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A Grounded Theory Study of
Protected Learning Time

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Abstract

Introduction

Protected learning time (PLT) has been adopted by a number of NHS primary health care organizations throughout the United Kingdom as a resource for learning. Primary health care teams are protected from service delivery by Out-of-hours services for a small number of afternoons per year. Learning events are generally of two types: practice-based PLT events organised by the primary health care team and usually held in practice premises; and large centrally organised meetings held in large conference venues, and arranged by a PLT committee.

PLT schemes were started by NHS Ayrshire and Arran in 2002 after a pilot study in 2001 was considered successful. A quantitative evaluation of the PLT scheme in two Community Health Partnerships within NHS Ayrshire and Arran in 2004 showed a significant difference in the views of Administrative and Clerical staff (A & C staff) and practice managers compared with clinicians in the team. Only 41% of A & C staff and 51% of practice managers wanted PLT to continue in one of the areas surveyed. An additional questionnaire study answered by practice managers in 2005 in NHS Ayrshire and Arran suggested that attendance of community nurses (health visiting and district nursing teams) at practice-based PLT events had fallen sharply, and that only a few were attending regularly. The questionnaires were unable to give the reasons for the low attendance, nor could they explain why some wanted the scheme to end.

Two research questions were developed to improve the understanding of what was happening during PLT:

1. What are the perceptions and experiences of A & C staff, and of practice managers with regards to PLT?

2. What are the perceptions and experiences of the community nursing team (community nurses and nursing managers) with regards to PLT?

Method

A Charmazian grounded theory approach was adopted, both as a method of data analysis, and as a research strategy. The data collection consisted of two phases: A & C staff, and practice managers (2005); and the community nursing team (2007). Focus groups were recruited, and the interviews were audio-recorded and transcribed. Transcriptions were coded, and themes and categories of themes were constructed from the codes. Mind mapping software was used to show the connections between the participants' quotes and the themes and categories. A grounded theory was then constructed from the three categories.

Findings

12 focus group interviews were held with a total of 88 staff members participating. Details of the categories constructed are as follows:

Structures in primary health care

Physical structures were important. There were perceptions of the organizational schism between individual practices and the community nursing team. Community nurses valued co-location with their general practice as this improved close working. Different working patterns of district nurses meant that they could not always be protected during PLT, and they felt their managers did not provide sufficient cover. The introduction of the 2004 GMS Contract emphasized the separation of community nurses from general practices. Some nurses felt that practice-based PLT was irrelevant as it was centred on the learning needs of the practice. Some practices were strongly hierarchical resulting in separate learning events for individual staff groups during PLT.

Relationships in primary health care

Relationships between community nurses and practices varied greatly. Some health visitors felt very isolated from the general practice. Community nurses wanted to work closely with practices and wanted their work to be visible and valued. Relationships between A & C staff and GPs varied considerably. Those practices with a high degree of hierarchy found collective learning difficult to

do. Other practices had good relationships between different staff groups, and made good use of PLT.

Learning processes

In general, participants did not feel their learning needs were identified or acted upon. As a result, learning offered to them was usually considered irrelevant, and based on the needs of others. A & C staff found some events to be dull and uninteresting, when passive learning methods were employed. Some practice managers perceived a lack of resources for learning events, and pharmaceutical representatives were keen to provide learning for clinicians. In some teams, practice-based PLT could be uncomfortable for community nurses, and some felt unwelcome by GPs. Practice managers were considered to be the natural leaders of practice-based PLT.

Grounded theory

A theory with three elements was constructed from the findings. Proximity was an important factor in the ability of teams to learn from each other. Those teams who were not co-located, or did not work together in the provision of patient care, found PLT to be difficult. Perceptions of power affected the experiences of PLT. GPs usually had learning based on needs, and they could influence who attended PLT with them, and what was learnt. Some staff groups had little power, namely A & C staff and community nurses, and at times, the quality of learning for these groups was low. Authenticity was important. Participants wanted PLT to be for the whole team and to involve everyone in learning together. Many were disappointed when this was not achieved, and considered it to be contrary to the original aims and objectives of the scheme.

Comparisons with other theories

The grounded theory was compared to Bourdieu's theory of practice. This helped with the understanding of issues relating to the element of power. The element of proximity had similarities to Wenger's theory of Communities of Practice. Those primary health care teams who displayed high levels of proximity were working as a Community of Practice.

Conclusions

A deeper understanding of participants' perceptions and experiences was gained and explored by the thesis. A number of recommendations were made to improve PLT in the future. These included improved learning needs assessment and aiding practice managers with the delivery of practice-based events. Individuals within primary health care teams need to improve team-working and need learning to help them with this endeavour. Health authorities need to value teamwork more, and require to locate teams together to facilitate the delivery of primary health care.

Table of Contents

Chapter Two – A literature review of the formation and development of primary health care teams 34

Chapter Three – A literature review of team-working and learning 87

Chapter Six - Relationships in protected learning time 185

Chapter Seven - Structures in primary health care 212

List of Tables

List of Figures and Boxes

List of Publications and Presentations

Peer reviewed, original research papers

Cunningham D, Fitzpatrick B and Kelly D 2006 Practice managers' perceptions and experiences of protected learning time: a focus group study. *Quality in Primary Care*, 14, 169-175

Cunningham D, Fitzpatrick B and Kelly D 2006 Administration and clerical staff perceptions and experiences of protected learning time: a focus group study. *Quality in Primary Care*, 14, 177 - 184

Cunningham D and Kelly D 2008 Community nurses' perceptions and experiences of protected learning time: a focus group study. *Quality in Primary Care*, 16, 27 -37

Cunningham D and Kelly D 2008 Nursing managers' perceptions and experiences of protected learning time: a qualitative study. *Quality in Primary Care*, 16, 39-47

Book Chapter

Cunningham D 2012 "Developing Protected Learning Time to Improve Patient Safety" in *Building a Safety and Improvement Culture in General Practice*. Bowie P, Kelly DR (eds) Radcliffe Press, Abingdon UK (in press)

Peer reviewed presentations

Oral presentations

October 2008: 14th Annual Qualitative Health Research Conference, International Institute for Qualitative Methodology, Banff, Alberta, Canada.

June 2009: Association for the Study of Medical Education (ASME) Annual Scientific Meeting, Royal College of Physicians, Edinburgh

Poster presentations

December 2009: Annual Conference of the Royal College of GPs, Scottish Exhibition Centre, Glasgow

June 2008: 60th year Anniversary of NHS in Scotland Conference, Scottish Exhibition Centre, Glasgow

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Finally, I would like to thank my family: Alison, Lesley and William, for showing their interest and support.

Declaration

I declare that the contents of this thesis are my own work except where work of others is cited.

………………………………………………………………

David Edward Cunningham

List of Abbreviations

A & C staff   Administrative and Clerical staff

CHP   Community Health Partnership

CREATE   Clackmannanshire Resource for Education, Audit and Training

GMS   General Medical Services

GP   General Practitioner

GTM   Grounded Theory Methods

KSA   Knowledge, Skills and Attitudes

LHCC   Local Health Care Co-operative

LPP   Learning Practice Programme

NES   NHS Education for Scotland

NHS   National Health Service

OOHS   Out Of Hours Service

PLT   Protected Learning Time

REC   Research Ethics Committee

SALT   Southern Area Learning as Teams

TARGET   Time for Audit, Review, Guidelines, Education and Training

UCSF   University of California at San Francisco

UK   United Kingdom

Ethical Approval

An application for ethical approval was submitted to the NHS Ayrshire and Arran Research Ethics Committee before each phase of research. The committee determined that this research did not require ethical approval as it considered the research to be a service evaluation. They granted ethical approval for the University of Glasgow's requirements for PhD students.

The NHS Ayrshire and Arran Research Ethics Committee approval was in two separate phases.

Phase One (A & C staff, and practice managers)

Reference Number: 05/S0201/8

Phase Two (community nurses and nursing managers)

Reference Number: 06/S0201/60

The research was also approved by NHS Ayrshire and Arran Research Governance Committee.

Chapter One – Introduction

"It's no' that bad that we would say no!" (A & C staff group 1, participant 4)

1.1. Structure of the thesis

This thesis consists of ten chapters. Chapter One will set the scene of protected learning time (PLT), explaining the background to the research, and will give the context of where the research was situated. Chapters Two and Three are the literature review chapters: Chapter Two focuses on the formation and development of primary health care teams within the National Health Service (NHS). Chapter Three is concerned with the literature on team-based working and learning. The literature search was undertaken after the construction of the grounded theory, but presented before the findings chapters, as per academic convention.

Chapter Four presents the methodology of the research approach and explains why a Charmazian grounded theory approach was chosen. This chapter gives a description of how the research was carried out. Chapters Five, Six and Seven each present a category of research findings. Chapter Eight presents my constructed grounded theory of PLT. In keeping with the constant comparative method of grounded theory, I compare my theory with the theories of Pierre Bourdieu and Etienne Wenger.

Chapter Nine compares my research findings with the literature on team-based working and learning. Lastly, Chapter Ten sets out my conclusions from the research, makes recommendations for changes, and identifies further research questions.

1.2. Setting the scene of PLT

Introduction

This chapter aims to introduce the thesis, and to give the context in which the research is situated. The chapter will include sections that give a description of the county of Ayrshire and Arran, and of the provision of primary health care by

NHS Ayrshire and Arran. The chapter will also give some historical details of how PLT started within NHS Ayrshire and Arran and present the quantitative evaluations of PLT which took place in late 2003 (North Ayrshire) and early 2004 (East Ayrshire). I will also present details of a survey of practice managers which took place in 2005. I will then offer some explanation of what motivated me to undertake the study.

Ayrshire and Arran

The county of Ayrshire and Isle of Arran are situated in the south-west of Scotland. Ayrshire forms part of the urban central belt of Scotland and the north of the county has close transport connections with the Greater Glasgow conurbation. The definition of the county of Ayrshire was changed in the latter half of the 20th century. Prior to the establishment of Strathclyde Regional Council in 1973 by an Act of Parliament, the county of Ayrshire had been in existence for some centuries (Great Britain 1973). Strathclyde Regional Council was formed from a number of pre-existing counties in West Central Scotland, and this included Ayrshire and Arran. Strathclyde Regional Council was then broken up in local authority changes in 1996 (Great Britain 1994).

The historic county of Ayrshire now consists of three smaller local government authorities: East, North and South Ayrshire. The map below illustrates the main population centres in Ayrshire. A significant percentage of the county's population resides in the area bounded by the towns of Irvine, Kilmarnock and Ayr. A large percentage of the land area is rural, with significant numbers of farming communities in all three local authority areas. In 2010 NHS Ayrshire and Arran estimated the population it served was 376,800. Ayrshire and Arran has significant areas of deprivation particularly in the urban areas to the north of the county. Measurements taken in 2004 and in 2006 showed that deprivation was apparent in a greater number of localities than in previous years (The Scottish Government 2009).

Figure 1: Map of Ayrshire and Arran showing CHP areas (http://upload.wikimedia.org)

NHS Ayrshire and Arran

NHS Ayrshire and Arran is charged with the responsibility of providing primary health care services to the population of Ayrshire and Arran, in addition to secondary health care provision. The map above shows the three Community Health Partnerships (CHPs) which were constructed by NHS Ayrshire and Arran to improve working relationships with community care agencies and social work departments of the three local authorities. The CHP areas are co-terminus with the three local authorities of Ayrshire, and Table 1 shows the population size, and the number of general practices in each CHP.

Data on primary health care in NHS Ayrshire and Arran (2005)

Table 1: Number of general practices and average practice list size, in each CHP as at 1st October 2005 (source: www.isdscotland.org)

CHP area	Number of practices	Average patient list size	Total population
East Ayrshire	16	7,670	122,720
South Ayrshire	20	5,848	116,960
North Ayrshire	23	6,404	147,292
Total for NHS Ayrshire and Arran	59	6,559	386,972

As can be seen in Table 1, the populations of the three CHPs are approximately equal. General practices in East Ayrshire were larger on average in comparison to North and South Ayrshire which both had a number of small towns and villages with relatively small practices serving each distinct town. Larger practices (over 10,000 patients) in NHS Ayrshire and Arran are relatively uncommon and most are located in the East and North Ayrshire CHP areas. In 2011 there were 56 general practices which were part of the three CHPs and their patient list size is displayed in Box 1. The total number of practices had decreased from 59 in 2005 to 56 in 2011, and this was caused by the merging of practices, and by the retirement of single-handed practitioners, their practices being absorbed by neighbouring practices.

Practice list size and gender of GPs in NHS Ayrshire and Arran

Box 1: Patient list size of general practices in NHS Ayrshire and Arran as at 1st October 2005 (source: www.isdscotland.org)
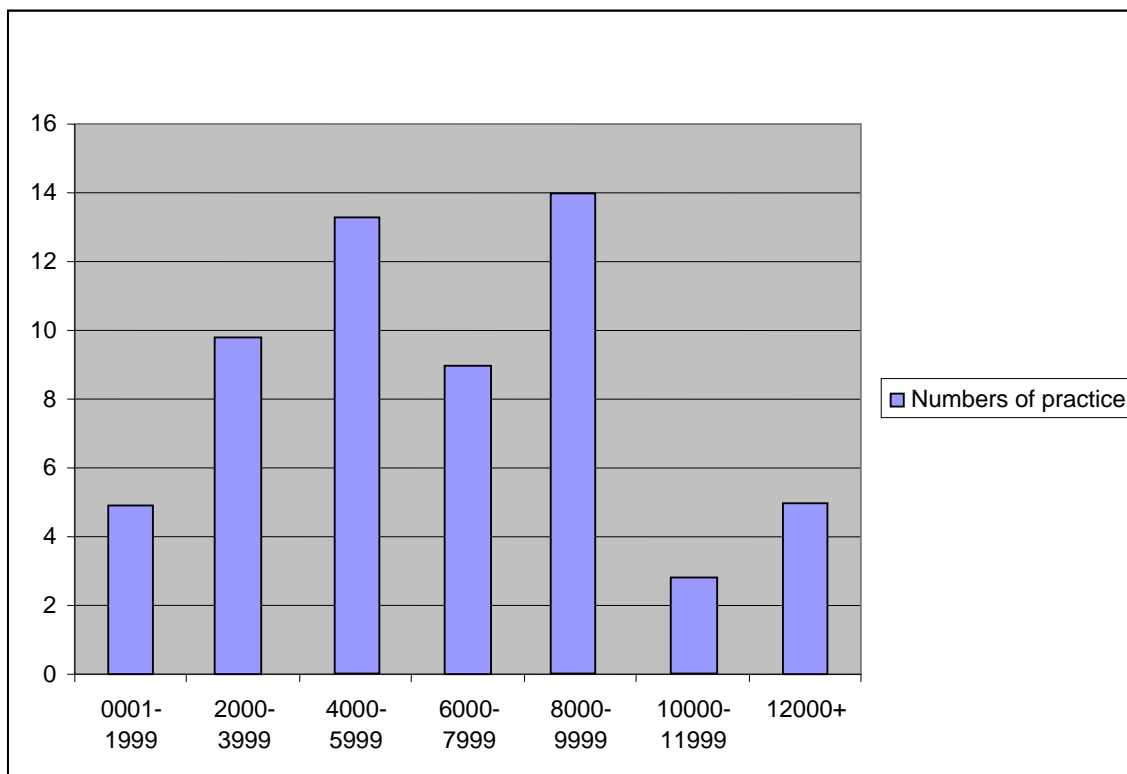
The total number of GPs in contract with NHS Ayrshire and Arran is shown in Table 2 (Information Services Division NHS Scotland 2011). This includes principals in general practice, and salaried doctors, but does not include locum GPs, or GP registrars.

Table 2: Number of GPs contracted with NHS Ayrshire and Arran, and their gender (Source: www.isdscotland.org)

Year	2004	2005	2006	2007	2008	2009	2010
Female GPs	105(35%)	110(37%)	115(38%)	117(38%)	121(38%)	128(41%)	135(42%)
Male GPS	193(65%)	187(63%)	188(62%)	189(62%)	201(62%)	183(59%)	188(58%)
Total	298	297	303	306	322	311	323

From 2004 to 2010 there was a rise of 6% in the total number of GPs in Ayrshire and Arran. The Information Services Division of NHS Scotland concluded that this increase was influenced by the 2004 General Medical Services (GMS) Contract (Information Services Division NHS Scotland 2011). Numbers of male GPs showed a small decline in this time and numbers of female GPs rose considerably. No statistical information could be found that gave figures relating to the employment of A & C staff, community nursing staff, practice managers or practice nurses.

Public health data of the Community Health Partnerships

Detailed public health data for 2009 is held for the three CHPs within NHS Ayrshire and Arran (Scottish Public Health Observatory Team 2010a;Scottish Public Health Observatory Team 2010b;Scottish Public Health Observatory Team 2010c). It is acknowledged that these reports were based on data collected two years after the last data collection phase of my PLT research.

Fifty-nine different elements of public health data were presented in each of the three reports. A considerable number of these elements show statistically significant differences in public health measurements compared to Scotland as a whole. Those figures were indicative of the effect of deprivation upon health. It was noted that East and North Ayrshire fared worse than South Ayrshire.

Community nursing structure in NHS Ayrshire and Arran

There are two distinct teams within community nursing in NHS Ayrshire and Arran: health visiting and district nursing teams. Both teams have been attached to general practices for at least ten years, the local policy mirroring national trends as presented in Chapter Two. During the time of data collection for this thesis, the Department of Health of the Scottish Executive published proposals to merge the two distinct teams, with the school nursing service to form a generic community nursing team (Scottish Executive 2006). NHS Ayrshire and Arran did not follow this guidance, in keeping with the majority of other health boards in Scotland.

With the introduction of CHPs in 2003 from previously existing Local Health Care Co-Operatives (LHCCs) management of community nurses was transferred to the

CHPs from the Primary Care Trust. Each CHP had several nursing managers who tended to be experienced nurses with management experience, often having been promoted from within the teams. These nursing managers were frequently members of the PLT steering committees, or they allocated a deputy to attend regular committee meetings. Although community nurses were 'attached' to general practices, individual nurses were employed by the CHP and could be moved on a temporary or permanent basis throughout the CHP. The community nursing team was managed as one CHP-based unit. Community nurses would be expected to cover duties for other teams if illness or other reasons caused a shortfall in provision. This contrasted with general practices that were distinct businesses and operated within a business model.

1.3. Introduction of PLT to NHS Ayrshire and Arran

The beginnings of PLT in the UK

PLT began in 1998, the first scheme being in Doncaster, England (Department of Health 2002). PLT only became possible as a result of the formation of Out-of-hours Services (OOHS). These services had been set up by groups of GPs in order to provide on-call cover for evenings, overnights, and weekends. The aims of these services were to reduce the burden of OOH provision for GPs, and to help reverse the decline in general practice recruitment. These services were often run as not-for-profit co-operatives. Drs Dakin and Coleman had the original idea of using their local OOHS to provide service delivery, during normal practice working hours, whilst learning events were provided for primary health care teams. The organisers called the first PLT scheme TARGET, and more information about this is presented in Chapter Two. Several years later, the first Scottish PLT was set up called CREATE, and this was piloted in Central Scotland in 2001 (Haycock-Stuart EA and Houston NM 2005).

Introduction of PLT to NHS Ayrshire and Arran

In 2001, one of my colleagues from the Associate Adviser team in NHS Education for Scotland attended a conference held by the organisers of TARGET, and had informal meetings with the educational lead from CREATE. My colleague proposed a PLT scheme for NHS Ayrshire and Arran. Details of the proposed PLT

scheme were presented to managers from the three CHPs within NHS Ayrshire and Arran, and it was decided to hold a pilot study in the East Ayrshire CHP, followed by spread of the scheme to the two other CHPs. I was involved with the initial pilot and delivery of the learning needs assessment (Cunningham D and Kelly D 2005). A formal evaluation of the PLT schemes in two CHPs was not held until late 2003 and early 2004. Although one PLT scheme in the UK had published an evaluation before PLT started in NHS Ayrshire and Arran, it had little impact on the PLT schemes within Ayrshire and Arran (Bell J et al. 2001;White A et al. 2002).

Details of NHS Ayrshire and Arran PLT schemes

Each CHP managed its own PLT scheme and funding for the schemes was provided by NHS Ayrshire and Arran, although one scheme approached representatives from pharmaceutical companies for additional funding. CHPs recruited representatives from the CHP itself, as well as from general practices and community nursing teams to form PLT steering committees (Cunningham D and Kelly D 2007). Steering committees had a number of roles including the financial management of the schemes and the arrangement of large centrally organised PLT events. The steering committee had a governance role and collected information with regards to attendance at practice-based PLT events, and liaised with pharmacists, the local OOHS and other parties who had an interest in PLT. The steering committee also communicated with NHS managers and executives of the NHS board, and with the public health department.

From their inception, all three schemes had approximately six PLT sessions per year, four being practice-based PLT events, and two large centrally organised events. All events were held in the afternoons of mid-week days. It was perceived that Mondays and Fridays were the busiest days for general practices, and that requests from patients for emergency consultations and house calls were usually received in the morning. Thus, it seemed practical to hold PLT events during mid-week afternoons.

Large centrally organised PLT events

These events were arranged by the steering committees. From my experience, learning needs were collated from a number of sources and although a formal learning needs assessment had been made of non-clinical learning needs, little emphasis was placed on the results (Cunningham D & Kelly D 2005). The committee generally asked key informants and staff group representatives for topics that would form large events. Committee members would offer suggestions of what they considered would make effective learning topics. Some events were based on suggestions and recommendations from the public health department and from the health board itself. With time, committees would ask those attending large centrally organised events to suggest future topics. Events were usually held in large hotels or conference centres that had sufficient auditoria for presentations to large audiences, and break-out rooms to encourage small group learning. Small group learning facilitators were trained by me.

1.4. Evaluation of PLT in North and East Ayrshire CHPs

Method

I decided to evaluate PLT in the two CHP areas that I had responsibility for in my role with NHS Education for Scotland; I had no involvement with South Ayrshire's PLT scheme. I decided an evaluation using a questionnaire to be completed by participants, either electronically or in paper format, was an appropriate method. It was considered by the two steering committees that this would be easy to complete, and could be disseminated via email and by internal mail, to the general practices and community nurses involved. Questions were devised by reference to Kilpatrick's work on evaluation and also to Knowles' work on adult learning theory (Kirkpatrick DL 1998;Knowles MS et al. 2005).

An email was sent by me directly to practice-based clinicians as they had entries in the email directory of NHS Ayrshire and Arran. Practice managers and nursing managers were asked to disseminate the questionnaire to A & C staff, and to community nurses respectively. The electronic questionnaire could be completed on-line by clicking a hyperlink to the NES website, or it could be

completed manually and returned to the CHP office. These returned questionnaires were then optically scanned in an NES office and added to the database. Respondents were asked to record which staff group they belonged to. They were asked to grade their level of agreement to various question stems and make a choice from:

- Strongly agree

- Agree

- Disagree

- Strongly disagree

Evaluation results

There was a 55% response rate from the estimated 900 participants in the two CHP areas. The results for 'agree' and 'strongly agree' for each question were then combined and are presented in Table 3.

Table 3: Survey results of North and East Ayrshire CHP PLT schemes

Question stem (figures presented as percentages)		AC	DN	HV	PM	GP	PN	All
PLT has been useful to me	North	69	77	92	83	96	100	82
	East	56	85	87	46	90	83	71
PLT has been enjoyable	North	76	87	100	83	97	100	80
	East	55	96	89	66	90	100	77
The topics covered have been relevant to my job	North	73	80	83	75	96	95	81
	East	55	83	95	62	96	73	73
My views on the content of events are sought	North	67	55	42	100	90	79	71
	East	66	74	79	82	87	90	75
I think our PLT should continue	North	53	84	92	76	93	91	74
	East	41	85	90	54	93	90	68
PLT can create work for the next day	North	86	59	71	100	77	75	78
	East	79	59	74	85	77	63	71
I benefit from learning with different occupations	North	83	96	100	92	90	90	92
	East	83	76	90	91	83	100	86

Abbreviations: AC = A & C staff, DN = district nursing staff, HV = health visiting staff, PM = practice managers, GP = GPs, PN = practice nurses.

1.5. Interpretation of results

Although I did not subject the data to statistical analysis, there were some clear trends to the data. Levels of response for strongly agree/agree from East Ayrshire were in general lower than North Ayrshire suggesting that with time respondents became less satisfied with PLT. The pilot scheme had started in East Ayrshire one year before the North Ayrshire scheme had started and the

evaluation in East Ayrshire took place a few months later than in the North. Perhaps the most important response to me was the one that asked respondents if PLT should continue. Only 41% of A & C staff in East Ayrshire considered that it should.

There are other distinct contrasts in the data. When asked about the usefulness of PLT, practice nurses in the North had a response (strongly agree/agree) of 100% for this question in comparison to A & C staff from East Ayrshire CHP whose response was only 55%. Practice managers also had lower levels of satisfaction with PLT. Only 46% of practice managers in East Ayrshire agreed with the statement that PLT was useful to them, and only 54% of East Ayrshire practice managers wanted the scheme to continue.

Survey to practice managers

A further survey was sent to practice managers approximately a year after the evaluation questionnaire (Cunningham D et al. 2006c). This survey sought to gather information about practice managers' perceptions of PLT, as well as the attendance of specific staff groups at practice-based PLT events. This was in response to information that had been sent to PLT steering committees by nursing managers indicating the declining attendance of community nurses. This survey showed that attendance by community nurses had fallen dramatically, with the majority attending infrequently. In contrast, attendance by the remaining staff groups that make up the general practice continued to be high.

Formulation of research study and research questions

It was these contrasts in the responses to the questionnaires that stimulated me to carry out the research that forms the basis for this thesis. I wanted to know what was behind these responses: what the perceptions and experiences of those who did not want PLT to continue were, why they did not want to attend, and why it was not useful to them. Clearly these questions could not be answered from the questionnaires; I needed a different research strategy to enable me to understand what was happening at PLT. Further details of the development of the research questions are given in Chapter Four.

Definitions of staff groups within the primary health care team

The staff groups which make up each primary health care team vary considerably and may be related to the individual context and situation of each primary health care team. For example a rural practice may have dispensing pharmacy staff, and some primary health care teams may have a pharmacist. For the purposes of clarity the following individuals and staff groups are described here:

Administrative and Clerical staff (A & C staff) consist of a variety of roles within the team. Originally consisting of receptionists, the role has grown to include medical secretaries and telephonists. Other roles include computer operators and staff who organise chronic disease management clinics within general practice. Some A & C staff have undergone further clinical training and help with tasks such as phlebotomy and immunisations for example.

Practice managers are in charge of many aspects of primary health care management. These usually involve directing the A & C staff and representing the general practice at area meetings. They are often a point of contact with the CHP. In NHS Ayrshire and Arran, many practice managers were recruited from the A & C staff, although increasingly managers from other commercial and industrial companies are now recruited. Typically, these practice managers are male.

District nurses, health visitors and staff nurses under their charge make up the community nurses. With their own management structure, I have called this team the 'community nursing team'. Community nurses work in small groups and are attached to a specific general practice, although some community nurses may cover two small general practices. District nurses provide a range of nursing services primarily to patients who are house-bound and not able to come to the general practice. They have a substantial involvement in palliative care. Health visitors promote health and are involved in health prevention. During the period of this study, their work was increasingly concerned with child protection.

