced a requirement by NHS healthcare organisations to support continuing professional development (CPD) in all healthcare professional groups. The introduction and implementation of quality improvement initiatives such as the National Service Frameworks and National Institute of Clinical Excellence (NICE) guidance also mean that CPD mechanisms must be responsive and effective in ensuring that the necessary information is communicated to healthcare professionals.
The learning organisation

PCTs, as new NHS structures and with little history, provide a backdrop for PCT boards to creatively change the focus of future health provision for the 21st century to meet the needs of the populations they are now charged to serve. PCTs are faced with the innovative challenge of NHS change, in a society with infinite health demands, needs and wants from an NHS organisation which is dealt a set budget resource and yet faces a sociological, demographic and technological time bomb affecting both human demands and resourcing. The philosophy of PLT sits well with the idea that the newly formed PCTs should reflect a culture of what is coined a ‘learning organisation’ and is highlighted within the context of the excellence literature. Senge noted earlier that learning organisations were seen as those where their people continually expanded their capacity in order to reach their desired results and within a culture where creative ideas were nurtured to allow collective information to be set free and where people were continually learning together. A learning organisation involves new approaches to problem solving, learning from best practice evidence and transferring knowledge efficiently throughout the organisation.

An Organisation with a Memory focused on learning from adverse NHS events and identified three development areas:

1. the development of a blame culture rather than exploration and improvement of the management systems, communications or practice
2. the need to learn from ‘near misses’ within the NHS
3. the need for more individual appraisal mechanisms.

The NHS is constrained with bureaucracy and even spreading good news and best practice is exceedingly slow and ad hoc. The idea of local, regional and national learning networks needs to be reinforced as an idea. PLT events can be seen as an example of a method of achieving part of this and a way to encourage organisational learning and growth.

Protected learning time

The overarching aim of a PLT scheme should be to increase the individual and collective learning capacity of members of the primary health care team (PHCT) in order to improve patient care. This should be underpinned by a number of key principles, some of which include:

- provision of a systematic approach to CPD
- inclusion of all practices and healthcare professionals
- provision of a supportive environment for CPD in which learning and change can take place
- provision of a scheme that addresses both local and national priorities.

Published and unpublished literature surrounding the benefits and successes of protected learning in the UK remains sparse with two notable exceptions to date.

In 1998 Doncaster Health Authority provided funding to launch a novel educational scheme called TARGET which provided protected learning time for GPs and general practice staff. TARGET reported high attendance rates (80–90% of general practitioners (GPs)) and stated that these have been consistent since the initiation of the scheme. Tangible improvements following PLT were identified for patients; for example, antibiotic over-prescribing was reduced by 23% in the first five months and more cost-effective prescribing (e.g. amoxycillin, tetracyclines rather than expensive antibiotics such as cephalosporins and beta-lactams) following a session on antibiotic prescribing, while the prescribing of statins has increased by 66% (50% above the national average). The National Tracker Survey of 72 of the 481 PCGs in England found that by December 2000, 93% of the PCGs were using education to improve quality through personal development plans and through shared learning. Half-day educational events organised across the organisations have become commonplace with regular attendances higher than 95%.

Methods

Accountability is a key element of public services and there is a need to understand and critically assess the functioning of services. With competing demands for finite resources, particularly around staff education and development, it is essential to explore whether PLT is providing value for money. A ‘formative’ evaluation framework was employed, as this is partly concerned with the developmental process providing information on services in terms of improvement, modification and management.

The cases

- North Charnwood Primary Care Group
- South Charnwood Primary Care Group
- North West Leicestershire Primary Care Group.

Data collection methods and results

Ethical approval was obtained from the local research ethics committee. Data was collected using two
methods: semi-structured interviews and questionnaires. The findings from the semi-structured interviews only will be presented in this paper.

Semi-structured interviews

Semi-structured interviews (either face to face or over the telephone) with healthcare professionals from general practice and the community and with non-clinical staff from general practice were conducted. These interviews facilitated exploration around the issues of access, relevance, the successful aspects of the PLT and areas which may require further improvement. A list containing 38 names was provided by the clinical governance team in the PCT, consisting of a range of health professionals and non-clinical staff from across the three PCGs who were regular and non-regular attendees of PLT. The researchers stratified the sampling to include the range of different staff groups across the three PCGs and, based upon available time and resources, 26 staff were invited to take part in a semi-structured interview. Nineteen staff agreed to take part in the interviews, these were as follows:

- administration/reception: 1
- GP: 2
- practice nurse: 3
- practice manager: 8
- manager: 2
- district nurse: 2
- health visitor: 1.