GPs offer primary medical care to those patients registered on their lists. This staff group consists of some salaried doctors although most GPs in the area

studied work in partnership with each other. A number of general practices in NHS Ayrshire and Arran are training practices and a doctor in training is attached to the team for 18 months.

Practice nurses provide a range of nursing services to patients in the practice building. They are usually trained in adult medicine and a number have had midwifery training. They are employed by GPs, and may be managed by practice managers. Their duties include practical tasks such as the immunisation of children and cervical cytology screening and increasingly they play an important role in chronic disease management.

The following chapter gives an historical account of the development of the primary health care team from the inception of the NHS in 1948. The chapter also gives descriptions of effective team-based learning, and describes the call for PLT.

Chapter Two – A literature review of the formation and development of primary health care teams

"The domiciliary services of a given district would be based on a Primary Health Centre – an institution equipped for services of curative and preventive medicine to be conducted by the GPs of that district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists. Primary Health Centres would vary in their size and complexity according to local needs, and as to their situation in town or country, but they would for the most part be staffed by the GPs of their district, the patients retaining the services of their own doctors." (Ministry of Health - Consultative Council on Medical and Allied Services 1920)

2.1. Introduction

This chapter has the following aims:

Firstly, I will discuss the place of the literature review in grounded theory studies, and describe my search strategy.

Secondly, I will outline a short history of how the primary health care team was formed within the NHS in the UK. This section will include a description of how the different primary health care professions worked before the formation of the NHS. I will set out a chronology of how the community nursing team formed working and learning relationships with GPs, and then a chronology of the development of practice managers and A & C staff. I will then illustrate how the primary health care team was considered to be the functioning unit of primary health care provision within the NHS.

Thirdly, I intend to show the growing calls and recommendations for the established primary health care team to work with and learn more effectively from each other. I will cite examples of effective collective learning and working projects and schemes from a variety of studies of primary health care teams.

Fourthly, I intend to explore the early and later descriptions and evaluations of PLT schemes throughout the UK since the introduction of the first scheme: Doncaster TARGET in 1998 (Department of Health 2002).

Lastly, I will summarise the above findings before considering the literature of team-based working and learning in health care, in Chapter Three.

2.2. Grounded theory and the literature review

In general, literature reviews are undertaken at the start of any significant academic work, and may have several purposes. Literature reviews can identify where there is a knowledge gap and can prompt and enable the development of research questions. Literature reviews can also illustrate how a scholar has placed his or her own research within the context of previously published work. For grounded theorists, however, the timing of the literature review is important and may differ from other qualitative and quantitative research approaches (Kennedy TJT and Lingard LA 2006). As Charmaz stated:

> "The place of the literature review in grounded theory research has long been both disputed and misunderstood." (Charmaz K 2006)

Charmaz recalled that Glaser and Strauss, the sociologists who developed grounded theory, suggested undertaking the literature review in any grounded theory work after the data has been collected and analysed by the researchers. Glaser and Strauss argued that the emergent grounded theory could then be compared with the established literature of the research area. Glaser and Strauss contended that grounded theory researchers should enter into a research field with few pre-existing assumptions about the research question in order to have an open, but not empty, mind on the topic involved (Glaser BG and Strauss AL 1967). They maintained that if researchers performed an extensive literature research on their proposed field of inquiry prior to the collection of data, then the researcher's own theoretical sensitivity and thinking on the topic could be adversely affected by their literature review. Grounded theory students were encouraged to regard the literature as "data" that could be subjected to the grounded theory methods of analysis. Recommendations were also made to compare the emergent grounded theory with the literature using the constant comparative method.

Charmaz adopted a more pragmatic approach to the literature review (Charmaz K 2006). She has recommended an examination of the requirements of academic

bodies and publishers, and suggests that scholars and students need to adhere to such regulations but encourages researchers not to feel constrained by them. In view of these arguments, this literature review was undertaken at various stages during the research process. For the purposes of gaining ethical approval and local research governance approval, a brief literature review was undertaken before each of the two data collection phases. Most of the literature in this chapter and in Chapter Three was found in searches subsequent to the development of my grounded theory. In keeping with Glaser and Strauss's recommendations that the research findings and constructed grounded theory should be compared and contrasted with the existing literature, a separate chapter (Chapter Nine) is included after the chapters which deal with the research findings and my constructed grounded theory of PLT.

Search strategy

I adopted various search methods to identify the literature regarding PLT and collective learning within primary health care teams. I used Medline and CINAHL (Cumulative Index to Nursing and Allied Health) to find journal papers, and used the following keywords: protected learning time, team-based learning, and primary health care learning. I searched relevant journals to primary health care education including: *Education for Primary Care, Medical Education, British Medical Journal, The Lancet, Quality in Primary Care* and *The Journal of Inter-professional Care.* I also searched nursing and managerial journals. I identified key papers cited by earlier papers and these helped me find the relevant and important government publications of primary health care and team-based learning. In addition I used Google scholar to find further studies and papers not already identified by the above methods.

2.3. The formation of primary health care teams

GPs in 1948 – the establishment of the NHS

The structural and financial arrangements of how primary health care was delivered at the inception of the NHS were very different in comparison to today, but remnants of these structures still persist and influence what takes place in today's primary health care. Prior to July 1948, GPs in the UK worked in

a private context with their patients (Newton J and Hunt J 1997). The National Insurance Act of 1911 provided some funded health care for insured workers, who were normally male (Great Britain 1911). Other patients, such as women, non-insured men and children, paid their GP directly for medical services received.

The establishment of the NHS by the Labour Government after the Second World War strove to provide comprehensive health care for the entire population, based on their clinical needs rather than on their ability to pay for health care. The NHS Act (1946) based on the Beveridge Report allowed for the introduction of the NHS, which commenced in 1948 (Abel-Smith B 1992). A survey from that time (The Cohen Committee) showed that GPs were invariably male, and usually single-handed or in small partnerships of two or three practitioners (Rivett G 2011) Table 4 gives an analysis of the numbers of single-handed and doctors in partnership in 1952. Often, GPs would work from their own homes, or from small premises attached to their houses, and would employ their spouse or other family members as their main and often only administrative and clerical support (Kennie AT 1962). A number of studies describe the workload and professional lives of GPs in various parts of the United Kingdom around the inception and early years of the NHS (Crawford JCC 1954;Elder AT 1953;Walker CW 1953).

Table 4: Cohen Committee - List of GPs in the UK on 1st July 1952 (Source: www.nhshistory.net)

General practitioner structure	Number of doctors
Single-handed practitioners	7,459
All practitioners in partnership	9,745
As members of partnerships of two general practitioners	5,732
Of three general practitioners	2,577

Of four general practitioners	980
Of five general practitioners	315
Of six general practitioners	161

Administrative & Clerical staff in 1948

From these descriptive accounts of general practice, it is clear that there were very few Administrative & Clerical (A&C) staff employed in general practices, and there is no mention of the employment of practice managers. This remained relatively unchanged until the first government initiative for the primary health care team was implemented with the Family Doctor's Charter in 1965 (British Medical Association 1965). The findings of a committee that examined the state of general practice in the early 1960s showed that much investment was needed (Standing Medical Advisory Committee 1963). The resultant Family Doctor's Charter introduced the reimbursement of staff pay, and this allowed for growth in the numbers of A & C staff in primary health care. The Charter also encouraged the development of practice premises, and encouraged GPs to come together and form larger partnerships or group practices. This was promoted by the introduction of financial allowances given to GPs for these specific objectives. As small practices amalgamated, they became financially able to employ more A & C staff with some practices going on to employ practice managers.

Community nursing staff

Before the establishment of the NHS, community nurses (composed of district nurses and health visitors) were employed and managed differently from GPs (Sweet HM and Dougall H 2008). Their employers tended to be local health authorities (district nurses) or local government authorities (health visitors) but this varied from area to area. For a considerable number of district nurses, their remuneration was based on income raised by charitable ventures, or local insurance schemes that raised money to support them.

Prior to the establishment of the NHS, different professional groups in primary health care competed with each other for income, and it was common for there to be a degree of conflict, rather than of collaboration, between the various professions (Sweet HM & Dougall H 2008). The GP competed for care of the elderly and infirm patients with the district nurse, competed for maternity care with the midwife, and competed with the health visitor for the care of young children. Health visitors also competed with midwives for the care of infants in the post-partum period.

It was usual for health visitors to have a significant role in child health, and they were often employed by local government authorities for the provision of this service. Often doctors with some training in child health would work with them - this service often being referred to as 'the clinic' by GPs. With the inception of the NHS in 1948, these organizational structures did not change overnight. This structural arrangement continued for some years until the primary health care team began to form, with a team-based approach eventually becoming the dominant model of primary health care delivery many years later.

District nurses and GPs

Of all the relationships in primary health care prior to 1948, the relationship between GP and district nurse was considered the strongest, but as Hockey concluded, was not particularly effective (Hockey L 1966). Hockey studied the district nursing service in 1966 and used a mix of in-depth interviews with a questionnaire survey covering six contrasting geographical areas in the UK. She reported on how the skills and knowledge of district nurses were under-utilised. Hockey stated that for a variety of reasons, GPs failed to refer their patients to district nurses for nursing care. She gave various reasons for this: GPs' lack of knowledge of what skills the district nurse had, or what her role entailed was common. Some GPs had concerns that the district nursing service was overloaded and they did not want to add to this burden.

Much of the district nurses' workload seemed to be related to the provision of basic nursing care and Hockey's work emphasized the untapped potential of the qualified and experienced district nurse. Hockey recorded how a considerable number of district nurses surveyed in the six areas in her study undertook tasks

such as lighting fires for patients, or the preparation of simple meals and shopping. She recommended that ancillary support for district nurses, or the provision of home helps to patients would free up the district nurse's time and allow them to take on roles in keeping with their significant nursing training and post-qualification experience. A majority of nurses surveyed by Hockey were keen to extend their job away from this traditional role.

Hockey reported on poor communication between district nurses and GPs:

> "Many nurses, who customarily left message papers for the doctor in patients' homes, believed that the doctor never looked at them. In any case, they did not receive a reply. As one nurse put it: 'It's all one-sided, the doctors don't often bother to keep us in the picture.'" (Hockey L 1966)

GPs gave similar perceptions of the lack of communication between GP and district nurse:

> "The doctors in the country area attempted to make direct contact with the nurses concerned, but often encountered practical difficulties epitomised in comments such as: 'I hardly ever get a reply from the nurse's house', or 'By the time I contact the nurse, and she gets to the patient I can do the job myself.'" (Hockey L 1966)

It was clear that as the district nursing service was based on small geographic areas or districts that did not coincide with any one GP's list of patients (except perhaps in small rural areas) then each district nurse could have a potential professional relationship with a large number of GPs, and vice-versa. Communications were not planned and were ad-hoc, and thus often failed to be effective. Poor communications with each other had a negative effect on inter-professional relationships and fostered little sense of team-working.

Hockey demonstrated that communication between district nurses and health visitors, at times could be very poor in some of the geographical areas she investigated. She reported that one-third of district nurses did not know the name of the health visitor who worked in their shared district (Hockey L 1966).

Structural issues in 1948

It was these structural differences, prevalent at the start of the NHS that influenced how future primary health care teams would interact with each other and with their patients. At the inception of the NHS, GPs kept their self-employed status. This had been their method of remuneration prior to the establishment of the NHS whereby most patients paid their GP privately. After 1948, individual principals in general practice had new contracts established by the NHS. This meant that GPs remained in control of their existing businesses and held the service contract: only they were in a position to employ others such as A & C staff. The future expansion in numbers of some of today's primary health care team staff groups for example, practice managers and practice nurses would operate within this business model, whereby the GP held a contract with an NHS health authority (or health board in Scotland) and could employ staff to help him or her in their endeavours.

The gradual introduction of shared premises

Health centres, envisaged by the planners of the NHS Act (1946), did not come into operation until the 1950s and many GPs remained the owners of their health care premises. It was hoped that health centres would provide working accommodation for one or more partnerships of GPs, but also include space for community nurses and other staff groups, such as podiatrists. This was in contrast to GPs' existing surgeries, which were small and had room only for GPs.

Beales stated that a survey undertaken by the British Medical Association in 1951 showed that only 38% of GPs supported the introduction of health centres (Beales JG 1978). Even when health centres were constructed, their numbers were small, and some GPs were reluctant to move out of their own privately owned premises into centrally controlled health centres. Beales' analysis of the reasons why GPs were reluctant to move revealed that it often related to their feelings of loss of control and loss of professional and business autonomy. Many GPs were suspicious of health authority managers and preferred to work in cramped surgeries that they owned, rather than move into larger premises that did not belong to them. As Beales stated, the perceptions of GPs to health centres were as follows:

> "But there was a longer-term fear too: a misgiving that health centres might be part of a plot to impose a salaried service upon GPs and to impose direct control by the local authority upon them. Instead of being seen as desirable places in which doctors could join with others involved in community health care to provide a comprehensive service to the patients; health centres were condemned as impersonal buildings which would reduce the doctor to some sort of clinical automaton, destroy his status in the eyes of the patient and perhaps ultimately put him in a bureaucratic straightjacket, striping him completely of his professional freedom." (Beales JG 1978)

There were concerns that the construction of health centres was the start of an erosion of general practice and GPs were fearful of the potential loss of their self-employed status, and loss of their autonomous businesses. Beales stated that by 1959, there were only 23 health centres in England, Scotland, and Wales, and by 1969 (some 21 years after the creation of the NHS) only 8% of GPs were practising from health centres. Some GPs did foresee the potential improvements that a health centre may bring to their own domestic lives, with the separation of their professional life from their domestic life, and the important liberating effect this would have on the doctor's spouse (Kennie AT 1962).

In contrast, individual nurses in the district nursing service, or home nursing services as it was often called, remained employed and their posts were funded by health or local authorities. Community nurses were used to being part of much larger teams with a distinct nursing hierarchy in contrast to GPs who had equal status with each other. Community nurses did not work from their own homes, usually having a central base that may have been part of the local district general hospital, or in a community clinic.

Early calls for working together in health centres

Cookson and Millard reported on the importance of effective accommodation within health centres and surgeries for practice-based nurses (Cookson I and Millard FW 1970). They called for appropriate designs in health centres that would encourage collaborative working in order to benefit patient care. They described their employment of a practice nurse since 1950 and the positive impact this had on the day-to-day workload of GPs. Cookson and Millard emphasized that the practice nurses were given delegated duties from the GPs

and not from district or community nurses. Indeed the authors were aware of policy issues regarding the working of district nurses in health centres. This was seen as being a useful and efficient way for district nurses to see their own patients in the health centre, rather than seeing patients referred to them by GPs. Cookson and Willard stated:

> "It is becoming accepted that a nurse is a valuable asset in a GP surgery, but the use made of her services is influenced by the type of service given by local authority nurses in the home. Some local authorities are quite willing to attach a district nurse to a practice so that she may carry out more efficiently in a surgery the routine dressings and injections formerly given in the home, but they are less inclined to allow an attached nurse to take part in the general running of the surgery." (Cookson I & Millard FW 1970)

Workload reports of GPs

In various reports from 1948 to 1954, it would seem that GPs worked in a sense of conflict, rather than collaboration, with some of their different professional colleagues in primary health care. An extensive report on the nature of general practice undertaken from 1951 to 1952 by Hadfield and published in 1953 provided much information on how GPs perceived their role and the primary health care service that they provided (Hadfield SJ 1953). In this report, it was clear that working relationships with other community-based health professionals were rudimentary. Contact between GPs and midwives, district nurses and health visitors was irregular, unplanned, and often infrequent. Much of Hadfield's findings regarding poor communication in primary health care concurred with those identified by Hockey (Hockey L 1966).

In his survey sent to GPs, Hadfield commented on inter-professional relationships, and focusing on health visitors stated:

> "Seventy two percent of the practitioners whom I asked (I did not introduce this subject until I had seen about forty) have no complaints about health visitors. Neither were there any reports of co-operation worthy of notice. Some of these have no knowledge of health visitors' activities. Twenty eight percent complain bitterly about them. Some regard them as a waste of nursing man-power." (Hadfield SJ 1953)

Hadfield expressed dissatisfaction with the working relationships between health visitors and GPs and gave further examples of how poor these were. He referred

to an experimental relationship in which a health visitor and a GP met on a daily basis to discuss information relating to the care of patients. Thus since the initial years of the NHS, there had been calls for better working relationships amongst primary health care professionals in order to improve patient care.

In contrast to his findings of poor inter-professional working arrangements, Hadfield reported a growing sense of co-operation amongst GPs themselves in the first five years of the new NHS. He described how a number of GPs had set up partnerships, and that these had started as a group of doctors coming together to share their out-of-hours duties. The establishment of the NHS created a growing sense of co-operation in primary health care rather than that of competition and of poor relationships, at least amongst GPs.

The integration of GPs and nurses in primary health care

Introduction

This section of the literature review aims to chronicle the slow but steady development of collaborative working and learning between GPs and community nurses. It will first describe the introduction of the employment of practice nurses.

Several studies from the 1950s described the work and working arrangements of GPs shortly after the introduction of the NHS in 1948. These reports documented the isolated working of professionals at that time. Backett and colleagues described the workload, consultations, and the diagnoses of patients attending a principal in an NHS general practice in London from April 1950 to March 1951 (Backett EM et al. 1954). This detailed description of a year's work gave no reference to the work of nursing staff (either community nurses or practice nurses) and no mention of the employment of A & C staff by the GP. In this case study, the GP worked with two other assistants, but their health care endeavours were uni-professional in nature.

Crawford reported in significant detail on his workload as a single-handed GP in Northern Ireland and his account had much in common with Fry's report of his professional life in outer London (Crawford JCC 1954;Fry J 1952). Neither Crawford nor Fry made much reference to collaboration with other professionals

in primary health care. Fry mentioned the employment of a secretary to help with administrative and secretarial duties.

Early examples of practice-based nurses

Scott, Anderson and Cartwright reported on the work of a practice significantly involved with the teaching of medical students. The study taking place in Edinburgh from 1956 to 1957 (Scott R et al. 1960). In this report the authors described the employment of a nurse in the practice who worked closely with the doctors. It was of interest that the commonest "therapeutic action undertaken by [the] Doctor" at that time were activities that perhaps now, would be perceived as treatment-room nursing duties. This highlighted the lack of access to nurses for ambulant patients who were able to attend a surgery or health centre. Publishing in 1961, Cartwright and Scott described in more detail the role of the nurse employed in their practice (Cartwright A and Scott R 1961). Their introduction stated:

> "While everyone agrees about the importance of co-operation between doctor and nurse in the provision of an effective domiciliary medical service, the general administrative organization does little to ensure or encourage integration." (Cartwright A & Scott R 1961)

The authors described how the practice-based nurse undertook visits to patients in their homes, although district nurses also provided similar services. In their discussion section, Cartwright and Scott commented on this new nursing service and suggested this contrasted with the situation faced by most GPs at that time:

> "With few exceptions, however, none of these [nursing] services is available at the consulting-room, where the GP does most of his daily work. Most of these services have this in common, that the nurses are employed by an organization or an authority which determines the type and range of services which will be provided, the GP having little influence on determining policy and no direct executive authority to control or modify in detail the day-to-day work of the nurse or nurses concerned." (Cartwright A & Scott R 1961)

It is clear from this statement that most GPs were working independently from community nurses and that there was little common or shared work. The authors suggested that there was no co-ordination between the various professional groups who provided primary health care. It may be interpreted that the GPs

were interested in shaping, to some extent, the workload of the community nurse, and of involving them with the provision of nursing services to patients within general practice premises.

Sanctuary and colleagues described the benefits of having a nurse based in their practice. They described the workload of a nurse employed by a large practice of 17,000 patients. It is of note that much of the nurse's workload related not only to the performance of tasks previously undertaken by GPs, but also the execution of duties more commonly performed by district nurses (Sanctuary JCT et al. 1965).

In 1967, Weston-Smith and Mottram described the innovative role of a practice nurse who was directly employed by GPs (Weston-Smith J and Mottram EM 1967). The nurse's main duties involved triaging of house calls, the assessment of patients at home, and routine tasks within the surgery building. A further paper by Weston-Smith and O'Donovan described the employment of a practice nurse in a semi-rural practice in 1968 (Weston-Smith J and O'Donovan JB 1970). This paper concurred with the findings of Weston-Smith and Mottram's earlier paper that examined how employed practice nurses had been delegated a number of tasks that were traditionally performed by GPs. It was noted that visits to patients at home were performed by the practice nurse, but that the purpose of these were not to replicate district nursing tasks, but to reduce the workload of GPs.

In 1976, Reedy and colleagues published a large survey sent to over 9,000 general practices in England (Reedy BLEC et al. 1976). By this date, it was estimated that 24% of general practices directly employed a practice nurse, and 68% had an attached nurse from the community nursing team. The study concluded that the role of the practice nurse was growing and was being increasingly recognised by GPs and also by community nurses.

Attachment of community nurses to general practices

Swift and MacDougall publishing in 1964, described their own large general practice in Hampshire, England which had attached midwives, health visitors and district nurses. This large practice of 17,000 patients had enough physical space

to accommodate all of the primary health care team who shared access to consulting rooms and patient care records. The authors described the benefits of informal information exchange between community nurse and GP, and of the growing sense of team development (Swift G and MacDougall IA 1964). Communication between professionals was improved by three main factors: joint-working; shared patient case notes; and co-location.

In 1968, Warin reported on the United Kingdom's first large scale attachment scheme of community nurses to specific general practices in Oxford (Warin JF 1968). This project started in 1956 with the first attachment or linkage of a district nurse to a partnership of three GPs. Warin described how the scheme spread throughout the town of Oxford from 1956 until 1965, by which time every general practice in the town had a midwife, district nurse and health visitor attached to it. It would seem that this paper was the first documentation of the birth of the primary health care team: a group of different professionals who provided care for a distinct list of patients in a geographic area.

The early development of the primary health care team

Prior to the Oxford scheme starting, it seemed to be common for GPs to have worked in relative isolation from district nurses, whose area of responsibility was not to the GP's list of patients but to a territory or district, hence their title. In a slightly later published paper, Boddy called this type of nursing the 'Home Nursing Service' (Boddy FA 1969). Warin gave numerous reasons for the Oxford attachment scheme to be initiated. He stated that:

> "All the recognized means of achieving co-operation, including liaison schemes, had already been tried in Oxford, but in spite of great goodwill they were largely ineffective. GPs just did not understand the work of health visitors, and it was felt that they never would until both were responsible for the same patients and met regularly for consultation." (Warin JF 1968)

Warin described some of the reasons why the attachment of health visitors was of benefit to the GPs (Warin JF 1968). Much of this related to services and health promotion advice given to mothers with young children by health visitors. Warin also recorded how it was important to have local individuals with power and influence involved and in agreement to the introduction of the new scheme.

In this case this was the medical officer of health and the superintendent of the nursing staff from the area. Warin suggested that co-location, or the sharing of common premises, would be of benefit to the primary health care team. He suggested if this was not possible, that premises closely located to each other would work well.

Boddy from the University of Aberdeen developed a postal questionnaire, and sent this to Scottish GPs in 1967, his publication appearing in 1969 (Boddy FA 1969). From his study it was clear that there were considerable regional variations in the rates of attachment of community nurses to GPs throughout the UK. Warin's paper stated that 100% of Oxford general practices had attached community nurses, whereas Boddy reported that his studied area of Scotland showed an attachment rate of just 13%. Boddy's questionnaire also asked further questions to identify what respondents perceived would be the potential benefits for them of having community nurse attachment. It was clear that many of these hopes related to moving patient care workload from GPs to community nurses, concerning the follow up of patients, and involving the district nurse in nursing tasks within the practice premises.

This wish for the potential move of work from GP to community nurse contrasted with the perceptions of those GPs who already had a community nursing attachment. These GPs reported that their biggest perceived gain was not the transfer of workload to others in primary health care, but an increase in knowledge about their patients as the result of information shared by community nurses.

Development of community nursing teams

There were few papers found in the literature search relating to the development of community nursing teams in the 1950s and 1960s. In 1968, Hasler and colleagues, a collaboration of GPs and community nurses, presented a paper which described the benefits to patients of the development of community nurses (Hasler JC et al. 1968). This paper highlighted the earlier work of Hockey illustrating how she had seen the untapped potential of community nurses, and her disappointment of how highly trained district nurses were performing routine and mundane tasks (Hockey L 1966). Hasler's paper

illustrated the skill-mix within a community nursing team and the extensive variety of tasks undertaken by this group.

Dixon and Trounson also presented an evaluation of an evolving team of community nurses based in primary health care. They discussed the benefits of having nursing staff who worked in patients' homes and also in the health centre (Dixon PN and Trounson E 1969).

Social workers and GPs

The late 1960s saw the first connections being made not only with the community nursing team, but also with social services. Some GPs and others in the primary health care team were beginning to see the benefits of team-working with agencies that provided community care.

In 1968, Dickinson presented research based on the attachment of a social worker to a general practice in the West Midlands (Dickinson KG and Harper M 1968). Although social workers were not a professional group with any impact upon PLT in this thesis, this study illustrated how GPs and their practices were forming teams and alliances with other professionals in community care. Interestingly, in an earlier paper, Scott, Anderson and Cartwright in their description of their practice in Edinburgh described the work of "the almoner" (Scott R, Anderson JAD, & Cartwright A 1960). This role was perhaps similar to that of a social worker, or today's benefits adviser, whereby the almoner enabled patients to claim benefits and other government payments that may have improved health or reduced suffering.

In a similar project involving social workers and medical practitioners in the United States, it was noted that pre-existing professional stereotypical behaviours and traditional relationships prevented effective teamwork from taking place (Beloff JS and Willet M 1968). Beloff and Willet reported on a study concerning physicians in training, nurses and social workers and noted:

> "The traditional relationship of the physician with the nurse, social worker, or health aide was difficult to change. There is often a social and economic status gulf separating the doctor from the ancillary personnel which makes effective interaction difficult." (Beloff JS & Willet M 1968)

A later study of inter-agency collaboration and work between social work and primary health care showed that a pragmatic concern regarding finances was one of the main barriers to joint working and learning (Johnson P et al. 2003). In addition, organizational and cultural differences, especially between social workers and medical practitioners, resulted in reductions in collaboration.

Community nurses' perception of attachment

In 1969, Walker and McClure reported on the views of community nurses with regards to their attachment to GPs and their lists of patients (Walker JH and McClure LM 1969). They described a survey of community nurses and reported on the benefits of being attached to one general practice, but also stressed the need to have preparation before the attachment took place. They reported the benefits of having discussions of how the attachment should function for both parties and that prior planning of issues such as "working arrangements and methods of communication" were important. At this point in the history of the development of the primary health care team, it was clear that professionals such as GPs, health visitors and district nurses did not have a full knowledge of what the other professionals in the team did prior to the attachment. Walker and McClure reported that one of the perceived benefits of attachment was increased contact and communication between GPs and community nurses.

Again, as in Boddy's work, the authors called for preparation in the attachment mechanism:

> "The more we study this subject the more striking we find the similarities between nurse attachment to general practice and traditional concepts of courtship and marriage. There is good statistical evidence to support a suspicion of the durability and quality of 'shotgun' matches". (Walker JH & McClure LM 1969)

Perhaps this was an early reference to the importance of team-building, suggesting that primary health care teams need time and resources to form effective working relationships that would result in improvements for patient care. Teams that were brought together without time spent on team-building were, on occasions, nominal teams rather than functioning teams.

Increasing rates of attachment of community nurses

Anderson et al., undertook a survey in 1969 which was subsequently published in 1970 (Anderson JAD et al. 1970). Their questionnaire was sent to local health authorities in England and Wales. This survey reported a doubling in the rate of attachment of community nurses to GPs in the two years before the survey, from 11% to 24%. They reported on the establishment of long term relationships between GPs and community nurses in their study. Of the 23 attachments which ended, eight were due to "personality or relationship [problems]" (Anderson JAD, Draper PA, Kincaid IT, & Ambler MC 1970).

Richardson reported considerable variations in the referral rates to district nurses by GPs in Aberdeen (Richardson IM 1974). Richardson stated that referrals of patients from GPs to district nurses increased when the relevant professionals become more aware of each other's work:

> "It seems likely that this greater use of nursing services results from the learning that takes place when doctor and nurse (and health visitor) can meet, as they presumably do more easily in attachments." (Richardson IM 1974)

By 1970, it became clear that a significant number of primary health care teams had formed. There was evidence from published studies prior to 1970 that by bringing GPs and community nurses together, that team members learned more about their patients, and about how the other professionals in the primary health care team worked.

Development of larger general practices

Law undertook a survey of ten large practices and published his findings (Law R 1971). At this time the influence of the 1965 Family Doctor's Charter for general practice had encouraged significant structural changes in the way primary health care was delivered (British Medical Association 1965). This included a financial allowance for the forming of group practices, (three or more GPs), and financial assistance for the employment of A & C staff and for practice managers. In addition financial help was given to GPs to improve practice premises. Law's descriptions of these ten large practices presented a view of the future. These practices were considerably larger than most in the UK at that time, and

illustrated what could be provided with significant income. Practice staff numbers had risen and it became the norm to work in a team with community nurses. Law's work was one of the first to emphasize the benefits of GPs employing and working with A & C staff. They allowed the freeing up of GPs to spend more time on clinical work, rather than on performing administrative duties.

Bowling, publishing in 1981, examined the delegation of tasks and duties from GPs to practice nurses (Bowling A 1981). She found that there was considerable resistance from GPs in referring patients to practice nurses for tasks such as ear syringing or venepuncture and so on. Some GPs felt that such tasks were central to their own role, and thus did not refer. Other GPs felt that practice nurses did not have adequate skills to perform such tasks. Bowling noted that GPs who had higher levels of delegation tended to work in larger practices and were generally younger than their colleagues who had low rates of referral. In a contrasting analysis, Miller and Backett randomly surveyed 690 GPs, receiving a response rate of 77.3% (Miller DS and Backett EM 1980). Their survey showed that two-thirds of GPs were in favour of extending the role of treatment room nurses, and of them becoming practice nurses and ultimately nurse practitioners, as seen in other countries such as Canada.

Baker and Streatfield identified problems relating to enlarging primary health care teams, as general practices grew both in patient list size, and in the number of people working within a single team (Baker R and Streatfield J 1995). They presented the results of their survey, indicating that larger general practices had poorer results in the patient satisfaction questionnaire than smaller practices. They concluded that as teams grew larger, individual patients found it more difficult to consult or deal with individual clinicians and non-clinicians, and that continuity between clinician and patient was lessened as a consequence.

Evolving primary health care teams

A sociological analysis of primary health care teams and their inter-professional relationships was undertaken in 1968 and published in 1973 (Brooks MB 1973). The work showed that although primary health care teams were becoming used

to a team-based approach to providing health care, a number of staff groups had little appreciation of the breadth of their colleagues' work. GPs and social workers perceived that the role of health visitors was more limited than health visitors' perceptions of their own role. A number of different staff groups envisaged that GPs were the leaders of the primary health care team.

Lamberts and Riphagen drew attention to the varying relationships of professionals working together in primary health care (Lamberts H and Riphagen FE 1975). They described an evolving system of co-operation amongst primary health care professionals in a district of Rotterdam in The Netherlands. They used diagrams to demonstrate how professionals had come together and, over time, developed a primary health care team that had become less hierarchical, but had considerable overlap of work roles between each single profession.

Practice nurses and community nurses

With the growing numbers of community nurses attached to general practices, and the increasing employment of practice nurses by GPs, Reedy and colleagues compared the roles of these two different types of nurses, and their opinions on their working relationships with GPs (Reedy BLEC et al. 1980). It was clear that there was increasing role overlap between these two groups of nurses. A significant number of health authority employed community nurses were providing services both in health centre treatment rooms and in patients' homes. Nurses employed directly by the GPs (practice nurses) performed an important role in substitute for the GP in the practice premises. Thus, the practice nurse provided nursing services to his or her employer in order to reduce the GP's workload.

Hockey, publishing later in 1984 was against the concept of GPs directly employing practice nurses (Hockey L 1984). She argued that practice nurses should be employed by health authorities and managed by nursing managers. She considered that nursing managers were more effective in this role than GPs and their practice managers. Ross and colleagues evaluated several nursing teams, where district nurses, health visitors and practice nurses had collaborated in an attempt to provide integrated care between all the members of the nursing profession within the primary health care team (Ross F et al. 2000). One of the

study's findings was an increase in awareness of the different staff groups in primary health care, and it stated that participants learned from each other and welcomed joint training opportunities.

Learning opportunities of practice nurses

Although there was debate and discussion about which profession should manage practice nurses, Mourin demonstrated that the formal education of practice nurses lay, to a considerable extent, with GPs, and not the community nursing team (Mourin K 1980a;Mourin K 1980b). Mourin, publishing in 1980, stated that there were few formal learning opportunities for practice nurses, in comparison to hospital based nurses or community nurses, and as such, this educational deficit was being filled by GPs.

Publishing earlier in 1972, Hasler and colleagues drew attention to the lack of training available to treatment room nurses, commenting that much of the existing education focused on traditional district nursing topics (Hasler JC et al. 1972). The authors concluded that formal learning opportunities needed to reflect the move away from the nursing management of house-bound patients to that which included patients well enough to consult with a nurse in a general practice.

In 1991, Peter undertook a study of practice nurses in Glasgow, and their working and learning (Peter A 1993). He found that 68% of respondents indicated that they had been recruited in the year before his survey, suggesting that the 1990 GP Contract was a driver for expansion in the number of practice nurses. Peter considered that practice nurses were well qualified, but that they received few resources with regards to training and learning after their recruitment. Hibble also recorded an increase in employment hours of practice nurses in one area in England, and noted that practice nurses were undertaking a wider range of tasks than before the introduction of the 1990 GP Contract (Hibble A 1995). Hibble drew attention to the variations in training opportunities for practice nurses. Mackereth, and Ross and colleagues separately corroborated this view of lack of training for practice nurses, despite the expectations of a wider role for this group and a subsequent need for learning new skills (Mackereth CJ 1995;Ross FM et al. 1994).

Swanwick, publishing much later in 2005, drew attention to how little had changed since Mourin's papers on practice nurse training (Swanwick T 2005). Swanwick argued that there were still no formal learning or training requirements or assessments before a hospital-based nurse could become a practice nurse:

> "There is no required qualification for practice nursing. It is perfectly possible to be a staff nurse on an orthopaedic ward on Monday and to be running a practice-based diabetic clinic on Tuesday." (Swanwick T 2005)

Shared formal learning between GPs and community nurses

Elliott, Freeling and Owen in 1980 described changes to the assessment of training for district nurses (Elliott A et al. 1980). This was one of the first research papers to recommend that GPs and community nurses could learn together, and from each other. The authors recommended a potential sharing of learning between district nurses and GPs:

> "One can perceive some pertinent analogies between the development of general practice training and district nurse training in primary care and we have found it interesting, especially in the development of the examinations to see the similarities in the problems encountered in both disciplines and in attempting their solutions." (Elliott A, Freeling P, & Owen J 1980)

Brooks, Hendy and Parsonage followed up this call for community nurses and GPs to learn together (Brooks D et al. 1981). They stated that a considerable number of primary health care teams did not work well with each other:

> "Primary health care teams cannot be said to have achieved similar success [in comparison to hospital teams] at least as far as attached local authority staff are concerned. Even when teams appear to function satisfactorily, their members usually work alongside rather than with each other; they tend to work independently, develop a minimum amount of co-ordination, set individual rather than joint goals and do not identify joint training requirements." (Brooks D, Hendy A, & Parsonage A 1981)

Their paper described the reactions and perceptions of trainee GPs, trainee district nurses, and trainee health visitors, to a joint training event. In particular it was noted that trainee GPs seemed unenthusiastic about working and learning as a team, and trainee district nurses felt threatened and were

suspicious of the reasons behind such learning activities. The authors' recommendations for the future were as follows:

> "Release to appropriate ongoing courses should be seen as a necessary part of each training programme, according to the varying requirements of each discipline. Only in this way can trainees and students identify common learning needs. One of these needs must be a way of co-ordinating the team's activities positively and successfully, so that tasks which they have identified can be met." (Brooks D, Hendy A, & Parsonage A 1981)

This could be interpreted as a call to have resources for shared learning between community nurses and GPs. In an earlier paper published in 1976, Hasler and Klinger showed that joint education was successful in helping GP trainees and trainee health visitors in learning about each other's roles and responsibilities (Hasler JC and Klinger M 1976).

In 1983, Brooks made further observations about joint working and shared learning (Brooks D 1983). He was critical of the lack of evidence of effective team-working in primary health care. He also warned that lack of team-working would create critical problems by the year 2000:

> "First of all, and fundamental, there is the fact that the primary care needs of the community are multi-disciplinary and cannot be provided by one individual, and therefore, like it or not, nurses and doctors will continue to have to work together in some way." (Brooks D 1983)

Brooks recognised that there needed to be a considerable change in the attitudes of the primary health care team towards working and learning collectively, and that in-grained cultural differences and difficulties needed to be exposed, challenged, and changed. He recognised that sharing common premises and buildings was the foundation for team-working, but that in addition training and learning must also be shared. There was a growing realisation that co-location and attachment of professionals together as a team were not enough to guarantee that teamwork would occur. There was a commonly held perception of being in a team in a structural sense, but not working as a team in a functional sense.

The importance of team-building

In 1984, McClure revisited her earlier work in which she had collaborated with Walker (McClure LM 1984;Walker JH & McClure LM 1969). Her survey published in 1984 involved 93 attached community nurses (both health visitors and district nurses) in one health authority area, where attachment to general practices had existed for more than ten years. Her findings showed that the early recommendations to plan attachments and to cultivate relationships between professionals had been, to some extent, ignored. She reported that these preparatory processes were weak, and viewed with little importance by the area health authority. Additional findings were in relation to health care premises, only one third of respondents worked in shared premises with GPs, and approximately one-fifth (20 out of 93 participants) worked in premises with colleagues from the same profession only. It was also noted by McClure that co-location of the primary health care team did not guarantee close working. Some health centres were designed with separate entrances and other structural conditions that prevented the mixing of professional groups, resulting in isolation. This finding had been identified many years earlier by Beales (Beales JG 1978). McClure also alluded to the dual systems of management prevalent for community nurses: the practice manager based in the general practice; and the nursing manager based in the primary care organization.

In 1987, Jarman and Cumberlege called for better organizational working within primary health care teams (Jarman B and Cumberlege J 1987). This call was made almost 40 years after the start of the NHS and almost 36 years since Hadfield and Hockey had separately illuminated the poor state of co-operation between different professionals. Like earlier reports, this paper called for the model of care provided by the team to become the standard mode of delivery of primary health care, and that to achieve this aim primary health care needed to be carefully organised around geographic areas and teams. There was also a desire that patients should belong to only one team and provided with health care by a range of professionals, not just GPs.

Low levels of collaborative working

Bond and colleagues studied the levels of collaboration between two pairing systems: GPs and district nurses; and GPs and health visitors (Bond J et al. 1987). This work was published in 1987, 20 years after primary health care teams were perceived to be the performance unit of primary health care and almost 40 years following the establishment of the NHS (Waine C 1992). It was also almost 70 years since the Government's vision of collaborative primary health care working was published in 1920. Their research showed that the levels of full collaboration between the two pairings of professionals were very low. Bond described full collaboration as "Organizations in which the work of all members is fully integrated." The study stated that most members of the primary health care team at that time had a relationship of "communication." Bond defined this as being: "Members whose encounters or correspondence include the transference of information." (Bond J, Cartlidge A, Gregson B, Barton A, Philips P, Armitage P, Brown A, & Reedy B 1987).

Their research also found that a number of factors had a positive association with collaboration. Some of these included:

- Being based in the same building

- Chance meetings between health professionals

- High frequency of consultations and referrals of patients between professionals in the primary health care team

- Inter-professional meetings when both professional groups were present

Community nurses managed by the general practice

The 1990 GP Contract introduced GP fund holding: where general practices were allowed to be in charge of an amount of money which they could use to buy services for their list of patients (Department of Health 1990). This encouraged some practices to consider innovative ways of working, and increased the emphasis on practice management. One project described the contract arranged between a general practice and community nurses (Wood N et al. 1994). In this pilot project, community nurses were managed by the general practice rather than by the nursing managers, but were not employed by the practice. This

encouraged the combined nursing team of practice nurses and community nurses to work more flexibly and allowed for the development of new services. The study analysed the perceptions and experiences of the primary health care team and also that of the patients from the practice.

The authors concluded that there were benefits to this mode of working. There were perceptions from many within the team that cohesiveness was improved, new services became available to patients, and that there was an increase in multi-disciplinary team meetings. The findings were in conflict with a government policy report, the Cumberlege Report which in 1986 had recommended that district nurses should detach themselves from GPs and the general practice, and instead form community nursing teams based on localities (Department of Health 1986). This recommendation was not taken up by most health authorities.

The increasing role of practice managers

Although all general practices will have GPs in their team, not all may have a practice manager. The 1965 Family Doctor's Charter encouraged GPs to come together to form group practices, and allowed for the remuneration of increased numbers of A & C staff, and for the first practice managers to be employed (British Medical Association 1965;Hasler J 1983;Morrell DC 1991;Westland M et al. 1996). The Charter was needed to reverse the declining entry of newly qualified medical graduates into general practice, with considerable numbers of GPs choosing to emigrate to Australia and Canada, rather than work in general practice in the UK (Newton J & Hunt J 1997).

A case report from England described to the profession the potential advantages of a practice manager employed by a general practice, although this role is described as being a secretary (Byrne PS 1965). In 1970, Gibson published his recommendations on how primary care health centres should be organised and managed. Although his paper makes references to co-ordinating senior receptionists, and to other members of the primary health care team, there was no mention of a practice manager (Gibson R 1970).

Variations in levels of employment nationally

Rates of employment of practice managers varied amongst the regions in the UK and over time. Grimshaw and Youngs stated that general practice management had evolved greatly over the years from 1970 onwards, the time of Gibson's report on the management of health centres (Grimshaw J and Youngs H 1994). Grimshaw and Youngs suggested that in the early years of the NHS, general practice was: "essentially a small cottage industry". This viewpoint concurred with Kennie's observations of the importance of the GP's wife in the successful organization and administration of the general practice (Kennie AT 1962). Other surveys at that time emphasized the importance of the doctor's wife working in the practice (Drury M and Kuenssberg E 1970). Grimshaw's survey of Scottish general practices showed that by 1992, only 62.9% of all general practices in Scotland employed a practice manager. Grimshaw noted that the activities and responsibilities of practice managers differed greatly across Scotland. Some practice managers were performing in a strategic sense within the general practice whilst others were undertaking tasks delegated to them by the GPs.

Hannay and colleagues reported on their survey of general practices in Sheffield in 1991 and 1992, and showed that 52 practices out of a total of 64 practices surveyed employed a practice manager in 1991; a percentage rate of 81% (Hannay DR et al. 1992a). Baker's survey of general practices in Gloucestershire, Avon and Somerset showed that 77.5% of the 287 practices who responded employed a practice manager (Baker R 1992). Both surveys from England showed a considerably higher employment rate of practice managers compared to Scotland. Baker argued that having a practice manager was one of the factors, amongst others, that contributed to the development of the general practice. He concluded that of all the potential contributing factors: "The most easily corrected factor is the employment of a practice manager." (Baker R 1992). Dornan and Pringle emphasized the importance of the 1990 GP Contract for GPs because it stimulated and facilitated the development of practice managers. Increasingly they were being perceived as key personnel in the management structure that would deliver new services for patients (Dornan M and Pringle M 1991).

1990 GP Contract

The 1990 GP Contract, like the Family Doctors' Charter of 1965, brought about a series of significant changes to primary health care and to general practice (Department of Health 1990). The Department of Health introduced changes to funding to encourage GPs to increase their involvement in health promotion and preventative work. Targets and other financial incentives for GPs were introduced to promote high levels of childhood immunisation and of cervical cancer screening. Other changes related to chronic disease management with payments available for practices that provided clinics relating to hypertension, diabetes and other long-term conditions.

Laughlin and colleagues interviewed and observed six general practices, ranging in size from small to large, in order to investigate the effect of the 1990 GP Contract on practice managers and practice nurses (Laughlin R et al. 1994). The authors argued that many of the improvements for patient care brought about by the 1990 GP Contract were related to the work of practice managers and practice nurses. This work was delegated to them by GPs. As one GP in the study said:

> "The Contract hasn't changed what I do at all. Out there, with the nurses and clerical/reception staff, it is all change for them but I've just ignored it all." (Laughlin R, Broadbent J, & Willig-Atherton H 1994)

Laughlin and colleagues also observed the employment structure within general practices and how the changes brought about by the 1990 GP Contract emphasized the importance of these structures (Laughlin R, Broadbent J, & Willig-Atherton H 1994). They observed that power and authority lay with the GPs who were able to delegate work to practice nurses and practice managers who were unable to refuse these additional tasks:

> "The key difference is that the practice managers and nurses are not as free as the GPs to decide how best to manage unwanted tasks and requirements. As was clear from the discussions with practice managers and nurses, all were clearly aware of their status relative to the GPs." (Laughlin R, Broadbent J, & Willig-Atherton H 1994)

The authors argued that this power differential was related to some degree to gender differences and to professional status. In the six general practices studied, all six practice managers were women who had previously been experienced medical receptionists and had been promoted to practice manager within their own team.

This research noted that much of the administration and financial planning of the 1990 GP Contract was undertaken by practice managers rather than by GPs. Hannay, Usherwood and Platts noted that the 1990 GP Contract had resulted in longer working hours for GPs, but that practice managers had undertaken much of the administrative functions, and that GPs were spending more time with patients (Hannay DR et al. 1992b).

Evolution of practice management

Checkland described an evolution of practice management, stating that practice management and practice managers came to the fore in the early 1970s (Checkland K 2004). Her findings were in agreement with Grimshaw and Youngs' (Grimshaw J & Youngs H 1994). Checkland modified work by Fitzsimmons and White and described three different levels of practice management role as listed in Box 2 below: (Fitzsimmons P and White T 1997)

Box 2: Practice management roles

- Operational. Routine work required to keep the practice running: for example payment of wages and salaries, setting up systems to ensure all appropriate claims are filed to maintain practice income, management of maintenance of premises.

- Tactical. Managing short to medium-term objectives: for example, management of computerisation, overseeing audit work, overseeing service developments.

- **Strategic.** Contributing to the long-term development of the practice. This involves keeping abreast of NHS developments, assessing practice strengths and weaknesses, bringing ideas to team-meetings and liaising with outside bodies such as health authorities.

In an interview study of practice managers, Westland and colleagues showed that a significant number of practice managers delegated "operational" tasks to deputies such as senior receptionists, deputy practice managers or administrators (Westland M, Grimshaw J, Maitland J, Campbell M, Ledingham E, & Mcleod E 1996). Practice managers reported that their work was becoming increasingly strategic and that they had significant involvement in financial planning and workforce planning. Concurring with Checkland, Westland's study emphasized the importance of government contractual changes in the development and initial recruitment of practice managers, but also the importance of practice size. It seemed that as general practices were becoming larger (as a result of the merger of two or more smaller practices), they were more able to afford the salary of a more skilled practice manager who worked in this strategic fashion:

> "In the large practice there were more developed management structures allowing the managers to delegate tasks and undertake a more proactive planning and executive role. These managers could be said to be true 'practice managers' as described by Pringle et al, with the partners in the practice allowing themselves to be managed."
> (Westland M, Grimshaw J, Maitland J, Campbell M, Ledingham E, & Mcleod E 1996)

These findings agreed with earlier research from Law which had identified some of the benefits of larger general practices (Law R 1971). Fitzsimmons and White analysed the development of practice managers in the 1990s and argued that some of the increase in the development of practice managers related to the challenges of the 1990 GP Contract and the subsequent opportunities to become fund-holding practices (Department of Health 1990;Fitzsimmons P & White T 1997). Checkland made reference to the impact of each of the GP Contracts (1990 GP Contract and 2004 GMS Contract) suggesting that they have acted as stimuli for change and for further developments in general practice management (Checkland K 2004;Department of Health 2003;Morrell DC 1991).

Newton and colleagues performed a survey of 750 general practices in 1994 and found a diverse range of practice managers (Newton J et al. 1996). In agreement with earlier research, their survey identified that practice managers of larger practices were able to delegate work to deputies. A larger practice list size meant that practice managers had more autonomy. An example was of the recruitment and termination of the employment of A & C staff, and with other duties relating to strategic decisions in the practice. The survey also found that larger practices were more likely to recruit male practice managers from outwith the NHS, in comparison to smaller general practices. Smaller practices tended to recruit female practice managers often promoting someone from the existing team of A & C staff. The results regarding the importance of practice list size concurred with the work from a survey by Newton and Hunt (Newton J & Hunt J 1997). These developments led McCall and colleagues to call for improved investment in learning resources for practice managers in order to meet the increasing development and personal needs of modern practice managers (McCall J et al. 2010).

Administrative and clerical staff

Introduction

Literature specifically dealing with A & C staff, and their learning opportunities in primary health care was harder to find than the literature on other staff groups. The earliest papers referred to the important role of the receptionist and how this role was related to patient care. Other papers were found which showed that A & C staff had little previous training, and little opportunities for training once in post. Some members of the A & C staff showed reluctance to learn about clinical topics.

The important role of A & C staff in primary health care teams

Arber and Sawyer published research based on qualitative interviews from a sample of over 1000 adults from the general population in South-East England (Arber S and Sawyer L 1985). They sought to gain the perceptions and experiences of participants with regards to practice receptionists. The authors stated:

> "The receptionist is central to the operation of general practice, since she is generally the first person the patient contacts when attending the doctor's surgery, and is the intermediary through whom all contacts with GPs are made." (Arber S and Sawyer L 1981)

Their research findings showed that A & C staff were frequently involved in important decisions relating to patient care. An example was whether patients received a house call from a GP or not, or whether the patient received an appointment in the general practice as an alternative:

> "The receptionist can act as a major barrier to the receipt of home visits from the doctor. In general she will make the decision immediately on the basis of a telephone conversation as to whether or not a doctor will visit the patient at home." (Arber S & Sawyer L 1985)

A & C staff also had an important role concerning telephone access to GPs, and they used their communication skills to negotiate patients' access to clinicians.

Lack of training

Drury and Kuenssberg described how few receptionists had received training in the tasks that they were asked to perform (Drury M & Kuenssberg E 1970). Marsh postulated that GPs would be able to care for much larger lists of patients if duties, once considered to be medical, were delegated to others, including A & C staff (Marsh GN 1991). Law identified that larger practices had the resources to employ a diverse range of A & C staff, helping the GPs to work more efficiently (Law R 1971). The educational achievements of A & C staff were considered to be not as important as their personal qualities, such as the ability to maintain patient confidentiality and to understand people (Williams WO and Dajda R 1979). Later research carried out in 1982 showed that little progress had been made with A & C staff's training. Bain and Durno showed that only 10% of receptionists reported that they had undergone any formal training for their work (Bain DJG and Durno D 1982).

Copeman and van Zwanenberg concurred with earlier research regarding lack of training for A & C staff (Copeman JP and van Zwanenberg TD 1988). They found that only 13% of A & C staff had received any type of formal training, and that 53% of respondents considered themselves to be inadequately trained. The

authors also identified that A & C staff acknowledged that part of their role was to protect and shield GPs from the demands of their registered patients. Research undertaken some years later showed that formal training for receptionists was well received, and the research documented the relatively low formal educational achievements of A & C staff prior to taking up their posts (Silverstone R et al. 1983).

A & C staff involvement in clinical care

Middleton described joint training in a practice where the aim was to examine difficult stressful scenarios affecting both receptionists and GPs (Middleton JF 1989). He stated that when GPs and A & C staff learned about each other's perspectives based on these scenarios, there was an increased understanding about each other's roles and the difficulties faced by each staff group.

Eisner and Britten distributed a questionnaire to 150 receptionists who worked in one health authority area in Northern England (Eisner M and Britten N 1999). They followed up the questionnaire with in-depth interviews with 20 receptionists. They found that the role of the practice manager was considered important by A & C staff, as were their perceptions of the degree of teamwork within the primary health care team. Importantly their study identified that the A & C staff respondents did not consider themselves to be working as a team with GPs and that this was a consequence of the employment structure within the primary health care team:

> "Most responders felt that receptionists and GPs could not be regarded as part of the same team, because of the employer-employee relationship." (Eisner M & Britten N 1999)

Hewitt and colleagues further underlined the important role of A & C staff with regards to patient care, emphasising that their interactions were important to patients, and to the care processes in primary health care (Hewitt H 2006;Hewitt H et al. 2009). This perspective was shared by other researchers: White and colleagues were able to improve the services to patients with depressive illness by offering training to general practice receptionists (White C et al. 2008). Their research was one of few studies that offered clinical training for A & C staff. Carnegie and colleagues showed that even minimal training in some clinical

areas, such as health promotion could be well received by A & C staff (Carnegie MA et al. 1996).

Some practice managers, however, reported the reluctance of some A & C staff to engage in formal learning opportunities (McLaren S et al. 2007). There were also other reasons that prevented practice managers from developing their A & C staff. Protected time for learning specifically for A & C staff was usually regarded as difficult to find. As one practice manager said:

> "And also, to be able to take time out of the surgery, though we're a large practice you've got a small number of personnel and they're all in key positions. It's difficult to get other people to do the work. So I'd say those are the barriers." (Practice manager) (McLaren S, Woods L, Boudioni M, Lemma F, Rees S, & Broadbent J 2007)

A summary of the development of primary health care teams

It is clear that the physical and organizational structures of primary health care before the foundation of the NHS in 1948, and to an extent during the first two decades of the NHS, were markedly different from that which is experienced today. GPs often worked on their own, or perhaps with one or two other partners. Premises were small, there being room only for the GPs themselves and a limited number of A & C staff. Contact with other community-based health care professionals was limited, often unplanned and infrequent, and professionals did not know much about each other's workload or role. There seemed to be few opportunities or interactions that allowed primary health care professionals to learn from each other. The delivery of primary health care was fragmented, poorly co-ordinated, and poorly led.

Several structural issues caused this state of affairs. One related to GPs' premises as previously mentioned. The second issue was of community nursing accommodation. Community nurses may have worked from centralised buildings but usually did not see patients there, as they had no consulting rooms of their own to use. Their work was limited to seeing the chronically ill and disabled patients in their own homes as this was the only venue they had in which to practise. Thus they were physically isolated from the GP, only meeting him by chance or by specific arrangement. An additional strain for them was that much of their time was taken up with clerical and administrative duties and travelling

some distances between patients' homes. Consequently there was limited ability for community nurses to see ambulant and relatively well patients within the remit of their post. As a result, issues such as health promotion, immunisation and health education were undertaken by the GP and by the health visitor, with little co-ordination of either one's approach. There was a spirit of competition or conflict, rather than of collaboration between GPs and community nurses. The work of practice administration and management was often undertaken by the GP's spouse or by the GP himself.