Of the seven members of staff who were not interviewed, one refused consent (practice manager) and the remaining six were unable to take part due to reported problems with time, extenuating circumstances and the researcher and staff members not being able to make contact (three GPs, two practice managers, one practice nurse and one district nurse).

Results from the semi-structured interviews

The participants' role in the practice/PCT

The majority of the staff were involved with activities in the general practice only (n = 14, 73%) and these were related to their job, for instance practice managers undertook the financial aspects, organising training, etc. Within their roles, some of the staff undertook specialist roles; for example, a GP stated that he took the lead for information technology (IT) as well as psychiatry/psychiatric illness within the practice. Five of the staff (26%) were involved in PCT activities, namely current or previous members of clinical governance groups or PLT committees.

The participants' opportunities for learning new skills over the past year

Opportunities had been available to almost all of the staff (n = 17, 89%) to undertake new learning which consisted of ‘on the job’ learning, for example negotiating skills or more formal IT training, for example Egton Medical Information System (EMIS) GV system. Of the two members of staff who stated that they had not had an opportunity to learn new skills, one had been unable to secure several places on IT training due to high booking numbers.

The participants' perceptions of protected learning time

PLT was perceived as providing two options: in-house general practice-based learning and as a multi-general practice event (PCG wide). It was viewed as learning for everyone but mostly referred to general practice staff. There was very little recognition (n = 4, 21%) that this involved the attached staff, i.e. PCT staff or, at the time, of the PCGs community trust-employed staff. PLT was viewed as a method for learning, networking, gaining cohesion (across practices and staff groups), reflecting, discussing and addressing issues. A small number of staff (n = 4, 21%) also identified PLT as ‘deferred working time’.

The participants' attendance at PLT sessions

Findings relating to attendance at PLT sessions are shown in Table 1.

The participants' involvement in PLT sessions

Findings relating to involvement in PLT sessions are shown in Table 2.

The participants' views on finding out, ease of access, relevance, successes, improvements and their colleagues' perceptions of PLT

Finding out about PLT was relatively easy and took the form of several methods of communication including mail shots, via post, fax or email, via practice team meetings (through the practice manager) or from clinical governance leads within the PCGs.
Access to PLT was usually good if the general practice was supportive of PLT. One general practice ran a ‘three line whip’ whereby staff were expected to go as the norm and non-attendance was only acceptable for valid reasons. Dates were set well enough in advance to enable staff to co-ordinate their diaries and attend. Having the PCG arrange medical cover either through locums (North West Leicestershire and South Charnwood PCG) or the walk in centre facilities at Loughborough (North Charnwood PCG) facilitated this. The final access issue concerned PLT sessions coinciding with practice’s normal closing hours (n = 3, 16%). If general practices were normally closed on a particular afternoon when PLT sessions were being held, there was reluctance by some members of staff to attend in their own time. Remuneration was not necessarily the solution as staff had other commitments outside of work during this time, and some preferred not to use this time to attend PLT sessions.

The relevance of PLT was mixed. Of the 15 participants who rated the relevance three (20%) described it as very relevant, the remaining 12 (80%) found the sessions of mixed relevance, depending upon which session they had attended. One practice manager screened sessions for relevance, while the remainder of the staff varied between being able to take away something from the sessions to feeling that the sessions were watered down because they were too mixed, i.e. having clinicians and non-clinicians learning together. The perception was that clinical staff would have found PLT more relevant and better able to meet their needs than those of non-clinical staff groups (n = 13, 68%):

‘But one that I attended, and that my staff attended, we found to be not geared towards admin staff, it was more towards the GPs and nurses.’ (Practice manager)

The successes of PLT were felt to be the information-giving and networking opportunities, which generated

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**Table 1 Participants’ attendance at PLT sessions**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Attended PLT session</th>
<th>Not attended a PLT session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration staff (1)</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>GPs (2)</td>
<td>2</td>
<td>–</td>
</tr>
<tr>
<td>Practice nurses (3)</td>
<td>3</td>
<td>–</td>
</tr>
<tr>
<td>Practice managers (8)</td>
<td>8</td>
<td>–</td>
</tr>
<tr>
<td>Managers (2)</td>
<td>2</td>
<td>–</td>
</tr>
<tr>
<td>District nurses (2)</td>
<td>2</td>
<td>–</td>
</tr>
<tr>
<td>Health visitor (1)</td>
<td>1</td>
<td>–</td>
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</tbody>
</table>