The movement from uni-professional practice to primary health care team took many years. Reports from the 1950s and 1960s described how this evolution started as projects or experiments and grew steadily throughout the UK, eventually to become the normal structure and working practises of primary health care. Structural issues from the past however, continued to influence how teams would work and learn from one another. Research papers chronicled the growth of practice nurses, and how their workload and responsibilities increased with GP Contract changes in 1990 and 2004.

The next section of this literature review will describe and analyse how primary health care teams became the basic unit of primary health care provision.

Primary health care teams – the basic unit of health care provision

From the 1970s onwards, it became clear that a primary health care team consisting of various staff groups, often working from the same premises and serving the same group of patients, was emerging as the common functioning unit of primary health care provision within the NHS in the UK. The Royal College of General Practitioners saw this team as the basic building block of primary health care (Royal College of General Practitioners 2003). Van Weel argued that internationally, team-working in primary health care was strongest in the countries where primary health care itself was considered to be strong (van Weel C 1994). There was growing evidence that a team-based approach was beneficial for patient care and for the NHS. Some of the evidence is presented here.

Benefits of team-based delivery of care

Torrance and colleagues argued that a significant number of admissions to hospital could be prevented, and that patients could be cared for in the community, if the primary health care team was given the resources to manage patients at home (Torrance N et al. 1972). This concurred with research from Israel which showed that collaboration between GP, community nurse and social worker could prevent hospital admissions (Polliack MR and Shavitt N 1976). Confino concluded that the attachment of a medical social worker to GPs in a primary health care clinic in Israel resulted in less demand for medical appointments, prescriptions and other treatments (Confino R 1971).

In 1971, Hodes described how the work of GPs, district nurses and health visitors was co-ordinated and planned, and that those collaborative efforts improved the health of elderly patients living at home (Hodes C 1971). He stated:

> "The primary care team can therefore offer all geriatric patients organized care as part of one community of which they form part, but from which by so much fragmentation of the health service they have been separated." (Hodes C 1971)

How, in 1973, described how a primary health care team collaborated to provide long term support for elderly patients (How NM 1973). How suggested that GPs should be the leader of the primary health care team and that the sharing of common health care records by the team improved communication and ultimately patient care. In addition, Philp and Young described a collaborative approach adopted by primary health care teams towards the provision of care to patients who suffered from dementia (Philp I and Young J 1988).

Kendrick suggested that a considerable number of childhood accidents could be potentially reduced by the actions of the primary health care team (Kendrick D 1994). Although it was argued that a team approach may reduce accidents in this age group, Kendrick appeared realistic about how feasible this would be to implement comprehensively. She concluded:

> "Accident prevention is most likely to be successful if the primary health care team works as a team. Individual members will need a good knowledge of the roles of other team members..." (Kendrick D 1994)

She also added:

> "Many primary health care teams do not function in this way: the team is often a structure rather than a way of working." (Kendrick D 1994)

This quote is in agreement with Pringle who suggested that:

> "A team is more than a list of co-workers in a practice report, although that may vary widely. If a team is to mean anything it must embody a method of working, a process not a structure." (Pringle M 1992)

Crombie, building on his earlier publications, described how the primary health care team was structured hierarchically and how this impacted upon the operations of the team (Crombie DL 1970). He stated:

> "It is against this general functional background that we should examine the role of the team who must fulfil these functions and the structuring of such a team. Such an analysis must be concerned not only with the role or functions of the team as a whole but also with the structure of each of the roles of the individuals which constitute the team, and the rules which regulate the inter-relationships of those undertaking their various roles with one another." (Crombie DL 1970)

Crombie also considered that the independent contractor and self-employed status of GPs, and their union into partnerships, resulted in considerable stability in the provision of primary health care. He argued that such partnerships would become difficult if they consisted of more than six partners, and that other hierarchical structures or looser working arrangements may be desirable. It is this structure of joint partnerships of GPs to which community nurses must attach themselves.

More recently, researchers from The King's Fund evaluated large poly-clinics built in the early 21st century to improve primary health care in England (Imison C et al. 2008). Poly-clinics were envisaged to improve services in urbanised areas where it was considered existing general practice premises were small and ill-equipped. The building of poly-clinics (often called "Darzi centres") was an attempt to attract general practices into modern, purpose built centres that would house other primary health care agencies and secondary care outreach

clinics. The King's Fund concluded that bringing different professionals and staff groups together in this way often led to a worsening in team-working. They concluded that co-location by itself, was not a guarantee of team-working. As Beales had noted earlier, the designers of new health care premises must carefully consider having areas that encourage formal and informal interactions between individuals and staff groups. (Beales JG 1978). The researchers from the King's Fund stated:

> "Overall, little formal investment seems to have been made to support joint working. In one scheme, housing more than 100 staff, provision had not been made for a communal area where staff could eat and meet informally." (Imison C, Naylor C, & Maybin J 2008)

It would be appropriate now to consider how The Government, and medical educational researchers, made calls for primary health care teams to have time to allow them to learn, and to develop as a team.

2.4. The call for protected learning time

Introduction

This section of Chapter Two will describe the call, from various organizations and individuals, to have protected learning time. This includes recommendations for PLT from both Government and academics that PLT should be provided to allow primary health care to develop. The section will give details of a variety of studies that illustrate how primary health care teams could produce development plans for the team if protected time was made available to them. Other studies will demonstrate how specific health care projects were successful as a result of the adoption of a team-based approach.

Government recommendations

A number of publications from the UK Department of Health have called for collective learning opportunities for primary health care teams whenever it is possible. It was recommended as an important strategy for teams to adopt in order to improve the quality of their work and the services they offered to patients. In 1998, the Chief Medical Officer called for primary health care teams to learn together and to develop practice development plans that involved the

different staff groups, encouraging collective learning and development (Calman KC 1998). In 2000, another Chief Medical Officer called for teams to learn together and develop a culture that encouraged clinical governance and quality of services for patients (Scally G and Donaldson LJ 1998). To do this, it was recommended that primary health care teams needed to learn with and from each other in order to efficiently co-ordinate and deliver improved services for patients (Calman KC 1998;Department of Health 2001).

The need for protected learning time

Others have also called for the establishment of collective learning, and for the recognition of the need for PLT to allow this to happen. Rushmer and colleagues published a series of three papers describing the attributes of a learning practice, and stating that such learning practices would benefit from PLT in order to enable and encourage team-based learning (Rushmer R et al. 2004a;Rushmer R et al. 2004b;Rushmer R et al. 2004c). This work is described more fully in Chapter Three. Berwick argued that health care systems need to be changed, and that health professionals and teams needed to work in a more co-ordinated way to achieve improvements (Berwick D 1996). Clark contended that patient care was safer when teams work effectively with each other (Clark PR 2009).

Pitts and colleagues published research undertaken shortly after the Department of Health's recommendations on how education in primary health care should change (Pitts J et al. 1999). Their research suggested that the GPs interviewed were supportive of the Government's recommendations and that they appreciated the potential value of learning collectively as a team. Their study about collective learning also highlighted the need for all members of the primary health care team to become involved, and to be realistic about the degree of change that could be achieved.

A study of primary health care teams which attempted to improve the quality of services offered to patients through collective learning approaches showed that participants felt constrained by the lack of time given for such endeavours (Dean P et al. 2004). The authors stated:

> "Those advocating and promoting quality in primary care need to recognise the need to create protected time for quality improvement and its long-term implications in respect to on-going workload management across the whole team." (Dean P, Farooqi A, & McKinley RK 2004)

Dean and colleagues noted that the attitudes of individuals towards the different staff groups in the primary health care team were important to recognise. They recommended that practice nurses and allied health professionals needed to understand the time and financial constraints that GPs working as independent contractors faced. They also recommended that GPs needed to focus more on teamwork, and to include other staff groups in the planning of services for patients. The authors considered that GPs were aware that collective learning in primary health care needed protected time to allow it to take place.

Huby and colleagues undertook focus groups with GPs in relation to their workload and morale (Huby G et al. 2002). One of the conclusions from their research was the need for protected learning time:

> "Building and maintaining strong and supportive partnerships and practices needed protected time and 'space' for partners, and practice staff to get together to agree how to run the practice, and some slack in daily work routines that allowed personal or group problems to be noticed and tackled proactively, rather than reactively." (Huby G, Gerry M, McKinstry B, Porter M, Shaw J, & Wrate R 2002)

Boudioni and colleagues considered that the lack of time, and specifically the lack of time protected from service delivery, acted as a barrier that prevented primary health care teams from learning together (Boudioni M et al. 2007).

The lack of involvement of the primary health care team in creating change was considered a reason why GPs learning in a uni-professional manner did not always result in change in practice, or improvements in care. Uni-professional learning in isolation from the rest of the primary health care team had less impact (Campion-Smith C and Riddoch A 2002). Campion-Smith and colleagues considered that GPs embraced many of the theories of adult learning with a move towards interactive learning methods when involved in uni-professional learning (Knowles MS, Holton EF, & Swanson RA 2005). The authors suggested that unless members of the primary health care team were involved in shared

learning and change that included the team, then the learning undertaken by the GPs was likely to be ineffective. The authors considered that lack of time to allow collective learning on a clinical topic was the main reason why learning was not shared with the remainder of the primary health care team.

Bunniss and Kelly studied a number of primary health care teams, using interviews and observational visits to gather their data (Bunniss S and Kelly D 2008).They considered that team-learning was considered essential by primary health care teams to deliver services for patients. Again the authors argued that if collective learning did not occur, it was very difficult for such teams to provide co-ordinated care. A case study of one primary health care team in the North of England presented similar findings (Arksey H et al. 2007). The study concluded that everyone in the team was essential to its workings, and that clear communication within the general practice and the attached community nurses, helped with the team's performance.

West and Field presented reviews from the psychological literature relating to teamwork, and also studied six primary health care teams to gain their perspectives and perceptions of working as a team (Field R and West M 1995;West M and Field R 1995). Their literature review suggested that individuals in a team needed to feel valued, and to have their work valued by the others in the team. Their empirical work from primary health care illustrated the dominance of the GPs within primary health care teams, and that there were structural differences that interfered with learning. The authors stated:

> "It is well known that doctors have the mandate to take the lead, and may well be dominant. Even where they try to empower other staff, still they are leading shapers of the organizational culture. While five of the six practices visited mainly described themselves as 'hierarchical' most doctors suggested that they were trying to break down the traditional hierarchy." (Field R & West M 1995)

Examples of practice development plans constructed using PLT

The recommendation to develop practice development plans, and to develop such plans from the membership of the primary health care team, was heeded by various groups who reported on their work.

One practice in Dorset, South West England used PLT to develop a comprehensive practice development plan. This plan was constructed and implemented by different staff groups from one primary health care team (Campion-Smith C & Riddoch A 2002). A further study from Dorset showed that the primary health care team could use PLT to encourage inter-professional learning that led to improvements to patient care (Wilcock PM et al. 2002).

Another study of a number of general practices in Scotland showed that all of the primary health care team could work and learn with each other in order to develop and implement a practice development plan (McMillan R and Kelly D 2005). This study involved the use of locum medical cover to provide protection to practices on an individual basis, rather than the much larger scale cover provided by a PLT scheme. This study followed the call by Elwyn, echoing the earlier call by the Chief Medical Officers, emphasising the need for practices to construct development plans, and to involve the primary health care team in doing so (Elwyn G 1998).

Elwyn and colleagues undertook a study which explored the experiences of four facilitators who worked for 12 primary health care teams whilst each team constructed a practice development plan (Burtonwood AM et al. 2001;Elwyn G et al. 2002). These 12 primary health care teams had used PLT for this endeavour. Elwyn's research findings stressed how established structures and relationships in primary health care could impact upon the processes required in constructing a development plan. Elwyn concluded that primary health care teams with little sense of leadership, from an individual, or collectively from a professional group, found the construction of a development plan to be difficult. Such difficulties also occurred in practices where the partnership of GPs was dominated or controlled by a senior partner. Where relationships between GPs were strained or awkward, constructing a development plan proved to be difficult.

A study of Welsh primary health care teams found that practice development plans could be constructed by teams, but that protected time was needed from service delivery to allow this to happen (Carlisle S et al. 2000). Cross and White published two studies which showed that GPs and primary health care teams could develop and implement personal and practice development plans (Cross M

and White P 2004a;Cross M and White P 2004b). They argued that such plans needed protected time in order for them to be successful. Rutherford and McArthur also identified the need for primary health care teams to learn from each other in order to develop and implement a co-ordinated practice development plan, but suggested that such work needs to be given protected time in order for it to be achieved by teams (Bunniss S et al. 2011;Rutherford J and McArthur M 2004).

Examples of the benefits of team-working and learning

Studies show that working and learning as a primary health care team was helpful in the delivery of quality health services to patients. A study focusing on breast feeding showed that breast feeding rates were higher where there was a team approach to the promotion of breast feeding (Hoddinott P et al. 2007). In contrast, where breast feeding promotion was undertaken by only one professional group within primary health care, rates were lower. Primary health care teams perceived that good team-working abilities had a positive effect on the provision of care for patients who had diabetes mellitus (Stevenson K et al. 2001). A further study relating to a number of chronic diseases highlighted the importance of teamwork in the provision of quality health care services for patients (Campbell SM et al. 2001).

In the field of terminal care and palliative care, research was undertaken which illustrated the importance of teamwork within primary health care teams (Walshe C et al. 2008). In this study, participants had varying opinions on the team-working abilities of GPs with some having negative experiences of the ability of GPs to learn from other professionals who were involved in the provision of palliative care.

Downey and Waters described their attempts to use PLT in a health authority area in England by using trained facilitators recruited from practice teams (Downey P and Waters M 2010). Their scheme differed from others described in this chapter in that each individual practice chose the timing of their own PLT independently from others. This approach differs from most PLT schemes in the UK, which generally involves significant numbers of teams simultaneously having PLT, facilitating the deployment of large centrally organised PLT events, and of

employing Out-Of-Hours services. Downey and Waters described their project as being successful as local primary health care team members engaged in learning with and from each other.

There were other examples in the literature of successful projects which illustrated how primary health care teams could learn together and to improve care for patients (Harvey E et al. 2004;Underwood M et al. 2002). When primary health care teams learned about clinical topics and the introduction of new guidelines for managing patients it appeared to be well received by all of the staff groups. Further analysis suggested, however, that not all of the A & C staff in the study felt that learning about a clinical topic was useful for them. Non-clinical staff could learn about clinical topics, but that modifications were needed to make the learning relevant to their role. It was also noted in these study that GPs tended to dominate the interactions between different staff groups.

Firth-Cozens argued that health care teams who were willing to learn from each other and develop a climate of multi-professional and inter-professional learning would likely produce safer health care as a consequence (Firth-Cozens J 2001). The author also argued for the importance of leading a team in a method that encouraged mutual learning, and that such teams needed to be managed and cultivated in order to produce such results (Firth-Cozens J 2001).

A large study of primary health care teams illustrated that the degree of team-working in primary health care was variable and that some team members and staff groups were not committed to the philosophy of teamwork (Poulton BC and West MA 1993). GPs were identified by some participants as being less committed to the ideals of teamwork. Ultimately the authors considered that the employment and structural organizational differences between the GPs and the general practice, and community nurses had considerable influence on this difficulty. The authors recommended that:

> "Ideally all primary health care teams and team members would be employed and responsible to a primary health care organization."
> (Poulton BC and West MA 1999)

Their recommendation to change the future employment structure of primary health care acknowledged the history of general practice, and the structures that came into place with the founding of the NHS in 1948. The authors were also aware of this organizational schism and they stated:

> "As long as the structure of health care militates against the development of clear, shared team objectives, then attempts to encourage effective team-work require health care practitioners to swim against a powerful tide." (Poulton BC & West MA 1999)

Bower and colleagues built on the work of Poulton and West, and argued that the structures of teams, and the learning relationships that existed between team members were important to the quality of care provided by such teams (Bower P et al. 2003). They argued that for teams to perform well they must "share vision and objectives" and learn from each other in a non-threatening environment.

Pullon analysed team-working in primary health care in New Zealand and gave evidence of how structural and organizational differences impacted on how individuals in teams worked with each other (Pullon S et al. 2009). She identified that when primary health care teams were given protected time for team meetings: "good team-work was more often observed."

2.5. The introduction of PLT - reports and evaluations of PLT schemes

The origins of PLT

The initial idea for protected learning time came from Doncaster, England and was attributed to two GPs, Drs Dakin and Coleman. Although no publications are now available from the scheme itself it was cited by a number of subsequent published evaluations of other PLT schemes. A Department of Health publication refers to the initial Doncaster TARGET scheme starting in 1998 (Department of Health 2002). This publication described TARGET as an acronym of: Time for Audit, Review, Guidelines, Education and Training. The Department of Health's publication also described how the TARGET scheme had been used by other area health authorities as a model to establish the provision of learning for

primary health care teams. The Doncaster TARGET PLT gained a Health Service Beacons Award from the Department of Health (Department of Health 2002).

Publishing in 2001, Bell and colleagues described how they established their own PLT scheme, derived from the original in Doncaster: called TARGET Portsmouth (Bell J, Raw D, & White A 2001). This PLT scheme started in 2000, and the authors described the provision of two large centrally organised events with one for clinicians (GPs and practice nurses) and a separate event for non-clinicians (A & C staff, and practice managers). There was no description of community nurses attending either event.

An evaluation of the TARGET Portsmouth PLT scheme was published by White and colleagues in 2002 (White A, Crane S, & Severs M 2002). The evaluation paper described a mixed methods approach: a questionnaire was given to participants, and focus group discussions facilitated by a number of practice managers. Although the response rate to their questionnaire was low at 26%, the evaluation was essentially very positive about the use and value of the PLT scheme. It is of interest that the learning events in this PLT scheme were all large centrally organised events.

Scottish experiences

A study of the first Scottish PLT in one area of Scotland, CREATE, was published in 2005, based on research undertaken for a PLT pilot scheme that ran from March 2000 to March 2001 (Haycock-Stuart EA & Houston NM 2005). CREATE is an acronym for: Clackmannanshire Resource for Education, Audit and Training. This evaluation used both qualitative and quantitative methods. The quantitative evaluation used a questionnaire and this achieved a much higher response rate (83%) than that of the evaluation of TARGET Portsmouth. The qualitative evaluation was generally positive and indicated improvements in primary health care team members learning together and improved teamwork.

Various practical difficulties were identified by the evaluation of the CREATE PLT scheme. It was noted that practice managers were often tasked with the planning and preparation of practice-based PLT. It was perceived that they may not have had enough time to do this work. The identification of learning needs

was also an issue raised by the evaluation. It was noted by the researchers that some staff groups, such as A & C staff were reluctant to be interviewed for the qualitative evaluation of CREATE. One important theme drawn from this research was the difficulties related to the identification of learning needs for all of the primary health care team, and for delivering learning based on those identified needs:

> "For all practices the planning and running of educational sessions for their teams posed challenges in identifying topics and sharing the planning and organizing of sessions." (Haycock-Stuart EA & Houston NM 2005)

It was clear from this research that the planning and preparation workload of PLT had become a responsibility for practice managers.

Evaluations from NHS England

A qualitative evaluation of a PLT scheme in the Midlands was undertaken and published in 2004 (Brooks N and Barr J 2004). Like earlier evaluations and reports about PLT, it was clear that community nurses were not integrally involved with the planning and preparation of PLT, for large centrally organised events or for practice-based PLT. A & C staff were also treated differently in comparison to practice-based clinicians. The authors called for a change in culture so that A & C staff could have learning opportunities during PLT. A GP in this study stated:

> "With the admin staff it's difficult – they have little experience of this sort of thing [PLT]. The way they learn needs to be looked at ... it requires a culture change." (Brooks N & Barr J 2004)

Lucas, Small and Greasley reported on a PLT scheme from Bradford in Yorkshire (Lucas B et al. 2005). This PLT scheme differed in operational procedures from others previously reported as practices only sent a selection of staff who had been nominated by the practice. The study recorded that:

> "Whilst receptionists (A & C staff) were eligible to attend these events, in practice all non-clinical representatives were practice managers." (Lucas B, Small N, & Greasley P 2005)

Indeed this qualitative study focused on the perceptions and experiences of GPs, practice nurses and practice managers. Community nurses and A & C staff were not selected for interview. The authors concluded that the two different types of events held during PLT - practice-based and large centrally organised events - were valued differently by the participants in the study. Practice-based PLT was perceived to be more effective in making changes to clinical practice, and to changing the delivery of health care than large centrally organised events.

Lucas and Small produced a larger evaluation report for the Bradford PLT scheme (Lucas B and Small N 2004). The Bradford scheme contained a significant number of small general practices. These were often single-handed GPs or two doctor partnerships. In the introduction to the report they drew attention to the rapid spread of PLT throughout the UK, but the authors identified that there had been few long-term evaluations of PLT. Lucas and Small used qualitative interviews with a method of data analysis based on grounded theory methods. The interviews focused on practice-based clinicians and practice managers only. As in other qualitative studies there was no recruitment from A & C staff, or from community nurses. The report findings commented on a number of issues that were apparent from earlier studies. These related to the problems of identifying learning needs, and the difficulties of providing learning that was relevant to the needs of all those who attended.

Staff groups did find the ability to meet and interact with colleagues as being a useful outcome of attending large centrally organised events:

> "It's nice to get together and we can see that we are doing things correctly and it's nice to get together with other nurses. I can't speak for doctors, but yes. Before protected learning, lunch is provided and you can get together and you chat and you chat in coffee time and it's more informal, so that when you meet other nurses you ask them about other issues as well." (Practice nurse) (Lucas B & Small N 2004)

There were perceived benefits of the creation and maintenance of informal social networks, reducing the sense of professional isolation.

A further study from the Bradford PLT scheme was published to emphasize the importance of inter-professional learning (Pearson D and Pandya H 2006). This PLT scheme was not typical of other published PLT schemes as all the

professions involved were employed by the Primary Care Trust. This was in contrast to GPs usually being self-employed and contracted to NHS Ayrshire and Arran. The evaluation focused on the perceptions of clinicians who had attended six sessions of clinical learning. Small group work sessions during the clinical training helped different professional groups to discuss management of patients in an inter-professional manner.

Northern Ireland

The University of Birmingham's Health Services Management Centre evaluated a large PLT scheme in Northern Ireland and published their results in 2006 (Jelphs K and Parker H 2006). The Southern Area Learning as Teams (SALT) PLT scheme had commenced in 2002 and was evaluated in 2005. The authors stated that this evaluation was different from previous evaluations in the literature as the PLT scheme studied was larger than others, and had been functioning for several years before the evaluation took place.

In common with some of the earlier evaluations, the evaluation of SALT used mixed methods. A questionnaire was sent to all staff included in SALT, and focus groups were used to generate qualitative data. 329 out of a total of 1200 participants returned the questionnaire, giving a return rate of 24%, in keeping with the low rates of return from some of the earlier published evaluations. The authors' final conclusions were that the SALT scheme was successful and well-received by participants in general.

The SALT focus groups raised issues relating to equality of learning experience. Some community nurses raised concerns that practice-based PLT was often centred on the needs of the practice-based staff, and in particular the GPs, rather than the primary health care team. Community nurses also raised concerns that they did not have protection for learning and they perceived that their own managerial hierarchy was not supportive enough of PLT, and did not provide adequate nursing cover to allow for protection:

> "District nurses don't get the same protected time, if we have a day when they are there, they are answering their phone." (Nurse practitioner) (Jelphs K & Parker H 2006)

Other participants had raised positive perceptions and experiences of the SALT PLT scheme. These included the ability to make and maintain networks across professions and practices and to strengthen relationships as a consequence.

Improvements to clinical practice as a result of PLT

Siriwardena and colleagues published two papers which examined the changes to patient care as a consequence of shared learning that occurred during PLT (Siriwardena AN et al. 2007). Their first paper showed an increase in the prescribing of ramipril, a drug beneficial for patients who have both hypertension and type two diabetes mellitus. The authors considered that their large centrally organised learning event within PLT had a significant impact upon the appropriate prescribing of this drug within the county studied.

Siriwardena and colleagues' second paper on PLT examined the effects of a learning event on the care of patients with type two diabetes mellitus (Siriwardena AN et al. 2008). Data were collected from participants in focus groups and analysed qualitatively into five main themes. Learning from peers, and to a degree peer pressure to change, emerged as key findings from the study. The intervention also helped participants to identify barriers that would prevent them improving care, and by learning from others during their PLT, some of these barriers were overcome. This study focused on one learning topic from a PLT scheme and has shown how change may happen in general practices.

Stenner and Iacovou reported on the large centrally organised events organised in a PLT scheme from Wokingham and Reading in England (Stenner K and Iacovou N 2006). Their questionnaire included quantitative and qualitative questions and was given to participants attending a large centrally organised PLT event. With a response rate of 46% this was higher than some of the earlier published studies, and showed that PLT events were generally well received and useful to participants.

A large survey of PLT in Scotland was published in 2010 (Cunningham D et al. 2010). Although much larger than the individual surveys that had been published from 2001 onwards this survey had a similar response rate (25%) from participants as earlier surveys. The survey continued to show that PLT was well-

received by participants, but that practice-based PLT was preferred when compared to large centrally organised events. Reid and colleagues presented a study of the effectiveness and costs associated with PLT (Reid R et al. 2011). They argued that although participants enjoyed PLT and found it useful, other evidence of the usefulness of PLT was difficult to find.

Limitations of published PLT evaluations

The published evaluations of PLT had a number of limitations. Some related to the different designs of each PLT scheme in comparison to that adopted by NHS Ayrshire and Arran. Others related to the methods used in the evaluation themselves.

NHS Ayrshire and Arran had constructed the three different PLT schemes (one for each CHP) in 2001 and 2002. Staff who were invited consisted of six main groups: A & C staff; district nursing staff; health visiting staff; GPs; practice managers and practice nurses. Other staff were able to attend if they chose to. These staff groups included podiatrists and dieticians who were based in health centres. All staff were, in theory, able to attend both practice-based events and large centrally organised events. These working arrangements contrasted with some of the published evaluations described earlier, which, in some cases excluded A & C staff, or did not regularly invite community nurses to events. Some PLT schemes consisted only of large centrally organised events and these tended to be centred on the needs of clinicians in the practice – the GPs and practice nurses.

The response rate for questionnaire surveys of PLT schemes tended to be low, raising issues of the validity of conclusions drawn from such studies (McColl 2011). The authors of one study had raised concerns about the reluctance of A & C staff to be interviewed. (Haycock-Stuart EA & Houston NM 2005) The reluctance was thought to be in relation to fears expressed by A & C staff of their criticisms of practice managers and others who had planned and prepared PLT.

2.6. Chapter Summary

This chapter has detailed the slow but steady development of the primary health care team, starting from uni-professional working at the inception of the NHS in 1948 and ending with the description and examples of team-based learning and working. It has shown that this change was patchy, with considerable variation from practice to practice and within the regions of the UK. It was clear that there was no apparent nationwide strategy leading this change, and that different units of the NHS organization had the ability to make changes for their area only. An example of this from the 1970s was the rise of attachment of community nurses to general practices in Oxford to levels approaching 100% contrasted with other areas that had only marginal levels of attachment.