**Table 2 Participants’ involvement in PLT sessions**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Attendee only at a PLT session</th>
<th>Presenter or organiser at a PLT session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration staff (1)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>GPs (2)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Practice nurses (3)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Practice managers (8)</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Managers (2)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>District nurses (2)</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Health visitor (1)</td>
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</table>
cohesion between similar staff groups. For example the practice managers were able to support each other, which was well received, particularly in the more rural, and hence isolated, general practices. On the whole, workshop sessions were also perceived as more successful than the lectures. Three participants gave some specific examples of things they were able to take away and put into practice:

‘And the portfolio (session) yes, I set up my own, I am doing lots of things . . . So I have managed to put all that together . . .’ (Practice manager)

‘Caldicott was really good because I did need to add a confidentiality clause to the contracts for the girls, which made it even more important because you pick all these things up.’ (Practice manager)

‘The nurse prescribing allowed district nurses to think through ways to improve on the overspend in the budget.’ (District nurse)

All 19 participants were able to identify improvements for future PLT sessions which included quality control of the speaker (ability to speak well and hold the audience’s interest), providing content of the sessions in addition to titles (as these can be misleading), future content to reflect more closely the practices’ professional development plans and the PCTs’ organisational plans, review of joint clinician and non-clinician sessions (recognising the amount of diversity in terms of experiences and needs, even within the same staff groups) and creating more local ownership of future events.

All of the participants stated that their colleagues’ perceptions were largely positive although the extent of this tended to coincide with the staff’s own personal view of PLT. Although PLT was viewed in a positive light it was perceived as being more enjoyable than useful at times. There was also a general acceptance by the participants that PLT was a good idea but that it was difficult to put into practice. A concern was noted by two of the practice managers relating to providing non-clinical staff with clinical information, and the potential issues created through acquiring this additional knowledge.

‘A recent PLT I attended was to do with children, to be aware of whether they have got problems, whether they are being molested, stuff like that . . . they made you aware of them, but where are the resources you know, places where you can refer them?’ (Practice manager)

Barriers to attending PLT

All of the staff interviewed had attended at least one PLT session and were thus unable to identify any barriers to their attending PLT.

Considerations to ensure that PLT is a recipe for success

Arrangements

- The most common suggestions were afternoons excluding Mondays and Fridays, during normal practice working hours.
- Thursday seemed to be the most popular day.
- The sessions should mainly be separate – clinical and non-clinical staff.
- When there is a need for joint sessions the facilitators should encourage mixed participation.
- The format should be predominantly small group work.
- Venues should rotate around the PCT and the big multipractice sessions should be supplemented with in-house general practice sessions every two months.

The PLT committee

- The committee should reflect the diverse staff groups within the PCT.
- The committee should actively engage its constituents enabling them to get topics onto the agenda (balancing local and national issues). There should be advanced planning of the programme with information not only on the titles of the sessions but indicating content to enable staff to make a more informed choice.
- Future sessions could also be capitalised upon and meet other competing training demands, for example, by providing mandatory training. Over-subscribed training within the PCT, i.e. IT training courses, and training needs analyses should be identified from individual personal development plans.
- It was felt that this group should be adequately resourced so that they had dedicated time to undertake these activities. One practice manager identified this as an issue:

‘Resourcing the committee should be taken into account. We are always hearing how good the Doncaster project is – well they have four people working full-time on that.’ (Practice manager)

Wider issues/PCT trust board level

- On-call cover for the multipractice sessions with Healthcall was not providing a satisfactory service to all. One GP described this as ‘woefully inadequate’ and cited numerous occasions when this cover had been unable to be provided at the last minute.
- It would be valuable to explore the possibility of Lasercom Ambulance Service to triage telephone calls whilst in-house general practice PLT sessions
are underway rather than the PCT providing locum GP cover.

- It is important to establish how to engage the attached community staff and meet the learning needs of staff who work part-time or split shifts.
- Finally monitoring arrangements were identified by some of the staff (notably practice managers) in terms of who does and does not attend, which individuals leave early and whether time is used wisely especially in the in-house general practice PLT sessions.

'But I think if we are not careful it could be seen by practices just as a way of having an afternoon off. And then all that will happen is that they will close the doors and just catch up on jobs.' (Practice manager)

Finally three participants identified two further issues for staff to consider if they attend any future PLT sessions. Feedback and evaluations are an important improvement tool for PLT but the perception is that some staff do not fill these in honestly (reflecting overly positive feedback). Culture changes for non-clinical staff were also identified, i.e. acknowledging that development and training opportunities also apply to this staff group.