The influences of Government were significant in the development of the primary health care team. Various GP Contracts and Charters in 1965, 1990 and 2004 resulted in structural changes to the team and influenced what the team's working processes were. Much of this influence was financial and led to improvements in practice premises, and to a large increase in the numbers of staff joining the team. Practice managers increased in numbers and became more influential with the contracts in 1990 and in 2004. Practice nurses were recruited to cope with the move to health promotion and prevention by the 1990 GP Contract with further developments in the field of chronic disease management with the 2004 GMS Contract.

The educational projects described in this chapter have shown that primary health care teams can join in shared learning experiences, and evaluations of such projects show significant benefits for the functioning of the team and for patient care. A limitation of these projects and studies may be that these practices were volunteers for the endeavours, or included key members who were leaders in the area of team-working. The evaluations of PLT schemes has illustrated that when such projects and ideas are extended to all the practices in an NHS area in a long-term sense, the results may not be so convincing.

The next chapter examines the literature regarding team learning and working both in the context of the NHS and from health care in other countries. Primary health care teams are studied in addition to other health care teams.

Chapter Three – A literature review of team-working and learning

"The research being conducted in the University of Sheffield at the Institute of Work Psychology suggests that effectiveness is improved when teams take time out to review regularly their objectives, strategies and processes, and modify them in the light of changing views and environmental demands." (West M & Field R 1995)

3.1. Introduction

The previous chapter described the slow evolution of collective working and learning within primary health care teams in the NHS. Chapter Two gave examples of effective team-based learning and working and described the call for PLT to achieve these objectives. Some of the studies in Chapter Two dealt with short-lived projects and analysed a small number of primary health care teams which may not have been typical of primary health care teams. The studies may have involved well-motivated individuals, or teams, who had positive experiences of teamwork. In addition, the chapter presented quantitative and qualitative evaluations and descriptions of PLT schemes from its inception to the present day.

This chapter differs in that it is concerned with the literature regarding team-working and learning. This chapter will therefore review the literature of team-working and learning in primary health care teams, and of other health care teams. Firstly I will give some definitions of teamwork from the literature. I will then present and discuss some of the analyses of effective team-based working and learning. This will be followed by a discussion of inter-professional learning, and I will briefly present the concepts of learning organizations and of the learning practice in primary health care.

3.2. Search strategy

The search strategy for papers and studies of effective team-working and learning followed a similar strategy to that used for Chapter Two. Broad phrases and words were entered into various search engines. Key words and terms included: 'primary health care team learning' 'collective learning' 'team-

learning' 'team-working' and so on. Search engines used included Medline and Google Scholar. In addition on-line journals such as: *Medical Education, Quality in Primary Care, Medical Teacher* and *Education for Primary Care* were searched. References cited by research papers were also examined and further journals were discovered as a consequence. Further searches were made as new themes emerged from my initial analysis of the literature of teams and team-working. This led to the identification of studies relating to inter-professional learning, learning organizations and learning practices.

3.3. Definition of a team and of team-working

There were a number of definitions found in the literature of what a team is, and how a team could be identified. Katzenbach and Smith described a team as:

> "… a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable." (Katzenbach JR and Smith DK 1993)

Whereas Wiles and Robison defined teamwork in a primary health care setting as:

> "A group of people working at or from a primary care practice with common goals and objectives relating to patient care." (Wiles R and Robison J 1994)

Mickan and Rodger defined it as follows:

> "Commonly, teams are defined as a small number of members with the appropriate mix of expertise to complete a specific task, who are committed to a meaningful purpose and have achievable performance goals for which they are held collectively responsible." (Mickan SM and Rodger SA 2000a)

Mohrman, Cohen and Mohrman defined a team as follows:

> "A group of individuals who work together to produce products or deliver services for which they are mutually accountable. Team members share goals and are mutually held accountable for meeting them, they are interdependent in their accomplishment, and they affect the results through their interactions with one another. Because the team is held collectively accountable, the work of

integrating with one another is included among the responsibilities of each member." (Mohrman SA et al. 1995)

Implications for primary health care

There were a number of attributes common to each of the definitions. Having shared goals and objectives were noted by all four groups of authors. As has been shown from studies in Chapter Two, shared goals and objectives were not always apparent in primary health care teams. The 2004 GMS Contract caused divisions in some teams, and the different organizations involved in primary health care with different management systems, could have a negative influence on teamwork.

Team size was considered to be a significant attribute for the definition of a team. Both Katzenbach and Smith, and Mickan and Rodger described teams as having a small number of members. This concurs with Borrill and colleagues conclusion that the larger primary health care team of today, should be more accurately considered to be an organization consisting of teams, rather than being simply one team (Borrill CS et al. 2000). This view is consistent with Poulton who argued that twelve was the optimum limit for primary health care teams (Poulton BC 1995).

Having a diverse range of skills which were complementary to each other was also considered important. Mohrman and colleagues emphasized the importance of being accountable as a team, and that individuals had a responsibility to work in the sense of a team (Mohrman SA, Cohen SG, & Mohrman AM 1995).

Rationale for the team-based delivery of health care

Øvretveit has argued that there was little rationale for the provision of health care, or of other service delivery based organizations, to be team-based unless patients or clients benefited as a consequence of using this form of service delivery (Øvretveit J 1995). The argument for team-based delivery of primary health care services was based on the premise that teams may be able to offer a broader and more diverse range of services to patients than individuals could. A team's knowledge and skills were considered to be generally wider as the team included a diverse range of professionals and staff groups. Øvretveit concluded:

"A multi-disciplinary team without differences is a contradiction in terms. The point of a team is to bring together the different skills which a patient or client needs, and to combine them in a way which is not possible outside a team." (Øvretveit J 1995)

West and Field presented their views both from a theoretical perspective, by analysing literature from the psychology of organizations, and from their empirical studies of primary health care teams (Field R & West M 1995;West M & Field R 1995). They shared some common thinking with Øvretveit: they did not assume that the team-based delivery of services would necessarily be better in comparison to other structural arrangements. They also did not assume that simply bringing individuals together into a team would automatically result in a team being formed or teamwork being delivered.

3.4. Method of analysis

Details of the studies

The research studies which follow differ from those presented in the latter sections of Chapter Two. The research studies presented in this chapter identified a number of characteristics and attributes about effective teamwork and learning. These studies generally involved a much larger number of teams with some from different work settings other than primary health care. Some of the studies related to teams from other occupational areas. The majority of the studies presented here are empirical in nature. Knowledge was gained from observations of teams, focus group interviews of team-members, and questionnaires given to team members. Other papers are descriptive, drawing on the expertise and knowledge of the field by the authors and by the use of literature review. The strengths and weaknesses of each study, and the study's relevance to primary health care teams in the UK are also presented.

Analysis process

The research studies and papers were compared and contrasted with each other using the constant comparative method (Charmaz K 2006;Corbin J and Strauss A 2008;Glaser BG & Strauss AL 1967). Initially studies were described and summarised individually. Studies were then examined and comparisons and contrasts made with other studies. Comparative findings were merged, and

contrasting studies were added to the interpretive summary. The writing of memos added to the conceptualisation of this process. The quality of each paper was also examined aided by the methods recommended by a number of papers and texts on this topic (Barbour RS 2008a;Mays N and Pope C 1995b). In particular, texts on different research methodologies, including that of case study were examined (Bowling A 1997;Creswell JW 2007;Patton MQ 2002;Stake RE 1995;Stake RE 2005;Yin RK 2003).

The findings are presented in the following format:

- Attributes of effective teamwork and team-learning from the various studies – see section 3.5

- Table 5 which shows the context and details of the research method of each research paper

- Table 6 which shows the areas of comparison from the papers analysed

- An interpretive analysis of the attributes of effective teamwork with four key categories - see section 3.6

3.5. Attributes of effective team-working and team-learning

Introduction

The research papers are presented in four categories: qualitative research, mixed methods including quantitative methods, literature reviews and papers from opinion leaders.

Qualitative research

A number of qualitative research papers were found with diverse methodological approaches and different data collection methods.

In-depth interviews

Mickan and Rodger undertook a series of interviews in Australia with a range of staff groups involved in providing health care, and also those individuals who were involved in managing health care teams (Mickan SM and Rodger SA 2005). They identified a number of attributes that enabled them to identify effective teams, which they termed: "The Healthy Teams Model". These attributes are listed below:

1. *Purpose*: the aims and objectives of the team's function need to be collaborative and shared.

2. *Goals*: the link between the team's purpose and the aspired outcomes of the team's work.

3. *Leadership*: "good" leaders set and maintained structures for making decisions and managing conflict.

4. *Communication*: regular patterns of communication helped with the sharing of ideas and information.

5. *Cohesion*: a sense of camaraderie and involvement as team members worked closely over time.

6. *Mutual respect*: where individuals were open to the talents, beliefs and opinions of others.

The study's strengths included the involvement of a range of different staff groups from a large number of health care teams. A snowball sampling method was used to recruit participants who had positive experiences of teamwork. Their initial considerations were then given to a large number of health care professionals in hospital teams. Weaknesses of the study were apparent also. Participants were recruited with emphasis on positive experiences of team working, but there was no objective evidence of this claim. A large number worked in hospital settings, who may have held different perceptions and experiences from primary health care participants. This study was situated in Australia, which has a different health service organisation compared to that of the UK.

Semi-structured interviews

Field and West studied six primary health care teams to identify which attributes made them effective, and in contrast, which resulted in ineffective team working (Field R & West M 1995). This study took place before the introduction of PLT in the UK. Field and West identified that time is needed to allow the team to meet and make decisions with regards to patient care and other strategic matters. Field and West recognised that medical practitioners could dominate decision making in primary health care teams, and dominated the team in general, with strained relationships at times being described by participants.

There were strengths and weaknesses to Field and West's study. The authors interviewed a large number of participants from primary health care, and a wide range of staff groups were able to give their opinions. This study was based in the UK. Some of the primary health care teams had been involved in team-building exercises and others had not. Weaknesses included the lack of description of the data collection process – there was no description of how the interviews were coded or analysed.

Case study

Molyneux undertook a case study of a health and social care team of which she was a member (Molyneux J 2001). She reflected that this was an effective team and her interviews with her team members sought to identify the factors that resulted in the team's effectiveness. She noted that the boundaries between the professions in her team became blurred and that individuals worked more closely with each other as time progressed. Her main findings have been summarised by me as being:

1. *Equality*: where team members respected each other, and no one person or professional group dominated others.

2. *Communication*: effective interactions in both formal meetings and informal discussions between team members. This was helped by working in one site, with shared patient/client case records.

3. *Creativity*: where members were allowed to develop new ideas and ways of working.

Molyneux's reflections on her experiences had considerable comparisons with Field and West's findings on effective teams (Field R & West M 1995). Molyneux illustrated that her team members were respectful to each other and that there was a sense of democracy with regards to decision making. Members also perceived that their colleagues valued the work of other staff groups. Communication between individuals in the team was aided by it being a small team, and by working in the same building or location.

Molyneux argued that another factor in the success of this health care team was the absence of medical practitioners from their team. Group members perceived that medical practitioners often assumed a dominant leadership position, and maintained traditional methods and ways of working, rather than being open to innovation and equality. The team saw these characteristics of medical practitioners as having negative influences on effective teamwork.

There were strengths to this study: Molyneux presented findings from an existing team which worked in primary and community care. The team was studied in its natural setting. Molyneux's study had a number of weaknesses. Molyneux did not define what was meant by team effectiveness, nor did she expand on the claim that the team worked well. Team members had perceptions that they worked effectively with each other, and it is these perceptions that Molyneux explored. In contrast to primary health care teams, the team studied had no member who was a general practitioner, or a nurse. All participants were female in contrast to primary health care teams in NHS Ayrshire and Arran where the majority of GPs are male. In addition it was a study based on a team that was relatively newly established, in contrast to primary health care teams which are generally established for a considerably longer period of time.

Molyneux's research method focused on interviews by the author who was a team member and it is possible that bias was introduced into the results. It could be postulated that team members reported to the author the attributes that she wanted to hear. Molyneux commented that: "team members had themselves made a positive and enthusiastic choice to join this team." This method of joining a team may not be easily transferrable to other primary health care teams. Lastly, team members considered themselves equal to each

other, in contrast to the known hierarchical structure of primary health care teams in the UK.

Grounded theory study using focus groups

Sargeant, Loney and Murphy used some of the principles of grounded theory methodology in their research strategy (Sargeant J et al. 2008). They interviewed 61 participants from Canadian primary health care teams in nine focus groups. Participants came from a range of staff groups, and these were commonly found in UK primary health care teams.

They identified five key attributes of effective teams in primary health care:

1. Understanding and respecting team members' roles.

2. Recognizing that teamwork requires work. By this they did not mean team-building events, but rather the need for meeting colleagues and learning how to interact with them effectively.

3. Understanding primary health care. This was concerned with a common language and having shared knowledge of the purpose of the team.

4. Having the practical "know-how" for sharing patient care. The authors argued that health care professionals need to learn how to collaborate and work cohesively for patients.

5. Communication: Sargeant and colleagues stated that communication is "The glue that holds the team together and enables collaborative work."

They found that participants valued the importance of knowing, and respecting, the working roles of their team members. The authors also found that participants recognised the importance of team maintenance: with the taking part in activities that built up the team and maintained its effectiveness. Participants perceived that physicians were more likely to have traditional views, suggesting a more hierarchical relationship between professionals, and their working processes and team participation.

Effective communication skills were judged to be important to team participants, as was the use of an open communication style. Team members who welcomed contributions and comments from other team members were deemed to increase team effectiveness. The authors concluded that simply being in contact with each other did not result in effective teamwork and they suggested that teams needed to be maintained for teamwork to continue. They also recommended that teamwork skills need to be taught as well as learnt by team members, and that shared learning on the function of teams as undergraduate students would facilitate this.

There were strengths and weaknesses to this study. Strengths included a wide range of staff group involved in the research, and that participants were drawn from a number of teams in the region. These participants had quite diverse experiences in primary health care and community health care in contrasting communities. There were also weaknesses. The Canadian setting is different from the UK and also reflects a different geographical context and different health care organisation. Recruitment was from individuals who had positive views of inter-professional working and team-working in general and may hold different opinions in comparison to primary health care teams in the UK.

Case study of two teams of contrasting size

Grumbach and Bodenheimer described two different cases in a case study of effective teams (Grumbach K and Bodenheimer T 2004). They stated that effective primary health care teams had a high degree of cohesiveness, and that this attribute was linked to improved clinical outcomes for patients, and increased patient satisfaction. The authors stated that effective teams had the following five attributes:

1. Defined goals.

2. Effective administrative and clinical systems.

3. Division of labour with clearly assigned roles to individuals within the team.

4. Training – for everyone in the team, with a degree of capacity.

5. Effective communication structures, for example paper, electronic, team meetings etc.

The authors also suggested that there was an upper limit to the number of team members in order to ensure teams were successful. They considered that once teams comprised more than 12 members, communication between individuals became problematic.

Grumbach and Bodenheimer's paper has strengths and weaknesses. The paper gave descriptions and insights from two contrasting cases in the United States. Using illustrations from each in a method comparable to that of case studies, the paper presented examples of effective team working from both illustrations. Grumbach and Bodenheimer presented research from different health care systems in the world and reflect on their strengths with regards to teamwork. It may not be possible to transfer the research from the setting in the United States health care system to that of the UK.

Mixed methods

Lanham and colleagues examined data from four large studies of primary health care teams in the United States (Lanham HJ et al. 2009). Using a grounded theory approach of a number of research methods which included direct observations, in-depth interviews and surveys, they concluded that teams providing high quality health care had the following attributes, summarised by me below:

1. Trust – the willingness of an individual to be vulnerable to another individual.

2. Mindfulness – openness to new ideas and different perspectives.

3. Heedfulness – individuals are sensitive to the task in hand.

4. Respectful interaction – honesty and self-confidence.

5. Moderate level of diversity – differences in perspectives enhances the group's problem solving ability.

6. A range of social and task relatedness – conversations relating to work and non-work activities occur.

7. Communication effectiveness - a mix of face-to-face conversations, and the use of different written communications.

This study used an analysis of secondary data, the analysis of data directly collected by the research team may have been different.

Fay and colleagues studied practice innovations with regards to two different types of teams: 66 breast care teams and 95 primary health care teams. The authors used a Likert scale to measure team innovations that reflected change and outcome. Their study demonstrated that higher quality innovations were more likely to be associated with teams who were more diverse. They concluded:

> "We believe that the shared vision and the high interaction frequency provide the necessary integration [of teams] and 'glue'. They help to overcome the negative effects of social categorization processes and to develop shared mental models. Different professional groups have different KSAs, information and networks that are associated with their different professional and organizational roles. High levels of team reflexivity and safety are needed to present the diverse and certainly sometimes hard to communicate views to the team." (Fay D et al. 2006)

Fay and colleagues postulated that multi-disciplinary teams were often more effective than uni-professional agents as a consequence of their diversity. This was in agreement with Øvretveit's conclusions (Øvretveit J 1995). With diverse knowledge bases, skills and attitudes (KSA) such teams tended to be more innovative in their thinking and work processes compared to teams who were more homogenous. Fay and colleagues stressed the importance of team participation safety, meaning that individuals (especially those who may occupy positions of little power or in a minority group) should be able to safely contribute towards team thinking and development.

There are strengths and weaknesses of this research. A large number of teams from across the UK were involved and this included multi-disciplinary teams from primary health care and from breast care. A weakness of this study was that it focused on innovation in health care which may not have been a focus for primary health care teams studied in this thesis.

Borrill and colleagues from five UK universities consulted over 7000 individuals from 100 primary health care teams, 113 community mental health teams, and 193 secondary health care teams in the UK (Borrill CS, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D, & West M 2000). Their aim was: "to determine whether and how multi-disciplinary team-working contributed towards quality, efficiency and innovation in health care in the NHS."

Research methods included a questionnaire survey, and a diverse range of qualitative data collection methods. In addition their study presented an extensive literature review of studies regarding team-working in various health care settings.

The section of their study concerning primary health care involved a survey to 1156 respondents from 100 primary health care teams. The survey drew on earlier work from the Team Climate Survey (Anderson NR and West MA 1996;Anderson NR and West MA 1998). This was followed up with questionnaires and telephone interviews. In addition, multi-professional meetings were video-recorded and analysed. Further focus groups were held in the theme of a workshop, in addition to training events for primary health care teams.

The findings of the overall survey (to primary health care teams, breast cancer care teams, and secondary care teams) showed the importance of clear team leadership, with regards to high levels of participation, and team objectives and performance. The authors found that a lack of leadership clarity, or the presence of leadership conflict, predicted lower levels of innovation within a team. The authors also detected important links between team size and the degree of innovation present:

> "The data show that larger teams have higher levels of innovation across all three samples [primary health care teams, breast cancer teams, and community mental health teams]. This may be because larger teams process more diverse perspectives and therefore have the potential to achieve a more comprehensive processing of information and decisions, both of which processes are likely to lead to creative ideas." (Borrill CS, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D, & West M 2000)

The research concluded that the organisational structure of the NHS did not fully support the concept of team-working, and that significant changes were needed if the NHS continued to pursue team-working as a method of achieving quality care for patients.

There were a number of strengths of the primary health care section of the larger study. The study was large and included a diverse range of primary health care teams in the UK. Teams varied in size and in location and other factors such as variation in deprivation levels were included. A weakness of the study was that of recruitment, only 30% of primary health care teams surveyed made an initial response to the questionnaire. A final response rate of 56% was achieved after reminders were sent. This may suggest that there is an element of bias in that the views of respondents could be different from non-respondents.

Literature review

Mickan and Rodger identified the literature concerning teams from the world of business and commerce and compared and contrasted it with the literature from health care teams (Mickan SM and Rodger SA 2000b). They judged the effectiveness of teams based on the output, or outcomes of the team's work. Mickan and Rodger stated that effective health care teams had a clear purpose, and that they were also supported and resourced by their organization. The authors maintained that team leaders needed to be skilful, and that team members should have clearly defined roles.

Mickan and Rodger concluded that there was an expectation that health care staff groups would work in teams, and that the authors considered this expectation to be an assumption. They considered that as business teams often adopted teamwork to increase production and to meet customers' needs, health care teams often worked in the sense of a team when they jointly cared for patients and when that care was based on the patient's individual needs.

Guzzo and Shea's chapter in a text on teamwork is drawn from a literature review on this topic. It is noted that they referred to work groups rather than work teams but the authors suggested that such terms were synonymous. Guzzo

and Shea made a series of recommendations for attributes which, if present in a team, should enable that team to function effectively:

1. Individuals should feel they are important to the fate of the group.

2. Individual tasks should be meaningful and intrinsically rewarding.

3. Individual contributions should be identifiable and subject to evaluation and comparison.

4. Teams should have intrinsically interesting tasks to perform.

5. There should be clear group goals with inbuilt performance feedback (Guzzo RA and Shea GP 1990).

Opinion leaders

The views of opinion leaders has contributed to the academic literature of a subject and can be influential in changing behaviours of others (Katz E and Lazarsfeld P 1955).

Øvretveit suggested that the term "team" can be used inappropriately, and emphasized that individuals may be collectively called a team but not function as a team. Øvretveit described five main attributes that effective teams could be considered to have (Øvretveit J 1996):

1. The degree of integration or closeness of working between professions in the team.

2. The extent to which the team manages its resources as a collective or as separate professional services.

3. Membership of a permanent work group, and what this membership means to its members.

4. The processes which define a client pathway through the team, and how decisions are made.

5. Management – how the team is led and how its members are managed.

Øvretveit considered that teams needed to interact and network with each other in order to communicate. He considered such interactions could be formal, for example team meetings, but informal also. He also maintained that teams that

delivered health care should take responsibility for their performance and action as a team, and not as a collection of individuals. This paper is not based on empirical research. Øvretveit has a considerable number of publications in the field of inter-professional team working and this paper draws on his experience.

Summary of research methods

A wide range of research methods, and methodologies, were employed in the research studies and papers described above. There were marked differences in scale: Molyneux's research was concerned with one small team in which she herself worked, whereas Borrill and colleagues in their study used a number of different research methods involving hundreds of teams. I would argue that all the papers were useful in adding to the interpretive analysis that follows in this chapter. Some like Borrill could claim that their findings and conclusions were wider than that of Molyneux. However, much can be learned from a single case which described an effective way of team-working.

Table 5 gives details of these empirical studies: giving details of the types of team studied; the location of these teams; and what research approaches and data collection methods were used.

Table 6 records the key categories of themes from the empirical and descriptive papers on the attributes of effective teams.

Table 5: Contextual details and methods of the research papers			
Study authors	Type and number of teams studied	Countries/States involved	Methods used
Mickan and Rodger	39 hospital health care managers 202 health care professionals	Australia Australia	Interviews and questionnaires Questionnaire
Molyneux	One multi-professional team	United Kingdom	Semi-structured interviews
Sargeant, Loney and Murphy	61 participants from 8 primary health care teams	Canada	Focus groups interviews
Fay, Borrill, Amir, Haward and West	70 breast cancer teams 95 primary health care teams	United Kingdom United Kingdom	Questionnaire and survey using open-ended questions
Borrill and colleagues	98 primary health care teams 113 community mental health teams 72 breast cancer teams	United Kingdom United Kingdom United Kingdom	
Lanham and colleagues	84 primary health care practices 18 primary health care practices 80 primary health care practices 60 primary health care practices	Ohio Nebraska Ohio N. Jersey/Philadelphia	Analysis of four separate studies using a grounded theory approach

	Table 6:Interpretive Analysis –key categories			
	Relationships between individuals	Management and leadership	Purpose and processes of the team	Communication
Øvretveit	Integration/closeness of working. Membership of a group; should be important and meaningful to members	How the team is managed and led affects team function. Effective teams manage resources collectively	Processes defining client pathway through team are clear and understood by members	
Guzzo and Shea	Individual contributions should be identifiable. Individuals should feel important to the group	Clear goals with performance feedback	Tasks should be meaningful and rewarding/ Tasks should be interesting	
Mickan and Rodger	Mutual respect: where individuals were open to the talents, beliefs and opinions of others Cohesion: a sense of camaraderie and involvement as team members work closely over time	Leadership – good leaders set and maintained structures for making decisions and managing conflict	Purpose: the aim of the team's function need to be collaborative and shared Goals: the link between the team's purpose and the aspired outcomes of the team's work	Communication; regular patterns of communication helped with the sharing of ideas and information
Molyneux	Equality: where team members respected each other, and no-one person or professional group dominated over others		Creativity: where members are allowed to develop new ideas and ways of working.	Communication: effective interactions in both formal meetings and informal discussions between team members
Grumbach and Bodenheimer	Training for everyone in the team; with a degree of capacity		Defined goals Division of labour – clearly assigned roles to individuals	Effective communication structures e.g. paper, electronic, team meetings
Sargeant, Loney and Murphy	Knowing and respecting working roles of team members			Open communication style; welcoming comments and contributions
Fay et al	Participant safety – individuals should be able to contribute safely			
Borrill and colleagues	Team size; the comparisons between an individual and size of the team	Clear team leadership. Leadership conflict can cause poor quality team working.	Innovation is improved if teams are diverse and contain a range of different professions and staff groups	Teams with a greater number of team meetings have a higher level of innovation
Lanham and colleagues	Trust between individuals. Respect amongst colleagues. Varied interaction (mixing social and task relationships)		Diversity: broadens the team and encourages different views. Mindfulness: colleagues are open to different views and ways of working. Inter-relatedness: colleagues understand how their work affects each other.	Effective communication: using face-to-face meetings but also email and other 'lean' methods

104

3.6. Interpretive Analysis

Four main attributes of effective teams were found, as shown in Table 6, and these are described in turn.

Relationships between individuals in the team

The closeness of working, or the degree of integration of team members was an important and common finding in the empirical and descriptive papers. Teams were able to learn from each other and improve their team's performance if they worked closely together on existing work or on new projects. It could be argued that working collaboratively on projects that had shared goals and objectives was a common method of team-building, whereby teams formed naturally around shared or inter-related work. Katzenbach and Smith argued against the need for team-building activities for teams and suggested that teams will build themselves given the right atmosphere or climate, and if the team was focused on shared work and activities (Katzenbach JR & Smith DK 1993).

Being located in the same building or area helped with team work, but was not seen as being essential to allow closeness or cohesion to happen. The formation of effective teams was eased by open communication between individuals and different staff groups and will be discussed below. A number of researchers referred to the concept of participant safety in teams, and that individuals could generate ideas and voice them to the team and that they would be treated respectfully by other team members. Such teams encouraged a sharing of ideas and valued the participation of all its membership, not just those with authority or power. Other authors considered the concept of trust to be important, whereby colleagues felt able to generate ideas knowing or trusting that their colleagues would value their opinions, and would respect them as colleagues.

A number of studies emphasized the need for team members to respect each other and to be aware of the different roles and purposes of the individuals in the team (Lanham HJ, McDaniel RR, Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009;Molyneux J 2001;Sargeant J, Loney E, & Murphy G 2008). Molyneux drew attention to the concept of equality, suggesting that in effective teams, no one individual or staff group should dominate the work of the group.

Lanham and colleagues highlighted the need for team-members to have varied interactions in the sense of the working environment and also of knowing about colleagues outwith work (Lanham HJ, McDaniel RR, Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009). They stressed the importance of knowing about the personal and private lives of team members, describing this as "varied interaction" and taking an interest in all aspects of the individuals in a team.

Management and leadership

Who leads the team and how this leadership was undertaken was important to team effectiveness. Team members were considered to need clear goals and objectives to improve their performance, and specific feedback on performance helped with effectiveness. Teams which had a sense of democracy in the area of decision making, where resources were pooled and shared collectively, were considered to be effective. In addition those teams who had clearly defined leaders were likely to be more effective than teams where it was not always obvious where leadership came from. Mickan and Rodger have stated that in primary health care teams, it was often the medical practitioner who becomes the leader by default (Mickan SM & Rodger SA 2000a). They suggested that this is not always appropriate and that other individuals within the team may have better leadership qualities and thus be more able to lead the team. Molyneux commented that the absence of a medical practitioner in her team under study was one reason why it proved to be effective (Molyneux J 2001) .

Purposes and teamwork

What the teams' functions were, and how these functions were carried out were both influential factors on the effectiveness of the team. Effective teams were likely to have shared goals and be aware of each other's role in the achievement of shared goals. In addition working processes needed to be fluid and flexible, and effective teams usually consisted of individuals who were open to opportunities that encouraged diversity and change. Such teams managed innovation well and openly encouraged the creativity that allowed for new ideas and challenged existing ways of working.

Teams with clear and common objectives or goals, found that innovation and learning helped them become more effective in the achievement of their shared goals. This was helped by clear and unconflicting leadership, and the recognition that leadership was not permanent within the team, but could move from one person to another. Leadership was often characterized by individuals who led on a particular project for a given time, only for leadership to move to another individual when relevant to the team or to the performance objectives of the team.

Lanham and colleagues stated that those teams, that used the attributes of the inter-personal relationships that they described, and incorporated them into their working processes would be effective working teams (Lanham HJ, McDaniel RR, Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009). They argued that team processes were improved when teams embraced and valued diversity, 'mindfulness' and appreciated how their work affected others in their team.

Communication

A number of authors cited the importance of effective communication between individuals and the staff groups within teams. Regular and frequent communications were needed, and communication methods needed to be varied. Lanham and colleagues stressed the importance of 'rich' and 'lean' communication channels (Lanham HJ, McDaniel RR, Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009). They gave examples of 'rich' methods as being face-to-face meetings which included formal meetings and informal interactions. The authors also considered that 'lean' methods such as notices, emails and memos were important too. Molyneux considered that effective communication was vital to produce an effective team and argued that communication was eased by co-location of the team (Molyneux J 2001). Allowing enough time for team meetings was important, and this helped to develop good relationships amongst team members. Sargeant, Loney and Murphy's thinking on communication had much in common with Lanham et al, Molyneux, and Grumbach and Bodenheimer (Sargeant J, Loney E, & Murphy G 2008). They argued that effective teams communicated with each other using a range of diverse methods. These included formal meetings amongst the teams,

as well as the ability to approach others quickly and in a variety of informal venues and situations.

3.7. Barriers to team-working and team-learning

Field and West interviewed 96 participants from six different primary health care teams; each had varying experiences of team-building exercises and events (Field R & West M 1995). They identified that hierarchically structured teams often had difficulties in making decisions that involved all the team, and that power lay with GPs and to a degree, their practice managers. Some of the teams that had held team-building events had found these events to have a limited benefit to the processes within the teams. The need for repeated team-building events was recognised, but primary health care teams often had difficulty in finding protected time for such events. None of the teams studied by Field and West was involved in PLT schemes. Field and West called for protected time for team meetings. Some teams in their study had low levels of collaboration in practice, and this was often as a result of team members not knowing other colleagues in the team, and issues relating to lack of respect, and of feeling under-valued by colleagues.

Innovation and change

West and Wallace considered that a major challenge facing organizations and teams was the need to innovate ways and systems of working in a constant environment of change (West MA and Wallace M 1991). They defined innovation as follows: "Innovation involves developing new and improved ways of doing things, whether within or outside the world of work." The authors cited the work of West and Farr, who assumed that:

> "Innovative groups will be cohesive, have participative leadership, strong norms of innovation in the team climate, a focus on both rational and intuitive thinking, and a concern with quality task performance." (West MA and Farr JL 1989)

West and Farr studied eight primary health care teams, specifically trying to recruit teams that had undertaken a specific innovation in service delivery (West MA & Farr JL 1989). Their aim was to evaluate the quantity and quality of

innovations developed by a team. A questionnaire was devised and given to 43 individuals from the teams, and analysed statistically to determine the teams' attributes towards innovation and learning. The authors also used a number of other questionnaires developed to assess knowledge of work performance, clarity of individuals' roles, organizational commitment, and cohesiveness. In addition, they asked individuals to recall recent innovations in their team's work and practice, and such innovations were analysed by six individuals from diverse health care backgrounds. West and Wallace concluded that:

> "Innovative teams tend to legitimate controlled experimentation, be tolerant of diversity of approaches and support the initiation and development of ideas (climate)." (West MA & Wallace M 1991)

They also concluded that the most innovative primary health care teams had placed some constraints on the power and influence of GPs, and also tried to empower their patients more.

3.8. Inter-professional learning in primary health care teams

This section of the literature review on team learning will focus on the literature regarding inter-professional learning. Molyneux suggested that one of the difficulties faced by her team was the inclusion of a medical practitioner in the team (Molyneux J 2001). This led me to consider how professions and other staff groups in primary health care teams worked and learnt from each other. Therefore, this section will identify studies and reviews that examined how the different staff groups in primary health care teams viewed learning with and from others in the team. The Centre for the Advancement of Inter-Professional Learning defines multi-professional learning as: "Occasions when two or more professions learn side by side for whatever reason", and inter-professional learning as: "Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care" (Barr H 2002).

The 'readiness' or ability of specific professional groups to learn from other professionals in their team has been measured using a questionnaire (Parsell G and Bligh J 1999). This questionnaire, originally designed for use in under-

graduate settings was validated for use for primary health care teams (Reid R et al. 2006). When this questionnaire was given to primary health care teams within a Scottish health board during their PLT, the GPs showed a difference from other staff groups in their readiness to learn from others. They were less ready to collaborate with others in the provision of health care. The authors alluded to how their results agreed with a study from New Zealand which showed similar results in an under-graduate setting (Horsburgh M et al. 2001).

A further study from New Zealand showed a difference between the learning attitudes of primary health care doctors and nurses (Pullon S and Fry B 2005). This study examined how different professionals learned from each other whilst undertaking post-graduate study. The authors demonstrated that most participants increased their awareness of other professionals' work, but that nurses were more likely than doctors to have increased their understanding of other professionals and their roles after being involved in a post-graduate learning experience. In their conclusion, the authors considered that the employment structure in New Zealand primary care, where GPs are self-employed and may employ practice nurses, had a negative impact on learning opportunities.

Barriers to inter-professional learning

Axelsson and Axelsson suggested that territorial behaviours, related to different health care organizations, and adopted by different professional groups represented in primary health care teams can act as a barrier to collaboration, and to joint learning and working (Axelsson SB and Axelsson R 2009). They argued that professional behaviours and practices themselves can act to prevent collaboration between professions. The authors envisaged that collaborative working can be perceived as a threat by some staff groups and professions. They concluded:

> "In order to collaborate across professional boundaries, the professional groups must be able to see beyond their own interests and even be willing to give up parts of their territories if necessary." (Axelsson SB & Axelsson R 2009)

Wackerhausen suggested that some professional restrictions on collaboration were learned by the professionals from others in their profession, such behaviours were culturally acquired, and contributed to the identity of professionals (Wackerhausen S 2011).

Empirical research of different professionals involved in child care showed that there were a number of barriers to inter-professional working and collaboration (Robinson M and Cottrell D 2005). Robinson and Cottrell described a lack of knowledge and understanding of the different organizations involved in health care and how these different units were structured and managed. The use of a different vocabulary by each professional group also acted as a barrier to effective communication, as did the power that each group perceived they had. Some professional groups were critical of the high status that they perceived the medical practitioners enjoyed, to the detriment of team-working. They recommended:

> "Team-members with different backgrounds, trainings, explanatory models for understanding service users' issues, and language cannot be expected to just work together effectively from day one. Time needs to be invested in team-building activities and in allowing the creation of a shared language in team activities and service delivery."

> "Time should be set aside for team-building, for establishing joint activities for members from different agencies, and for developing shared protocols and documentation." (Robinson M & Cottrell D 2005)

Their view showed some comparisons with much earlier work carried out when GPs were first entering into professional working relationships with community nurses (Walker JH & McClure LM 1969). Walker and McClure recognised that simply allocating or matching one professional with another was not enough to facilitate good working relationships between them. Robinson and Cottrell, and Walker and McClure all clearly argued for resources to be provided for team-building work and activities. Stinson and colleagues agreed with this, arguing that teams needed time and permission from their managers for such activities (Stinson L et al. 2006).

A study from Canada underlined the importance of regular meetings to help team-building, but also found that events that were fun, and of a social nature, helped primary health care team members to get to know each other (Brown JB

et al. 2010). This ranged from a large party in the festive period, to a daily routine of having coffee together.

Brown and colleagues explored conflict within staff groups in primary health care teams (Brown J et al. 2011). They found that lack of knowledge of the jobs of other staff groups within teams led to problems relating to role boundaries. Team members were not always aware of colleagues' work or areas of responsibility. This study also found that participants were often too busy at work to correct such gaps in knowledge, and that the hierarchical nature of some primary health care teams meant that poor relationships between individuals and staff groups went unchallenged.

A further barrier to inter-professional learning in primary health care was that of stereotypical behaviour. Both Carpenter, and Hind and colleagues identified that the success of inter-professional learning was often hindered by professional's views of themselves and colleagues from the same profession, and views of other professions (Carpenter J 1995;Hind M et al. 2003). Carpenter identified that when participants held negative hetero-stereotypes (stereotypical views of professional groups other than their own), that these perceptions had a negative effect on the success of inter-professional learning. Such views may be particularly important when professional groups who do not know each other well, at either professional or individual level, then attempt to engage in inter-professional learning and in multi-professional learning. It is possible that individuals may rely on these earlier assumptions about how other professions will behave and react.

Dominance of medical practitioners

The dominance of GPs and a strongly hierarchical structure in primary health care were found to be factors that reduced the opportunities for primary health care teams to work and learn from each other (Shaw A et al. 2005). Shaw and colleagues' study from some primary health care teams illustrated that when a small number of GPs controlled the team this could have an inhibitory effect on teamwork. Shaw also reported that poor communication amongst the team and an absence of shared team goals were additional factors that resulted in poor team relationships.

Begley argued that the learning environment during inter-professional learning was very important, as was the need to have a degree of trust and mutual respect within primary health care teams (Begley CM 2009). Begley also stated that dominant groups needed to be restrained during team-based learning activities to ensure that less powerful staff groups were not overly controlled. Begley suggested that the employment of a neutral facilitator would help in this endeavour.

A lack of understanding of the different roles and organizations that were involved in the primary health care team was cited by Elston and Holloway as being a barrier to good teamwork (Elston S and Holloway I 2001). They stated that different organizational structures could impact negatively on teams:

> "The structures of nursing, medicine and practice management whose members have different ideologies and sub-cultures, develop during their education and training, experience inter-personal and inter-professional conflict with often arises from a lack of understanding of each other's professional roles and values." (Elston S & Holloway I 2001)

Some team-members had to operate with different rules and restrictions on their activities. These were derived either from their own organization (for example the primary care organisation influenced the practice of the community nursing team) or from restrictions from professional regulatory bodies, for example, The Nursing and Midwifery Council.

A study of multi-disciplinary teams caring for patients in a hospital stroke unit found that professionals could work well with each other, and share knowledge and skills (Baxter SK and Brumfitt SM 2008). However, this study also identified that medical practitioners tended to dominate such teams, and that they had the power to control much of the decision-making in the care of patients.

Historical professional roles

Hubbard and Themessl-Huber studied the relationships between primary health care teams and social care teams in Scotland, in the setting of services for older people (Hubbard G and Themessl-Huber M 2005). They found that participants wanted to work in an inter-agency format, but struggled to do so, and continued

to operate in a fashion governed by their profession and its history. With regards to professional roles they found:

> "Professionals' hesitation in embracing new or additional roles, the resilience of habits and traditional ways of working, and difficulties in accessing services appeared to be important factors in the development of joint working. Strategies to overcome these barriers included team-building activities, promotions, co-locations and the formalisation of links between health and social services." (Hubbard G & Themessl-Huber M 2005)

Wiles and Robison presented the perceptions of nurses, midwives and health visitors with respect to team-working in primary health care (Wiles R & Robison J 1994). The midwives struggled to identify themselves with the GPs and with the primary health care team. Their identity in community-based health care originated from their perceptions of belonging to a uni-professional midwifery team with strong structural links to the local maternity hospital. Health visitors felt their role in the primary health care team was threatened not only by the rising numbers and influence of practice nurses, but also by the relative isolation of health visitors from GPs. District nurses shared similar sentiments towards practice nurses, but in addition identified that their personal relationship with the GPs was important albeit a relationship that was in conflict at times.

Even when teams were formed from scratch, there were problems with professionals working with each other. Bateman and colleagues described an ethnographic study of a new general practice in England (Bateman H et al. 2003). The authors found that there was a lack of clarity regarding each professional's role in practice and that managing a primary health care team was a complex and difficult task. Allan and colleagues identified that the development of a learning culture in primary health care teams took some years to occur (Allan H et al. 2005). This practice used PLT in the form of 'away-days' and the team was protected from service delivery by the employment of locum GPs.

3.9. Learning organizations and learning practices

Introduction

This section will briefly describe the literature concerning learning organizations and learning practices. It will also give descriptions from the literature of how some practices attempted to become learning practices.

Learning organizations

In response to the Government's requirements for the providers of primary health care to consider how to improve the quality of health care, Davies and Nutley suggested that the adoption of policies that enabled and encouraged the development of learning organizations was needed and was important (Davies H and Nutley SM 2000;Secretary of State for Health 1998). Davies and Nutley drew on the work of Senge and presented his description of the key features of learning organizations (Senge PM 1990).

Sheaff and Pilgrim analysed publications relating to learning organizations specifically with regards to the health service, in order to define the principal characteristics that health care learning organizations should have (Sheaff R and Pilgrim D 2006). The authors were concerned whether teams in the NHS could develop some of the attributes of learning organizations. They were critical of existing organizational structural factors in the delivery of health care and considered that such structures did not encourage team-based learning:

> "The sort of team-learning that learning organizational theorists advocate runs against the grain of meritocratic educational structures from which a clinical professional typically comes into the workplace. Those structures emphasize individual learning and scholastic achievement – not collective learning."(Sheaff R & Pilgrim D 2006)

Carroll and Edmondson emphasized that in order to enable health care teams or other types of organizations to become learning organizations, educational leadership was needed for this to occur (Carroll JS and Edmondson AC 2002). They argued that: "leadership is an essential function to prepare and mobilise organization participants for change." The authors maintained that some

leaders of organizations had the ability to adopt a wide view of their own organization and have the power to make change happen.

Senge described a learning organisation as:

> "…where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together." (Senge PM 1990)

Senge presented five key attributes that he argued were central to the development of learning organizations:

1. Systems thinking

2. Personal mastery

3. Mental models

4. Building shared vision

5. Team learning

These five components are described here very briefly: *Systems thinking* reflects a larger scale perspective of how organizations work and the need to analyse problems in the context of an organization's history and interactions globally. *Personal mastery* is described by Senge as being a life-long commitment to personal development and continuing professional development. *Mental models* are related to our own views of the world, and strongly held assumptions of reality. *Building shared vision* is a characteristic of effective leadership, where leaders are able to direct their teams by developing a shared view of the future of the organization. *Team learning* relates to how groups collectively discuss and develop dialogue with each other in order to develop. Senge claimed: "Team learning is vital because teams, not individuals, are the fundamental learning unit in modern organizations." (Senge PM 1990).

Learning practices

The literature review in this thesis has chronicled the increasing development of learning within primary health care, the growing trend to envisage team-learning

and team-working as being the norm in primary health care, and the increasing recognition that patient care should be delivered by a team of professionals, rather than by professionals working in isolation. A number of studies and research papers in the primary health care education literature refer to the growing recognition of the concept of the learning practice (Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004a;Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004b;Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004c). Some primary health care teams have developed further and have become learning practices where learning together and from each other is considered a core behaviour and activity.

The concept of the learning practice originates from a variety of literature sources (Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004a;Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004b;Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004c;Sheaff R & Pilgrim D 2006;Wilkinson JE et al. 2004). The foundations for these publications originated from the world of industry and commerce with the work of Senge commonly being quoted (Senge PM 1990). Rushmer and colleagues have presented their description of what a learning practice could look like, and how it would operate in day-to-day practice. The authors defined a learning practice as:

> "A GP (or similar) unit where individual, collective and organization learning and development is systematically pursued according to Learning Organization principles, in order to enhance service provision in a way that is increasingly satisfying to its patients, staff and other stakeholders." (Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004a)

Their suggestions for the development of learning practices include the encouragement of primary health care teams to have a flatter organizational hierarchy, which, they argue would encourage all the team-members to participate in team-based learning. Rushmer and colleagues did not envisage such changes as being easy or readily adopted by GPs, quoting Miller:

> "In terms of learning and being a learner all should be equal. Those who currently enjoy high status positions may find it initially uncomfortable to undergo such a levelling experience." (Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004a)

Elwyn and Hailey cast some doubt on whether all primary health care teams could develop into learning practices. They considered that structural barriers such as poor practice premises may hinder this development (Elwyn G and Hailey S 2004). They also questioned whether GPs could fully adopt flatter organizational hierarchies, and whether PLT which is needed for learning practices, had permanently become part of the NHS's strategy for learning. This view concurred with that of Sheaff and Pilgrim who identified the lack of support available to practices who were keen to develop into learning practices (Sheaff R & Pilgrim D 2006).

In their final paper on the Learning Practice, Rushmer and colleagues called for the provision of PLT in order to allow the primary health care team to learn from each other to enable them to improve patient care. The authors collaborated with others to produce a diagnostic survey to identify learning practices, and to enable practices to become learning practices (Kelly DR et al. 2007;Rushmer R et al. 2007). Other surveys have been developed. Sylvester produced a questionnaire to disseminate to practices and primary health care teams to find out if teams had the characteristics of learning practices (Sylvester S 2003). Dobson analysed his own primary health care team to identify if it had the attributes of a learning practice, using a questionnaire adapted from that of Sylvester (Dobson C 2008).

Dobson and Sylvester have argued that much of what is required by a practice to become a learning practice, or a learning primary health care team, is the value placed on the development of a 'learning culture' by team-members. Stinson and colleagues have recommended a number of strategies in order for practices and teams to embrace this learning culture (Stinson L, Pearson D, & Lucas B 2006). One of their recommendations was for the need to have PLT. Another was the necessity to develop and promote informal relationships that encouraged team members to spend time together both in and out of work. Gray and colleagues have published a study as to how practices can develop a learning culture that results in organizational developments for their teams (Gray F et al. 2010).

A pilot study of two practices which had undergone a collective learning experience within a learning practice programme (LPP) found that participants

regarded this learning positively (Bunniss S, Gray F, & Kelly D 2011). The programme involved four shared sessions of collective learning, focusing on the primary health care team getting to know each other better, and working on a development plan that would encourage real changes to the team. PLT was used to allow teams the opportunity to complete the LPP. A number of different data collection methods were used to capture data, including observations of meetings, examination of written suggestions for change, and in-depth interviews.

The study found that individuals benefited from learning with other staff groups, and that the LPP itself had a degree of team-building.

> "The use of small, inter-professional (mixed) role discussion groups emerged as a particular strength of the LPP initiative. Participants talked extensively about how valuable it was for them to learn about everyone else's role and 'to see things from a different perspective.'" (Bunniss S and Kelly D 2011)

The programme used a trained and experienced facilitator to reduce the effects of hierarchy within the team, and to encourage participant safety within the programme's operation. An additional finding of the research was the appreciation of intimacy, where team members know each other well, having gained this knowledge from within work, and also from social events outside of working hours.

3.10. Chapter Summary

This chapter has presented the research findings of large-scale studies of team-working and learning. I have drawn these findings together and presented this as an interpretive analysis of team-working and learning, showing what the key attributes of teams could be. I have then considered some of the issues relating to inter-professional working and learning and concluded the chapter by presenting thinking and research on learning organisations and learning practices.

It is now timely to move on to the chapter which will describe the methodological basis of my research, and present my research methods.

Chapter Four – Methodology and methods

"What are grounded theory methods? Stated simply, grounded theory methods consist of systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories 'grounded' in the data themselves." (Charmaz K 2006)

4.1. Introduction

This chapter aims to present the methodological and philosophical underpinning the research design of this thesis. The chapter also aims to present some description and discussion around the different qualitative research methodologies that were available to me, and to justify why a grounded theory approach was chosen. In addition, I will present some of the different types of grounded theory that have been developed from the original grounded theory methods first described and published in 1967. I will then explain and justify why I have chosen a Charmazian social constructionist approach to grounded theory. Following this, I will provide a detailed description of how the research was carried out, how the data generated was analysed, and how the findings and resultant grounded theory were constructed.

4.2. Research questions

The quantitative survey undertaken by me in 2003 (North Ayrshire CHP) and 2004 (East Ayrshire CHP) involved a questionnaire sent to participants in these two CHP areas within NHS Ayrshire and Arran. The results were presented in Chapter One. They showed considerable differences between the responses of practice-based clinicians (GPs and practice nurses) in comparison to the practice-based non-clinicians (practice managers, and A & C staff). Perhaps the most significant finding of the questionnaire was that the majority of non-clinicians wanted PLT to end. Their preference was to continue at their work during the PLT afternoon rather than experience the learning events that were made available to them. It was this single research finding which motivated me to undertake and continue this study. The second survey undertaken by a questionnaire a year later showed a significant decline in the attendance of community nurses at practice-based PLT events (Cunningham D, Stoddart C, & Kelly D 2006c).

Although the surveys identified key differences in responses, it did not clarify why community nurses and practice-based non-clinicians expressed these responses. This is a limitation of questionnaires, in that respondents only have the ability to respond to pre-set questions devised by the researcher at the beginning of the study. Therefore it was important to increase my understanding of the situation by learning what community nurses and practice-based non-clinicians' perceptions and experiences of PLT were. It was clear that a strategy was needed to directly identify the opinions of those in the primary health care team who were dissatisfied with PLT, explore these, and therefore develop a deeper understanding of PLT.

After a period of reflection and discussion with NES and NHS Ayrshire and Arran colleagues, the following research questions were formulated:

1. What perceptions and experiences do non-clinicians within the primary health care team have about protected learning time?

2. What perceptions and experiences do members of the community nursing team have about protected learning time?

The questions were deliberately open-ended and generic in style in order to open up the research. No hypotheses were made. At the time of the questionnaire surveys (2003-2005) there was a limited number of published evaluations of PLT in the UK (Bell J, Raw D, & White A 2001;Brooks N & Barr J 2004;Haycock-Stuart EA & Houston NM 2005;Lucas B & Small N 2004;White A, Crane S, & Severs M 2002). As discussed in Chapter Two, only a few of these evaluations used qualitative methods and a number of them did not include non-clinicians in the PLT schemes, or in the evaluation of PLT. One survey identified the reluctance of non-clinicians to be interviewed in the evaluation process (Haycock-Stuart EA & Houston NM 2005).

Although there are only a few published evaluations of PLT, I did not think this would restrict my research. Some social scientists argued that a grounded theory approach is most useful when there is little known about a research area. Glaser and Strauss recommended having a 'tabula rasa' or an empty mind when starting with grounded theory research (Glaser BG & Strauss AL 1967). They suggested

that pre-conceived ideas about a research area, from other published work, could restrict the researcher, and prevent the gaining of a deeper understanding of the area. Charmaz argued that this tabula rasa was not always possible or advisable, especially when undertaking academic work, or work towards university degrees. She was aware that research funding and ethical approval may not be available to researchers who have not undertaken some preliminary reading of the existing literature. Instead she suggested an open mind was kept, thereby, allowing for the findings to guide researchers towards the grounded theory, rather than any earlier formulated pre-conceived ideas (Bryant A and Charmaz K 2007b).

It was evident to me that a qualitative approach rather than a further quantitative survey was required to improve my understanding of the participants, and to explore their perceptions and experiences underlying their opinions. A different research paradigm was needed to gain a deeper understanding of PLT.

4.3. Research paradigms

Guba and Lincoln defined a paradigm as: "A basic set of beliefs that guide action." (Guba EG and Lincoln YS 2005) They added that a paradigm encompassed four terms: ethics or axiology, epistemology, ontology and methodology. Patton has described a paradigm as: " A world view – a way of thinking about and making sense of the complexities of the real world." (Patton MQ 2002)

Creswell stated:

> "Researchers bring their own world view, paradigms, or sets of beliefs
> to the research project, and these inform the conduct and writing of
> the qualitative study." (Creswell JW 2007)

Creswell acknowledged that others may have described more than the four different paradigms listed in his text: post-positivism, constructivism, advocacy/participatory, and pragmatism. It would be useful to contrast Creswell's opinions on the post-positivism paradigm with the social constructivist (constructionist) paradigm. Post-positivism is regarded as the paradigm where

much research in the bio-medical world is situated. Social constructionism is one of the research paradigms that has influenced qualitative research and is the research paradigm that influences and informs constructionist grounded theory. For the purposes of brevity, post-positivism and social constructionism are compared in Table 7, adapted from Creswell's text (Creswell JW 2007).

Table 7: Differences between post-positivism and social constructionism

	Post-positivism	Social constructionism
Research approach	"Scientific" emphasis on data generation	Researchers see understanding of the world in which they live and work
Involvement of the researcher	Objective thinking. Distant from research participants and research arena	May be close to participants, or involved in social arena of research
Ontology (the nature of reality)	There is one true reality which requires to be discovered	Reality is subjective and multiple, as seen by participants in the study. Researcher co-constructs reality with participants
Epistemology (how the researcher knows what he or she knows)	Researcher is distant from research site and from research 'subjects'	Researcher collaborates with participants, spends time in the field, and may become an 'insider'

Epistemology and ontology

Epistemology is concerned with the study of knowledge, and how knowledge is generated or known. Crotty defined epistemology as: " The theory of knowledge embedded in the theoretical perspective and thereby in the methodology."

(Crotty M 2003) Crotty drew attention to the often confused series of definitions relating to epistemology, theoretical perspectives, methodology and methods. He has described the four elements as being in the following relationship:

Epistemology

⬇

Theoretical Perspective

⬇

Methodology

⬇
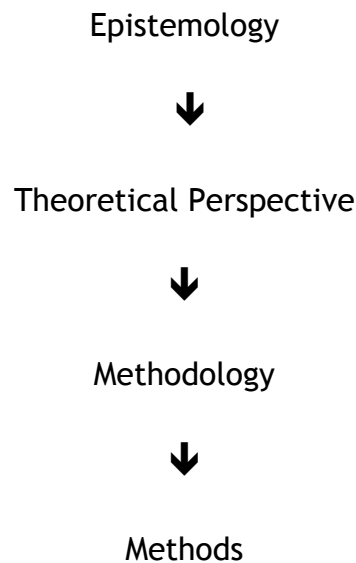
Methods

Crotty has suggested that our theoretical perspective is: "A way of looking at the world and making sense of it." (Crotty M 2003) A methodology is the adopted research strategy that combines methods into a research approach. Examples of these include grounded theory, ethnography and phenomenology. Crotty also described methods as being individual ways of collecting or generating data. Examples of these include interviews, observations and questionnaires and so on.