'The GP's are used to holding their own and there is a danger that they end up running the whole discussion. The receptionists are too timid in practices where doctors always know best.' (Practice manager)

Discussion

This study was undertaken using a formative evaluation the purpose of which has been described as ‘being done to provide feedback to people who are trying to improve something’. The use of two researchers as external evaluators does bring an independent stance and a fresh perspective and may be more productive than perhaps an internal evaluator in providing suggestions for moving PLT forward in the new organisation. With this type of design however, researchers are often provided with the primary source of evaluation data by the stakeholders which in this case was the initial contact names for the semi-structured interviews and this may have some bearing upon the results.

The benefits

This evaluation adds to a sparse body of knowledge around PLT. Benefits of PLT have been identified, such as networking opportunities, team building, and time for reflection. Some individuals were able to identify specific knowledge acquired through PLT which they had been able to implement into practice, for example portfolio and Caldicott. While all these examples are important, evidence of change on a wide scale, for example, change in antibiotic prescribing as in the TARGET scheme was not evident. Demonstrating change in practice as a result of education has long been a contentious issue. Following a systematic review of 14 medical education studies it was concluded that there was some evidence that educational sessions can effect change in professional practice and, on occasion, healthcare outcomes. However the method by which the educational activities are delivered is key to this success, i.e. interactive or a mix of interactive and didactic sessions seems to demonstrate best results. The potential benefits of continuing nursing education have also been demonstrated through audit and observation. Agreeing and setting targets following future PLT sessions may be something that the PCT may wish to consider, as this may not only provide wide-scale evidence of change but may also be effective in convincing staff who are less enthusiastic about the benefits of PLT.

The limitations of PLT

PLT also has its limitations, namely around meeting the education and learning needs of wide staff groups, timing of sessions with varying practice working hours, balancing local and national needs and engaging part-time and attached, i.e. community staff. There was also a perception that PLT was sometimes enjoyable rather than useful. However PLT is a new concept and is part of a wider culture. Creating a learning culture requires wholesale transformation in the way that staff groups embrace change and are willing to learn and review their own practice. Therefore embracing PLT should be viewed as part of a whole systems approach.

The potential for individual and collective learning

Individual and collective learning is viewed as one of the overarching benefits of PLT. Collective learning benefits included cohesion and transfer of common issues. There were however mixed feelings about the benefits of collective learning across clinical and non-clinical staff. The issues of wide and varied staff groups, skill mix within staff groups, different cultural beliefs regarding education and learning and different educational needs, resulted in sessions being described as ‘too diluted’ by a large number of non-clinical and clinical staff. However, meeting the agenda for diverse
groups of staff is problematic. The review of CPD recommended the integration of educational processes into personal development plans. Thus future analysis of these may identify commonalities for future PLT sessions.

Meeting the needs for individual practices, attached staff, the PCT and the government’s agenda

Participants welcomed the support that the PCGs had given in ‘getting PLT off the ground’ and the concept as a whole was viewed in a positive light. PLT was seen as a good communication tool, which enabled the exploration of current topics and agendas. However, there were issues of local ownership with PLT seen as a top-down PCG/PCT government-driven agenda. Ensuring wide staff group representation on the PLT organising committee (including general practice and attached staff), engaging staff across the PCT actively in identifying topics for the agenda and in evaluating the effectiveness of future sessions may help to balance different needs.

Limitations of the evaluation

The sampling frame was based upon staff who had attended at least one PLT session. Although some of the staff who attended did not view PLT in a positive light, recruiting staff who had little interest in attending or had been unable to attend may have identified additional results. This also explains why the majority of the participants were based in general practice.

The results from the semi-structured interviews are only part of the evaluation which may impact upon the external validity of these findings. There were 112 completed questionnaires which also formed part of this evaluation, however, this method focused more specifically on local delivery – timing, venues, dates etc. Where there was overlap between the questionnaire and semi-structured interviews, findings were consistent, i.e. the suggested changes for the future delivery of PLT.

Conclusion

The semi-structured interviews with clinical and non-clinical staff have provided the PCT with insight into the then status quo of PLT across the three former PCGs. These data in conjunction with the findings from a questionnaire survey should enable the PCT to make an informed choice as to the future planning and delivery of PLT in the PCT.

REFERENCES

6 TARGET reports: www.targetfoundation.co.uk

CONFLICTS OF INTEREST

None.

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