Ontology deals with the nature of the world, and methodology is how we acquire our knowledge about the world (Guba EG & Lincoln YS 2005). Many researchers have commented on the conflict between those who work in different research paradigms. Patton at times described this conflict as a paradigm war (Patton MQ 2002). Albert has concluded that such differences also exist in the field of medical education research (Albert M 2011). He maintained that the positivist or post-positivist paradigm was considered by some to be more valid than sociological research in medical education, which is situated in the interpretivist paradigm. He alluded to Irby's thinking that qualitative and quantitative methodologies should be seen as complementary to each other, rather than being competitive (Irby DM 1990).

4.4. Qualitative research approaches and choices

Denzin and Lincoln have described qualitative research as follows:

> "Qualitative research is a situated activity that locates the observer in
> the world. It consists of a set of interpretive, material practices that
> make the world visible. These practices transform the world. They
> turn the world into a series of representations, including field notes,
> interviews, conversations, photographs, recordings, and memos to the
> self. At this level, qualitative research involves an interpretive,
> naturalistic approach to the world. This means that qualitative
> researchers study things in their natural settings, attempting to make
> sense of, or interpret, phenomena in terms of the meanings people
> bring to them." (Guba EG & Lincoln YS 2005)

There is a wide range of qualitative research approaches and methods of data generation. Atkinson stressed the evolving nature of these approaches, and the increasing documentation of method and processes (Atkinson P 2005;Guba EG & Lincoln YS 2005). Patton suggested that when using qualitative research methods, the researcher is the research instrument in the study: researchers may be close to their research participants, and indeed ethnographers would deem this as being essential. This is in contrast with quantitative approaches which have a positivist epistemology, in that the researcher seeks to be distant from the research area in an effort to gain objectivity in the research strategy (Patton MQ 2002).

Although the number of qualitative research papers accepted for publication in medical journals has risen in recent years, some are critical of the different philosophical positions and backgrounds emphasized by qualitative researchers (Paley J and Lilford R 2011). In particular, criticism is directed at social constructionism as an epistemology, and of the influence of Lincoln and Guba in the field of qualitative research. Paley and Lilford argued that it is not necessary to align specific qualitative methodologies and methods with any philosophical or epistemological underpinning. In contrast, Mays and Pope argued for the understanding of qualitative research, and of the benefits that this paradigm has brought to medical research (Mays N & Pope C 1995b). The authors recommended that qualitative researchers should: "attend to issues of validity, reliability and generalisability." Barbour argued that these recommendations in themselves may distort the qualitative research process (Barbour RS 2008a).

Qualitative research approaches

Creswell described and analysed five main qualitative research approaches: narrative research, phenomenology, grounded theory, ethnography and case study (Creswell JW 2007). He stated that these five approaches were 'pure' forms of research design, but that there were many adaptations and blends. Four of these methods (the four other than grounded theory) will be briefly described here. Wertz and colleagues have published a similar text that examined and contrasted five different research approaches to one research context. Some of the research approaches examined by Wertz and colleagues were shared by Creswell, and both texts include grounded theory (Wertz FJ et al. 2011).

Narrative research

Narrative research, or narrative studies, deals with the analysis of texts or oral conversations with specific individuals (Creswell JW 2007). The number of individuals in a narrative study is often small. Narrative research also includes descriptions such as biography and autobiography, as well as life histories and oral histories. Atkinson argued that a weakness of the narrative approach is a lack of analysis of the narrative, and instead a description of events may be presented (Atkinson P 2005). Patton concurred with Atkinson's thinking of the weakness of narrative research (Patton MQ 2002). He argued that the story is the basis of narrative research, and that listening to individuals and their unique stories was crucial in narrative research and analysis. Wertz and colleagues suggested that narrative research had similarities to ethnography, whereby individuals and their stories could be interpreted to represent the narrative and experience of an ethnic or culture-sharing group (Wertz FJ, Charmaz K, McMullen LM, Josselson R, Anderson R, & McSpadden E 2011).

Phenomenology

Phenomenology and phenomenological research methods focus on the lived experiences of a small number of individuals. Moustakas described the collation of experiences that individuals had of a specific phenomenon, and the synthesis of shared or common threads which resulted in improved understanding of a specific phenomenon (Moustakas C 1994). Moustakas was influenced by the

earlier phenomenological works and arguments of Husserl. The former considered the aim of phenomenology as follows:

> "The aim is to determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the individual descriptions general or universal meanings are derived, in other words the essences or structures of the experience." (Moustakas C 1994)

Creswell stated that in-depth interviews (and repeated interviews with research participants) were a common method of gathering data from participants in phenomenological research studies. Data is read, coded and analysed and the essence or common experience of participants is described (Creswell JW 2007;Moustakas C 1994). For Patton, phenomenology examines the consciousness and the interpretations that individuals have made in their reactions to phenomena in their lives (Patton MQ 2002):

> "This [phenomenology] requires methodologically, carefully, and thoroughly capturing and describing how people experience some phenomenon – how they perceive it, describe it, feel about, judge it, remember it, make sense of it and talk about it with others." (Patton MQ 2002)

Ethnography

Ethnography is the study of a group of people who have shared cultural values (Agar MH 1996;Creswell JW 2003;Patton MQ 2002). Ethnographic research strategies usually involve prolonged observations of behaviours and having conversations with a number of individuals coming from a culture-sharing group as the main means of generating data. Ethnographers spend many hours in the research field, as a result they may become participants in such studies, and are often exposed to groups of participants in a phenomenon called immersion. Gold described a spectrum of the position of the researcher, from distant observer to full participant, with many ethnographers adopting positions at various points between these two poles. It is possible, and likely, for the ethnographic researcher to become more participatory in the field, as the research study progresses (Gold RL 1958).

The usual methods of data collection are not unique to ethnography, as Agar stated:

> "Ethnographers have invented numerous methods appropriate to their research settings. They have also begged, borrowed, and stolen methods from most of the other social, biological, and physical sciences, as well as from the humanities." (Agar MH 1996)

With its beginnings in anthropology, ethnography is now used in a variety of settings to gain a deeper understanding of a cultural group. It has become a recognised research method in medicine and in medical education (Atkinson P and Pugsley L 2005;Mays N and Pope C 1995a;Pope C 2005;Reeves S et al. 2008;Savage J 2000). Atkinson and Pugsley suggested that the early works of the Chicago School of Sociology were influential in the ethnographic method and of the development of urban sociology (Anderson N 1923;Cressey PG 1932;Whyte WF 1993). Timmermans and Tavory reasoned that some ethnographers share the same theoretical perspective of symbolic interactionism as some grounded theorists. They argued it is possible to use a grounded theory strategy and grounded theory methods of data analysis in ethnographic studies (Timmermans S and Tavory I 2007).

Case study approach

Yin and Stake described the different types of cases and case studies. Case studies deal with the generation of data and analysis from research subjects who are in a bounded system (Stake RE 1995;Stake RE 2005;Yin RK 2003). This may involve individuals in a specific context, for example a school, or hospital or place of work. Case study researchers draw on data collected by a variety of methods including observations, interviews and analysis of written data (Yin RK 2003).

Stake proposed three different types of case studies:

- Intrinsic cases – there is an interest in the case purely to increase understanding in the case itself, and the case cannot be generalised wider than this.

- Instrumental case studies – where one case is examined specifically to generalise to other examples or cases. Stake suggested that *Boys in White* (1961) is an example of this (Becker HS et al. 1977). Such cases are

studied specifically to learn what can be generalised to other similar or linked cases.

- Multiple case studies – where a series of separate cases is studied separately and then together in order to generate knowledge, for example, a study of primary school classes.

Stake maintained that a variety of data generation methods can be used legitimately in case studies (Stake RE 2005).

It is now appropriate and timely to consider the remaining methodology of the five described by Cresswell, that of grounded theory.

4.5. Grounded theory

Introduction

> "The grounded theory approach is the most influential paradigm for qualitative research in the social sciences today. It appeals to many. It provides a set of steps and procedures any researcher can follow in the construction of a theory fit to a particular problem." (Denzin N 1997)

This section of Chapter Four chronicles and describes how grounded theory originated, and gives some historical details of the first generation of grounded theorists. The section describes how grounded theory evolved, and developed, and shows the different types of grounded theory – the work of the second generation of grounded theorists. The section leads onto a description of Charmazian grounded theory methods and the philosophical underpinning of this approach.

Importance of grounded theory methods

Denzin stated that grounded theory methods and grounded theory research approaches were the most dominant form of research strategy in the social sciences (Denzin N 1997). Bryant agreed with this claim (Bryant A 2007;Bryant A and Charmaz K 2007a). Harris claimed that grounded theory methods and approaches have much to offer researchers in medical education topics (Harris I

2003). LIngard and colleagues argued that grounded theory has come of age in the field of mainstream research in medicine, and is now a legitimate method and approach for answering some research questions (Lingard LA et al. 2008).

History of grounded theory

Barney Glaser and Anselm Strauss developed the grounded theory approach, and published the first description of their methods in 1967 (Glaser BG & Strauss AL 1967). I consider it important and relevant to understand their personal histories and backgrounds in order to comprehend the development of grounded theory. Morse and colleagues regarded the different backgrounds of Glaser and Strauss as important in the understanding of how grounded theory methods were developed (Morse JM et al. 2009). Morse has given details of the genealogy of grounded theory and has captured its evolution since its inception in 1967 (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009). Bryant and Charmaz concurred that historical analysis aided the understanding of how grounded theory methods have evolved since its inception (Bryant A & Charmaz K 2007a). Bryant also stated that: "It is widely acknowledged that one of the strengths of the early statements of the grounded theory method was the diverse backgrounds of the two originators." (Bryant A 2009)

First generation

Strauss was a student at the University of Chicago, where he obtained both Masters and Doctoral degrees in Sociology (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009). Glaser, originally from California studied at Stanford University and then at Columbia University in New York City. Charmaz stated that this collaboration between Glaser and Strauss involved two different paradigms: positivism, from Glaser's background and research training at Columbia University; and pragmatism from Strauss's roots in the University of Chicago School of Sociology (Charmaz K 2006). Wertz and colleagues also stressed the quantitative background of Glaser, and suggested that his origins from Columbia University resulted in a quantitative approach to grounded theory (Wertz FJ, Charmaz K, McMullen LM, Josselson R, Anderson R, & McSpadden E 2011). Wertz and colleagues emphasized the importance of quantitative methods

at the Department of Sociology at Columbia University, and that researchers there sought to make sociological research "scientific".

> "The logic of quantitative research influenced Glaser's approach to grounded theory. His strong quantitative training surfaced in his treatment of grounded theory as a form of variable analysis and in the language of coding and sampling that he adopted to categorize grounded theory strategies." (Wertz FJ, Charmaz K, McMullen LM, Josselson R, Anderson R, & McSpadden E 2011)

Others argued that this analysis is too simplistic, and that both original authors studied in university sociology departments each with a background and expertise of qualitative and quantitative methodologies (Bryant A 2009;Bulmer M 1984;Harris I 2003).

Glaser collaborated with Strauss researching on the topic of dying and in particular the awareness of dying in hospitals (Glaser BG & Strauss AL 1967;Glaser BG and Strauss AL 1968). After they published on this topic, they published and presented their innovative research methods, and also lectured and taught nursing and sociological students at the University of California at San Francisco (UCSF). These students included the second generation of grounded theorists, and researchers such as Juliet Corbin, Kathy Charmaz and Adele Clarke amongst others (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009).

Glaser and Strauss's first publication of their research methods, aimed to capture the methods that they had used in their research on dying, and the study was used in UCSF as guidance for their students. This was in contrast with the thinking about qualitative methods of data generation and analysis at that time. For students, the research processes in qualitative research had seemed mysterious and shrouded rather than being open and transparent. Charmaz and Bryant argued that the acceptance and popularity of *The Discovery of Grounded Theory* was as a result of their clear descriptions of their research methods and methodology (Bryant A & Charmaz K 2007a). This clarity was uncommon at the time in the United States, and was one reason why quantitative researchers were critical of qualitative researchers' methods. They perceived that qualitative research methods and methodologies did not appear to be transparent. Charmaz argued that the construction and development of Glaser

and Strauss's qualitative research methods and approach arose during the time when quantitative research methods were dominant in the 1960s (Charmaz K 2006). Morse described the importance of their new research method as being: "ordered, systematic and marked by rigor." (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009)

Much has been published on the subsequent schism that occurred between Strauss and Glaser after the publication of their first text on grounded theory. (Bryant A 2009;Creswell JW 2007;Kennedy TJT & Lingard LA 2006)Creswell described the schism as being centred on Glaser's perception that Strauss's evolving approach to grounded theory research was overly prescriptive particularly related to data analysis (Creswell JW 2007). Charmaz and Bryant suggested that the different backgrounds and experiences of Glaser and Strauss's sociological research were responsible for their differences, which came to the fore with the subsequent collaboration of Strauss with Corbin and the publication of their text on grounded theory (Bryant A 2007;Corbin J & Strauss A 2008;Strauss AL and Corbin J 1998). Bryant and Charmaz considered Glaser's positivist background and training in positivist research methods and contrasted these with Strauss's background which Charmaz and Bryant argued was epistemologically social constructionist in nature. Charmaz and Bryant drew attention to the rise of social constructionism in qualitative sociological research with the publication of *The Social Construction of Reality* at approximately the same time as *The Discovery of Grounded Theory* was published (Berger PL and Luckmann T 1967;Glaser BG & Strauss AL 1967).

Covan suggested that the different references cited by the two authors in *The Discovery of Grounded Theory* emphasized their disparate research foundations (Covan EK 2007). She noted that Glaser referred to Lazarfeld and Merton from Columbia University, while Strauss referred to Blumer, Becker and others from the Chicago School of Sociology.

The Chicago School of Sociology

It is necessary to understand the importance of the development of sociological research methods and approaches in the 20th century. Charmaz emphasized the important influence of the Chicago School of Sociology (also called The

University of Chicago School of Sociology), both for herself and for the development of grounded theory in general (Charmaz K 2006). She also saw the important influence of this school on Strauss. Glaser and Strauss made a number of references to the Chicago School in their own text: *The Discovery of Grounded Theory* (Glaser BG & Strauss AL 1967). In addition they referred to the important influence of the earlier qualitative works of Cressey and Anderson amongst others from the Chicago School (Anderson N 1923;Cressey PG 1932).

Bulmer asserted that the Chicago School was the most important and influential University Sociology department in the world in the years 1915 to 1940 (Bulmer M 1984). The school had transformed sociological research from being 'library based' to a discipline that embraced a diverse range of empirical research methods. Bulmer described the development of an inter-disciplinary school that identified and developed high quality research stemming from a variety of different academic foundations. Bulmer stated:

> "The hallmark of the Chicago School of Sociology was this blending of first hand inquiry with general ideas, the integration of research and theory as part of an organised program." (Bulmer M 1984)

The Chicago School was committed to the collaboration of different social scientists such as sociologists, anthropologists and philosophers who incorporated intensive fieldwork, with analysis of personal documents from a range of sources to develop sociological theory. Bulmer argued that quantitative methods were used by the Chicago School as well, and that those who considered the Chicago School as being wholly qualitative in their research methods were wrong.

The Chicago School had developed a reputation for innovative research methods and much of the department's work was founded on the study of the city itself (Bulmer M 1984;Lutters WG and Ackerman MS 1996) . The city of Chicago had undergone a major transformation and enlargement in the late 19th and early 20th centuries. Qualitative research methods such as ethnography were used to gather data from a diverse range of ethnic groups within the city boundary, capturing the extensive immigration from different European countries. A significant number of researchers at the Chicago School had been educated in German universities. At that time Germany was considered to be the world's

most prominent country with regards to sociological thinking and research. As a consequence of a shared training in similar research methods, collaboration proved easier. The Chicago School pioneered the gathering of research data from participants and the formation of mid-range theories from this data. This was in contrast to the then orthodox methods of developing sociological theories using deductive approaches.

The result was the domination of American sociological research by the University of Chicago, which overtook Columbia University in the number of publications and other markers of academic success. For example, many of the presidents of the American Sociological Society from 1924 to 1950, had gained their PhD from the University of Chicago (Bulmer M 1984). The publication of *The Polish Peasant in Europe and America* in 1918 was followed by a large number of important monographs describing communities in Chicago, and deriving theory from such empirical work (Thomas W and Znaniecki F 1996). This included monographs such as Cressey's *The Taxi-Dance Hall* and Anderson's *The Hobo* (Anderson N 1923;Cressey PG 1932). It is likely that this connection between studying people and communities in their natural situation, followed by the development of theory from the data collected contributed to the development of grounded theory methods. Wertz and colleagues stated that Glaser and Strauss documented some of the techniques and methods that they had learnt from other qualitative researchers at the University of Chicago. They also mentioned that Glaser and Strauss did not invent each individual research technique, but that they were the first to publish these techniques or methods into a methodological approach (Wertz FJ, Charmaz K, McMullen LM, Josselson R, Anderson R, & McSpadden E 2011).

Lutters and Ackerman commented that Strauss and Becker were important researchers in the "second generation" of the Chicago School (Becker HS, Geer B, Hughes EC, & Strauss AL 1977;Lutters WG & Ackerman MS 1996). In contrast, Denzin has considered that Strauss and Becker belonged to a third generation of the Chicago School (Denzin NK 1992). Denzin also considered that grounded theory was: "a new Chicago method" thus seeing grounded theory as being developed from the Chicago School, rather than being a hybrid product of the University of Chicago and Columbia University (Denzin NK 1992).

Second generation

Background

Morse and colleagues published their thoughts on their evolved grounded theory approaches, and showed how the original methods devised and published by Glaser and Strauss have been modified and altered with time (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009). Almost all the approaches were developed by researchers who themselves had a strong working and learning relationship with Strauss or Glaser, of in some cases, both. Although many approaches are modifications of grounded theory, some new approaches are blends or hybrids forms of two different research approaches and grounded action is one example. In the grounded action approach, grounded theory has been modified by action research strategies (Dick B 2007).

A short summary of the second generation of grounded theory approaches is now presented, followed by more detailed description of Charmaz's approach.

Adele Clarke

Clarke published her own evolved form of grounded theory (Clarke AE 2005;Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009). This approach focused on using grounded theory methods to analyse situated activity. Clarke, like Charmaz, stressed the influence of the Chicago School in her work. Clarke considered her methods, and her approach to grounded theory as being strongly influenced by the theoretical perspective of symbolic interactionism. Moreover, she interpreted that much of the Chicago School's work had focused on situations. The Chicago School's researchers often illuminated a specific area of Chicago, often occupied by one dominant ethnic group, or the research focused on activities and processes relating to specific buildings or geographic areas in a city such as taxi-dance halls, street corners and so on (Cressey PG 1932;Whyte WF 1993). Clarke has acknowledged that her grounded theory method was bounded by an arena - the situation in which action is seen to take place. Clarke emphasized the importance of this: "The key point is that in SA [Situational Analysis] the geographic situation itself becomes the fundamental unit of analysis." (Clarke AE 2005) There are comparisons between Clarke's work of situational analysis, and the case study methods of Yin and

Stake (Stake RE 1995;Yin RK 2003). Clarke has contrasted her approach to the work of Charmaz which has centred on social processes, rather than social situations.

Juliet Corbin

Corbin, in contrast to Glaser, accepted that techniques and research approaches will change and adapt over time, and that they will be changed and adapted by the different researchers who adopt or use grounded theory methods (Meetoo DD 2007;Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009). She has described and analysed her evolving grounded theory methods in the different editions of her collaborative grounded theory work with Strauss (Corbin J & Strauss A 2008;Strauss AL and Corbin J 1997;Strauss AL & Corbin J 1998). Corbin emphasized the importance of her own background for the foundations of her philosophical approach to grounded theory:

> "I had no simple term to classify the person I'd become methodologically over the years since Dr. Strauss's death. I realized that, like him, I was a mixture of many philosophical orientations." (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009)

In addition, she presented a pragmatic view of the development and evolution of grounded theory since its origins in 1967:

> "Perhaps it would be better to think of grounded theory as a compendium of different methods that have as their purpose the construction of theory from data, with each version of grounded theory method having its own philosophical foundation and approach to data gathering and analysis, while sharing some common procedures." (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009)

Later in her chapter, Corbin stated:

> "Although grounded theorists today come from different perspectives and have their own approaches to analyzing data, I think certain threads run through all our methods, for example, doing comparative analysis and asking questions of the data, theoretical sampling, and writing memos." (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009)

A dominant concern for Corbin is the requirement that grounded theory methods should be used to develop or construct a theory that helps students and participants to understand more about the social processes taking place in the research area. Corbin was keen for grounded theory to be understood for its purpose and outcome, rather than memorised and adopted as a research procedure (Strauss AL & Corbin J 1998). Corbin suggested that the theoretical component of grounded theory was crucial to its correct use. Ultimately Corbin argued that the purpose of grounded theory methods was: "[to] develop useful theory that is grounded in data." (Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009)

Charmazian Grounded Theory

Charmaz defined grounded theory methods as follows:

> "Grounded theory methods consist of systematic, yet flexible guidelines for generating and analyzing qualitative data, to construct theories 'grounded' in the data themselves." (Charmaz K 2006)

Bryant and Charmaz concluded that grounded theory methods can be explained as follows:

> The Grounded Theory Method (GTM) comprises a systematic, inductive, and comparative approach for conducting inquiry for the purpose of constructing theory. The method is designed to encourage researchers' persistent interaction with their data, while remaining constantly involved with their emerging analyses." (Bryant A & Charmaz K 2007b)

Charmaz defined the important components of a grounded theory as being:

- Simultaneous involvement in data generation and analysis

- Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses

- Using the constant comparative method, which involves making comparisons during each stage of the analysis

- Advancing theory development during each step of data generation and analysis

- Memo-writing to elaborate categories, specify their properties, define relationships between categories and identify gaps

- Sampling aimed toward theory construction, not for population representativeness

- Conducting the literature review *after* developing an independent analysis. (Charmaz K 2006)

Kennedy and Lingard asserted that researchers may use a grounded theory approach to the analysis of their data, but fail to use the grounded theory method as a research strategy in general. They maintained this was incongruous to the recommended strategy of Glaser and Strauss (Kennedy TJT & Lingard LA 2006). Thus, some researchers have used grounded theory as a method of data analysis, rather than a methodological research approach. Charmaz and Corbin argued that researchers were valid in adopting a "smorgasbord" approach to grounded theory methods, selecting and using a variety of methods and techniques on offer (Charmaz K 2006;Morse JM, Stern PN, Corbin J, Bowers B, Charmaz K, & Clarke AE 2009). They argued that grounded theory methods should not be overly prescriptive.

Glaser was critical of the evolution of grounded theory, suggesting that Charmaz's development of constructionist grounded theory was against its initial development and purpose (Glaser BG 2002). However, Bryant, a collaborator of Charmaz, strongly defended her grounded theory approach (Bryant A 2003).

Charmaz regarded her form of constructionist grounded theory as being epistemologically distinct from the objectivist form of grounded theory initially developed in 1967. She identified Glaser as being the main proponent of this objectivist perspective. She further argued that her evolved form of grounded theory, and its methods has strong links to the symbolic interactionist group which had its roots in the University of Chicago's School of Sociology. Indeed, she sought to reclaim the traditions of the Chicago School for the development and benefit of grounded theory (Charmaz K 2005).

Charmaz argued that her thinking on grounded theory, and her development of a social constructionist approach to grounded theory, is a modification of the original grounded theory methods of Glaser and Strauss:

> "Constructivist grounded theory is a contemporary revision of Glaser and Strauss's classic grounded theory. It assumes a relative epistemology, sees knowledge as socially produced, and acknowledges multiple standpoints of both research participants and the grounded theorist. It takes a reflexive stance towards our actions, situations and participants in the research field." (Charmaz K 2006)

To understand Charmaz's approach and perspective fully it is necessary to describe and understand the important influence of symbolic interactionism and social constructionism.

4.6. Symbolic interactionism and social constructionism

Symbolic interactionism

Timmermans and Tavory, in common with other qualitative commentators, considered that grounded theory is anchored in the theoretical perspective of symbolic interactionism (Denzin NK 1992;Timmermans S & Tavory I 2007). Wertz and colleagues defined symbolic interactionism as:

> "This theoretical perspective sees self, situation, and society as social constructions that people accomplish through their actions and interactions. Symbolic interactionism is predicated on the use of language and symbols. Both pragmatists and symbolic interactionists (1) view humans as active agents who can interpret and act upon their situations; (2) take language and interpretation into account: (3) treat events as open-ended and emergent; (4) study individual and collective action; and (5) acknowledge the significance of temporality." (Wertz FJ, Charmaz K, McMullen LM, Josselson R, Anderson R, & McSpadden E 2011)

Crotty suggested that symbolic interactionism was developed from the thinking and writings of George Herbert Mead, one of the main principals from the Chicago School (Blumer H 1969;Crotty M 2003). Blumer defined three basic assumptions about symbolic interactionism:

- That human beings act towards things on the basis of the meaning that these things have for them

- That the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows

- That these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters. (Blumer H 1969)

If Crotty's structure, presented earlier in this chapter, is represented by Charmaz's thinking of constructionist grounded theory, the following may be assumed in this thesis:

Epistemology	Social constructionism
⬇	⬇
Theoretical perspective	Symbolic interactionism
⬇	⬇
Methodology	Grounded theory
⬇	⬇
Methods	Focus group interviews
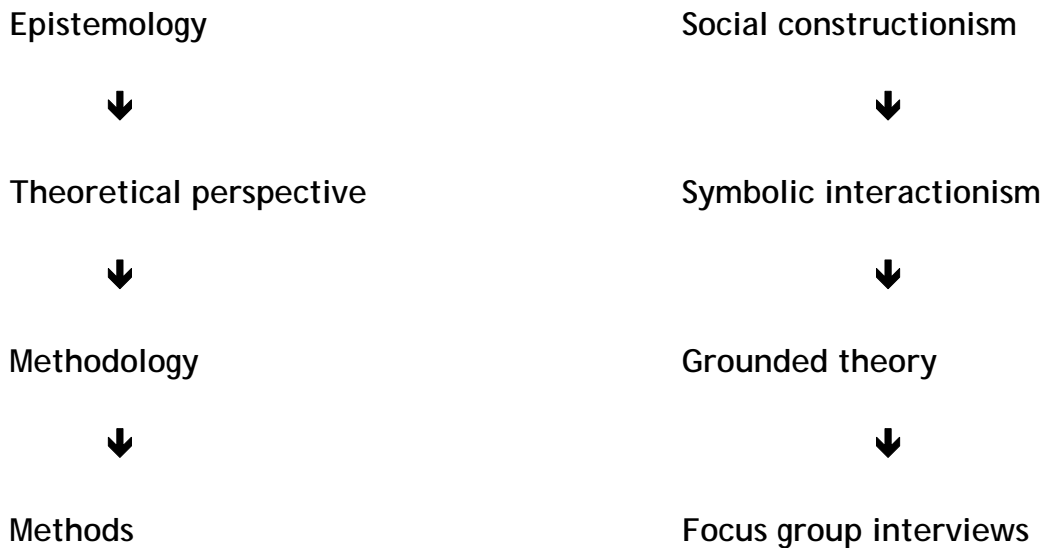
Social constructionism

Burr stated that social constructionism was developed from the thinking of Marx, Kant and Nietzsche (Burr V 2003). She also stated that Berger and Luckmann's publication in 1966 of *The Social Construction of Reality* was influential in modern thinking of social constructionism, and influenced by the Chicago School. She stated:

> "If our knowledge of the world, our common ways of understanding it, is not derived from the nature of the world as it really is, where does it come from? The social constructionist answer is that people construct it between them. It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated." (Burr V 2003)

Charmaz maintained that the underlying cause of the schism amongst grounded theorists was their position with regards to the interpretivist and positivist traditions (Burr V 2003;Charmaz K 2006). Charmaz divided grounded theory into two main approaches: constructivist grounded theory, which is part of the interpretivist tradition, and objectivist grounded theory, which is derived from positivism. Table 8 is adapted from the chapter on theory from Charmaz's text,

and aims to summarise her arguments for the differences between social constructionist grounded theory and objectivist grounded theory.

Table 8: Comparisons between objectivist and interpretivist grounded theory approaches

	Objectivist grounded theory	Interpretivist grounded theory
Creation of data	Grounded theory resides in the positivist tradition. Data is real in, and of themselves	Data and analysis are created from shared experiences, relationships with participants and other data sources
Objectivity of the data	Social context from which data emerges is erased. Data represents objective facts about a knowable world	Assumes an ever-changing world, recognises diverse local worlds and multiple realities
Epistemological nature of knowledge	Data already exists in the world, researchers finds data, and discovers a theory from the data	Data and theory are constructed from the data and interpreted by the researcher
Relationship of data, and knowledge to the researcher	This view assumes an external reality, awaiting discovery and an unbiased researcher who records facts. Researcher is a conduit of research, not the creator of knowledge	Constructionist grounded theorists assume that both data and analyses are social constructions that reflect what their production entailed. Researcher cannot be independent from the knowledge created

4.7. Why Charmazian grounded theory was chosen

Why grounded theory

Researchers, unless they are introducing a new methodology like Glaser and Strauss achieved in the 1960s, usually adopt a methodology that is already in existence and which is established as an orthodox or conventional research approach. Qualitative researchers have an extensive list of choices, but should be able to justify why their chosen methodology and methods are appropriate for their research area, their research questions, and ultimately for their self (Bowling A 1997;Mason J 1996;Ritchie J and Lewis J 2003;Silverman D 1993).

Earlier in this chapter, I described other qualitative research methodologies, including phenomenology, case studies, narrative analysis and ethnography. It is important to examine why I did not ultimately use any of these four methods and chose grounded theory instead. I would also like to record why I chose a Charmazian grounded theory approach, rather than the methodologies described earlier.

A phenomenological research approach may have produced useful findings for my study. The disadvantages may have included lack of clarity with regards to coding of data generated, and a smaller number of research participants would have been involved. Phenomenologists search for the essence of the shared experience, and in my opinion, this would have neglected those participants who had alternative ideas and thoughts about PLT. An ethnographic approach would have used different methods of data generation: mainly in-depth observations and participation in PLT. This would likely have incurred many hours in the research field and may have been a strain on my time. In addition, I had concerns that my participation in observational field work of PLT events might have influenced what was happening. I was not confident that a general practice or primary health care team would not alter its PLT afternoon if they were conscious that I would be observing and participating with them during the PLT event.

I rejected narrative analysis as I felt that the very small numbers of research participants that typically feature in such studies would be too few to facilitate

the development of a deeper sense of understanding of the members of the primary health care team under study. There was also no biographical or auto-biographical material available to study, nor were there any extensive documents to peruse. I also rejected a case study approach as I felt it may have resulted in a description of PLT, and that this approach would not have increased my understanding of PLT.

I considered that grounded theory was the most appropriate research approach for me, for my participants and for the research questions. I was confident that I could learn the methods, in particular the data analysis processes, and the specific approach to sampling. There had been no previous research undertaken in this area and I felt that grounded theory was an appropriate methodology that would open up this area. In addition, I was intrigued by the use of memo writing, and felt that the construction of a grounded theory would result in a deeper understanding of my research participants, and of PLT.

Why Charmazian grounded theory

As described earlier, there are a number of evolutions of grounded theory, more than outlined in the brief descriptions of Clarke, Corbin and Charmaz. I decided to select a Charmaz approach for various reasons. This included the clarity of her writing, with the detailed description of her research methods and methodology. I also shared her assumptions with regards to epistemology, seeing that knowledge was co-constructed by researcher and participants in the manner of social constructionism. I also agreed with the principles of symbolic interactionism, and shared Charmaz's enthusiasm for the University of Chicago's School of Sociology. Finally, I appreciated her thinking, shared with Corbin, that grounded theory methods could be used in a selective way, rather than the prescription of Glaser and Strauss. Although Clarke and Corbin give good descriptions of their methods, I was not convinced that the situational analysis approach would work in my study. I thought that the 'situation' in NHS Ayrshire and Arran was too heterogeneous for such a method to work well.

4.8. Data generation

Introduction

This section will describe the planning and preparation of my research, and give a detailed account of how both phases of the research were carried out. It will also present a review of the ethical issues relevant to the research strategy.

Reflexivity

As qualitative researchers are usually the research instrument in their studies, it is important to consider my own background, influences, and assumptions. The position and role of the researcher in the study has a significant influence on how the study proceeds and what findings are constructed. Charmaz argued that researchers can never be distant from their research, or their research participants (Charmaz K 2006). Indeed, she stressed that researchers co-construct the findings with their participants rather than perform this task in an objectivist fashion. Barbour argued that it is impossible for qualitative researchers not to be subjective in their analyses, in particular within the context of grounded theory:

> "… the question of whether it is *ever* possible to put to one side 'what you know.' … Indeed, personal and disciplinary identities are so closely bound up (by virtue of our professional socialization from a relatively early age and for long periods of time) that this is probably impossible." (Barbour RS 2008b)

Barbour also alluded to the potential conflict between the agenda of the researcher and the agendas of the research participants. Mruck and Mey see reflexivity as being an essential component of grounded theory methods: "One would expect reflection on the interaction between researchers and research participants to be a constitutive element of doing GTM [grounded theory methods] research." (Mruck K and Mey G 2007)

It is important for the researcher to consider how his or her position, background or views may contribute to the construction of a grounded theory. My involvement in PLT within NHS Ayrshire and Arran was critical to this thesis, and

it would be useful for me to record my own reflexive thinking on how I, as an individual and researcher, influenced the research and the findings.

I started the research with two main areas of influence on PLT. I am an Associate Adviser within NHS Education for Scotland (NES), a special health board focusing on education for the NHS workforce in Scotland. My role as an associate adviser centred on continuous professional development for GPs and their teams. I was closely involved with the delivery of large centrally organised PLT events in North Ayrshire, and to a lesser extent in East Ayrshire. I was the chair of the North Ayrshire PLT steering committee, and contributed educational advice to the PLT steering committee of East Ayrshire. I had no involvement in the South Ayrshire PLT scheme, although one of my colleagues from NES did.

Furthermore, I was a partner in a large practice in one of the CHP areas studied, and was relatively well-known to a number of practice managers, and to many GPs. When the research started, I had been a GP for 17 years. My contact with other local general practices was increased by my work in the Scottish GP Appraisal Scheme, and I had visited most of the general practices in North and East Ayrshire at some point in the years before the research started, and afterwards. I am male, in contrast to all of the female members of the community nursing team focus groups, and to the majority of the practice managers. All of the participants in the A & C staff focus groups were female.

I appreciated the value of team-based learning as my own practice had undertaken a variety of learning events and had seen significant improvements in how our services were delivered as a consequence of these events. Lastly I placed considerable value on life-long learning, having completed some qualifications since my medical graduation, and encouraged similar activities within my primary health care team.

Thus it could be perceived by some research participants that I come from a background of authority and of education. I am a male senior GP who had some degree of power and influence within various local roles. To counteract these assumptions I sought to achieve the following:

- To be aware of my position within primary health care in the local area

- To consider myself as an advocate for those in the primary health care team who had little sense of voice

- To explicitly mention to participants at the start of each focus group that it was important for them to be able to express their frank and honest opinions

- To remind myself that I was acting as a researcher for the benefit of the groups under study, and to try to be unbiased in my interpretations of their perceptions and experiences

- To remind participants not to tell me: "What they thought I wanted to hear" about PLT, but to tell me their own perceptions and experiences

To this aim, I summarised and documented these concerns in my email communications to participants. I also emphasized the importance of them at the introduction and welcome to the focus groups that I moderated.

I was aware of the concerns raised in the evaluation of another Scottish PLT scheme which identified that A & C staff were reluctant to participate in an evaluation (Haycock-Stuart EA & Houston NM 2005). The authors considered that some A & C staff were fearful that their criticisms of the PLT scheme would be identified by practice managers, and that their criticisms could be attributable to them. I decided that an independent moderator should be employed for the A & C staff and practice manager focus groups, and that I would not listen first-hand to their audio-tapes, but would deal only with the anonymised transcripts. Moreover, participants were given explicit guarantees that not only would their opinions be anonymised but also they would be non-attributable. This was for the purposes of my interpretation of the data generated, subsequent presentations to NHS Ayrshire and Arran, and for publication in journals and in this thesis. I was conscious that although a person may not be identifiable by name it was possible for participants to be identifiable by their situation or unique characteristics.

Ethical issues

Introduction

It is mandatory for researchers to be aware of issues related to ethics or morality when conducting research. The Chief Scientist Office in Scotland is ultimately responsible for the ethical supervision of research undertaken within NHS Scotland (Chief Scientist Office 2012). It sets out the following regulation for Research Ethics Committees to oversee and regulate research:

> "Research Ethics Committees (RECs) are convened to provide independent advice on the extent to which proposals for research comply with ethical standards. The purpose of a REC in reviewing the proposed study is to protect the dignity, rights, safety and well being of all actual or potential research subjects. Ethical approval from the appropriate NHS Research Ethics Committee is required for any research proposal involving NHS staff recruited as research participants by virtue of their professional role." (Chief Scientist Office 2012)

To this end, ethical approval from a Research Ethics Committee is often required both by universities and by NHS health boards before research is carried out (University of Glasgow 2002). If formal ethical approval for research is not required, researchers still need to act in an ethical manner. For the purposes of this research, ethical approval was sought from the NHS Ayrshire and Arran Research Ethics Committee before each of the two phases of research described in this chapter. The reference number of each ethical approval is listed on page 18. It would, at this point, be appropriate to describe the ethical issues that were important and relevant to this research.

Ethical framework

When ethical issues are described or discussed with others, the use of an analytical framework can be helpful. Gillon promoted the use of Beauchamp and Childress' analytical framework to assist with the consideration of ethical problems or dilemmas within the context of health care (Beauchamp TL and Childress JF 2001;Gillon R 1985;Gillon R 1994;Gillon R 2003). Gillon stressed that the use of this framework does not provide the answer or solution to a moral problem, but can aid in the analysis of it. As Beauchamp and Childress stated:

> "Our four clusters of principles do not constitute a general moral theory. They provide only a framework for identifying and reflecting on moral problems." (Beauchamp TL & Childress JF 2001)

Clinicians and ethicists have also reported the advantages of using Beauchamp and Childress's principles to aid ethical thinking (Jeffrey P and Millard PH 1997;Sheather J 2011). Sokol expanded on Beauchamp and Childress's principles by the addition of four quadrants within the context of clinical ethical problems (Sokol DK 2008;Sokol DK et al. 2011).

Beauchamp and Childress described four principles which make up their framework. I will briefly describe each principle, and then use their analytical framework to describe the issues relevant to this research.

Respect for autonomy

Autonomy is a word derived from two Greek words. 'Auto' is defined by the concept of self, or of a unit such as a country or organisation. 'Nomas' is a Greek word that can be interpreted as 'ruling' or 'governing'. Thus autonomy is concerned with the ability of self-rule or of self-government. Autonomy is seen as the ability of individuals (or of larger groups such as nations) to be in charge of their own affairs and to make decisions for themselves. In medical jurisprudence (the philosophy underpinning medical law) adults are considered to be autonomous individuals, who have the ability or competence to weigh up issues relating to decisions, and to decide what the best course of action for them is. Issues relating to autonomy include consent, confidentiality, and the rights of adult patients to refuse treatments that they do not want.

Non-maleficence

The principle of non-maleficence relates to the concept of not harming others. This principle is broadly reflected in medical law. For example, patients are protected from harm by medical practitioners with common law legislation regarding medical negligence. The rising interest in patient safety focuses on reducing harm to patients from the actions of health care professionals.

Since the age of Hippocrates, medical practitioners (and more broadly, health care professionals and health care providers) have been challenged with causing

no harm to their patients. Indeed the Declaration of Helsinki by the World Medical Association in 1964, and subsequent modifications to this document, gives clear guidance and instruction to medical researchers and to other interested parties, of what actions are permissible in medical research (Goodyear MDE 2007). The Declaration of Helsinki followed the Nuremburg Code, which itself was influenced by the Nuremberg War Trials wherein a number of medical practitioners were prosecuted for harming patients in medical research during World War Two.

Beneficence

Beauchamp and Childress described acts of beneficence as those that benefit patients (and also of society) and may be acts of kindness or charity. They argued that health care, in general, should exist to improve well-being and health, both for individuals and for larger groups, and that the principle of beneficence should influence the actions of health care professionals.

Respect for justice

Issues relating to justice in health care centre on concepts relating to fairness, entitlement and respect for the law. Some moral philosophers have argued that citizens of a country have a right or entitlement to a certain level of health care and that this right is just. Justice is often related to issues regarding the laws of a country or jurisdiction, and justice can involve societies as well as individuals. Health care professionals are often tasked to use resources in a just and fair way. For example, they may wish to allocate resources based on health care needs, rather than on the basis of ability to pay for such resources.

A moral framework relating to this research

If we accept the validity and usefulness of the above four principles of bio-medical ethics, it would be useful to consider how they can assist with the description of ethical issues relating to this research, and how the four principles may be used to decide what is ethical research conduct and behaviour. Beauchamp and Childress argued that almost all moral dilemmas or debates involve at least two of the four principles described above. I will consider how their principles could help with the analysis of the issues relating to the research

participants, the health care organisations involved in PLT, the researcher and the research itself.

Issues relating to autonomy

Research participants are autonomous individuals who are capable of deciding for themselves whether they will take part in research, or not. To respect this, no participant was compelled, coerced, or forced into taking part in the research. Each individual received a communication (either from me or from their practice manager) which invited them to attend a focus group, or interview. Consent forms were given to participants, and participants were included in focus groups and interviews only if they gave explicit agreement to take part. Their signature on the consent form demonstrated their agreement. In addition, participants were given information sheets which detailed the purpose of the research, and what were perceived by me to be the key ethical issues relevant to the research strategy. These consent forms and information sheets are included as appendices to this thesis.

Although the research was sponsored and supervised by NHS Education for Scotland, and received financial support from NHS Ayrshire and Arran, and from the three CHPs within NHS Ayrshire and Arran, the research strategy, and analysis of findings was conducted independently from these organisations. These organisations had an interest in the results, but I acted in an autonomous sense as the researcher, and aimed to identify and interpret the opinions, perceptions and experiences of the research participants, and to analyse and present them.

Issues relating to maleficence

Taking part in research has the potential to cause harm to research participants, and to others. Some research may present more risks to participants and other individuals than other forms of research. For example, clinical research may expose participants to side effects of medicines that are known or unknown. Participants may also be harmed by being involved in non-clinical research topics. In the field of medical education, research participants may take part in qualitative research studies, some of which attempt to answer questions relating to the participants' perceptions and experiences of an educational endeavour.

These perceptions and experiences are expressed in interviews of various formats, and captured on audio-tape, and transcribed. Individuals may be reticent about expressing their honest thoughts regarding an educational endeavour if they are concerned that their opinions may be used against them.

The employment structure in primary health care described in Chapter One illustrated how GPs employ practice nurses, practice managers and A & C staff. In addition, practice managers are the leaders of the A & C staff and are usually involved in recruitment and termination of their employment. As a consequence of this, I felt it was important to protect A & C staff from potential harm by emphasizing the confidential nature of their focus groups. Focus groups were also separated into individual staff groups, not only to encourage the free expression of their opinions, but to allow A & C staff to feel able to do so without being concerned about the consequences of this. I was concerned that there might be repercussions for those A & C staff who were critical of their practice managers' efforts in the planning and preparation of PLT. If comments were attributable to an individual A & C staff member, then this may come to the attention of their own practice manager. This may result in difficulties for that participant. For example, it may affect the working atmosphere, relationship with their practice manager, or promotion potential.

The use of an independent moderator reinforced the confidentiality and neutrality of the interviews. Phase one research participants were also informed that the audio-tapes would not be heard by me and that the transcripts would be anonymised to a degree that would be impossible for participants to be identified.

Issues relating to justice

The research is related to two issues centred on justice. The first relates to the requirement to identify the perceptions and experiences of participants with regards to PLT, and to represent these views in a transparent and honest way. In this respect the research findings were returned to participants for their considerations in both phases of the research. Participants were asked to consider whether I had captured their perceptions and experiences, and they were invited to tell me if I had achieved this or not. The use of coding, the

writing of memos, and the construction of categories based on identified codes and themes allowed me to reflect how my grounded theory was constructed from the perceptions and experiences of participants.

The second issue related to that of the CHPs who had funded the research and who had a responsibility, by their involvement in PLT, to identify where areas of educational practice may be improved. To this end, I produced written and oral reports of the research findings for each of the three CHP educational steering committees.

Issues relating to beneficence

The aim of this research was to identify the perceptions and experiences of four different staff groups with regards to PLT. The earlier questionnaire had shown that PLT was not valued by these staff groups as strongly as it had been by general practitioners and by practice nurses. It was anticipated that by inquiring into the perceptions and experiences of the four staff groups that PLT may be improved for them and subsequently increase practice learning and services offered to patients.

Focus groups

There are many methods for generating data in qualitative research studies. Often methods are dependent on the research topic, the participants in the research area, and the background of the researchers. For example anthropologists will commonly adopt research designs that include ethnographic methods of data generation. Data generation methods are also influenced by the time and resources available to researchers and the need to consider transcription costs and travel costs amongst other issues. The availability of participants to be interviewed may also be problematic if participants have busy professional lives. Many studies incorporate a degree of triangulation in data generation, with the addition of analysis of documents and observational methods adding to data generated by interviews.

Interview methods include focus group interviews and one-to-one interviews, either in person, over the telephone, or by other means of technology (Kitzinger J 1995). Barbour stated that focus groups have become a common and popular

method of generating data from research participants (Barbour RS 2005). She considered that focus groups were useful in obtaining data for research studies in the field of medical education. She also stated that the use of focus groups to generate data can result in rich data, and that focus group discussions may be more attractive to women than men in some cultures (Barbour RS 2008b). Patton commented that focus group interviews allow for interactions between participants (Patton MQ 2002). Participants with contrasting views may reveal more details of their thinking and stance when challenged with a conflicting view in a focus group. This may foster the generation of data that shows the connections between their perceptions and reasoning, and their practice.

Focus groups have their inherent weaknesses. Confidentiality can be an issue and participants may be wary of expressing their true feelings if they are aware that colleagues in the focus group can readily connect expressed opinions with specific individuals. This may be particularly important with focus group interviews centring on professionals and their work. Although moderators may appeal for discussions to remain confidential, there is no guarantee that this will happen. Patton argued that those participants who hold minority views compared to the rest of the focus group may not feel able to share their feelings and a focus group may be incorrectly envisaged as being homogenous when it is not (Patton MQ 2002). Participants with strongly held beliefs who are also dominant in the focus group may prevent quieter or more reticent individuals from expressing their own perceptions and experiences.

Sampling strategy

In quantitative studies, a large number of research subjects, perhaps typical of a larger population group, are invited to participate in research. This is needed to make the statistical analysis of the results valid and to ensure that the study subjects are representative of the general population. This aids the generalisability of the study.

Qualitative research is different, and recruitment seeks to include participants who represent the diversity of the population relevant to the study. A purposive sampling strategy is often used in qualitative studies in order to generate data from a diverse range of participants. Qualitative researchers may consider what

participant attributes could influence any of their experiences or opinions that might be captured by the data generation process. Attributes may include differences such as gender, age, occupation and so on. Recruitment of participants to qualitative studies usually end when the data generated is thought to be saturated. This is usually decided when no new themes or issues are generated from participants.

Theoretical sampling

Grounded theorists have made modifications to purposive sampling. A grounded theory approach typically involves the construction of a theory as the data collection and analysis processes take place. This allows researchers the opportunity to modify their questions and also their sampling strategy. As theory evolves from data generation and data analysis, grounded theorists can use 'theoretical sampling' to test out evolving theories and to construct deeper and richer findings. At the start of data generation, purposive sampling strategies are used, but should be replaced by theoretical sampling as early theory is developed from the initial data analysis. Researchers may choose to go back to individuals or groups who have been interviewed before and ask them further questions based on the researcher's evolving theory. Or they may choose to recruit different individuals to question, resulting in a deeper understanding.

Phase One –practice managers and A & C staff

Sampling strategy

At the start of each phase of research in 2005 and in 2007 I adopted a purposive sampling strategy. For phase one I developed a list of the general practices in 2005 (59 practices) and excluded one mainland practice that did not take part in PLT. Four of the practices were in the Isles of Arran and Cumbrae and because of logistical difficulties of OOHS cover, could not take part in PLT. I adopted a degree of stratification to recruitment. Each CHP planned and prepared large centrally organised meetings independently from each other, so it seemed sensible to hold at least one focus group for each CHP area. Each CHP contributed to the funding of the phase one research, and thus had an interest in the research findings for their area.

Stratification of primary health care teams

The list of general practices was then split into three groups within each CHP depending on the size of the practice. I considered that one of the influences on how practice-based PLT might differ could be the size of the primary health care team. I knew from first hand knowledge of the general practices in the area that larger teams had more practice managers and assistant practice managers than smaller practices. I observed in my experiences with practices that much of the planning and preparation work of practice-based PLT had been delegated to practice managers. I also perceived that the educational and managerial background of practice managers varied considerably in keeping with Checkland's findings about practice managers and their operational skills (Checkland K 2004). In recent years, some of the larger general practices in NHS Ayrshire and Arran had recruited practice managers from other industries, or from other sectors of the NHS.

In the years from 2005 to 2007 in NHS Ayrshire and Arran there was only one general practice with a patient list size of more than 15,000 patients. The three separate stratification groups that I used were: 1-5,000 patients, 5,001 to 10,000 patients, and 10,001 to 16,000 patients. A graph of the distribution of general practices according to their list size was presented in Chapter One.

Recruitment

Practice managers received a written invitation from me to attend the practice manager's focus group for each CHP, and to ask them to select A & C staff to attend the focus groups for A & C staff. Although practice managers in NHS Ayrshire and Arran were identifiable as a group within the email system used locally, no such information was available for A & C staff. There was no centralised register of A & C staff held within the CHP, reflecting the structure of employment of A & C staff by GPs. I was also aware that the recruitment of A & C staff would need the consent and agreement of their individual practice manager. It seemed sensible and practical to acknowledge this, and involve practice managers with the recruitment of A & C staff focus groups.

Using this stratification strategy allowed each focus group to contain participants from small, medium and large practices. Recruitment ended when

eight participants were recruited to each focus group. Each staff group had separate focus groups to encourage participants to be frank and honest about their perceptions and experiences. I was aware of the formal and informal networks of practice managers that existed in the study area, and that some A & C staff would feel inhibited about expressing their views on PLT if they knew that their own practice manager might learn about potential negative feelings via this network. Venues chosen for the focus groups were independent of general practices and of the NHS in general. Local hotels were used to emphasize this distance.

Independent moderator – phase one focus groups

The focus groups for practice managers and for A & C staff were moderated by SC, a female psychology graduate employed by NES for another research project and who had experience in moderating focus groups. I perceived that the non-clinicians would regard her as being a neutral researcher from NES, and that this might encourage more honest responses, rather than the groups being moderated by me. I asked SC to emphasize to research participants before the focus group discussions started that she was not a clinician, did not work for NHS Ayrshire and Arran, and did not have a background in educational provision in the area. Focus groups were held approximately six weeks apart, allowing time for the audiotapes to be transcribed, checked and read through. The transcripts were checked with the audio-tapes by SC as it would have been possible for me to have identified individual participants from the audio-tapes. Early coding and discussion of the transcripts allowed for the iterative selection of questions for the next focus group. Questions were altered or added to in order to explore earlier themes.

Phase Two –the community nursing team

Recruitment of community nurses

Recruitment to these focus groups followed a strategy similar to that of phase one. Community nurses in NHS Ayrshire and Arran were organised into three CHP areas, and initially three focus groups were planned. A further group was added as sampling moved from being purposive to theoretical. Analysis of the first two focus group's transcripts showed that there were emerging themes

relating to power and authority within PLT. As a result, a fourth group was arranged and recruitment to this group included a number of staff who had no formal nursing qualifications. These were auxiliary nurses and support personnel who worked for either the district nursing team or the health visiting team.

Focus groups were held in the CHP headquarters where community nurses held their area meetings. In some cases, the focus group was held before or after the normal monthly community nurses' meeting. This was convenient for the participants, and reduced their time involved in travelling as they were already coming to the area meeting. Three out of the four focus groups in phase two were uni-professional in nature. Two groups contained members of the district nursing team from two different CHPs, and the third consisted of health visiting team participants from the third CHP.

Recruitment of nursing managers

Two focus groups of nursing managers were held. Two CHPs had a nursing manager and an assistant. One CHP had two nursing managers who were of equal status to each other. In total all six members of the community nursing management team took part in the focus groups. It was decided to hold focus groups for nursing managers at separate times and locations from the community nurses to encourage frank and honest expressions of perceptions and experiences.

Moderation

Phase two of the study took place 18 months after phase one. This allowed me time to undergo formal training in focus group moderation. I had experience of facilitating small group learning within primary health care but I recognised that focus group moderation was significantly different from this. I moderated this phase of focus groups personally as I considered that the community nursing team were in general more senior than the non-clinicians and that 'the gap' between a GP and community nurse was less than that between a GP and A & C staff members.

Question topic guide

Examples of questions posed to the community nursing team are shown in Box 3. This is similar to the question guides for the other staff groups with modifications being made depending on the group. Changes were made to the questions in an iterative way.

Box 3: Question guide for community nursing team focus groups

What do you think of PLT?

What are the benefits of PLT?

What are the disadvantages of PLT?

If we were to start from scratch, what should we do differently?

What are your thoughts on practice-based PLT?

How does this compare with large events?

Attendance can be low at times for various groups within the team, why do you think that is?

Do you think community nurses are able to participate in the practice-based events?

Do the events meet your learning needs?

4.9. Data analysis

Coding process

> "Qualitative coding, the process of defining what the data are about, is our first analytic step. Coding means naming segments of data with a label that simultaneously categorizes, summaries, and accounts for each piece of data. Coding is the first step in moving beyond concrete statements in the data to making analytic interpretations." (Charmaz K 2006)

After the audio-tapes were listened to again, the resulting transcripts were corrected, making sure that what had been transcribed was accurate to what was said in the focus groups. Over-talking made this difficult at times during the focus groups. Transcripts were read, and re-read. I then coded the transcripts, by reading through each sentence and interpreted what was being said. I did not use the fine line-by-line coding method advocated by Charmaz, but instead used

a modification of this, by identifying phenomena or happenings in the data. My codes were also longer than those used by Charmaz, in an attempt to manage with the large number of codes that were constructed from 12 focus groups. However, extended codes also made them amenable to interpretation. Thus the initial code 'conflict' was amended to me as 'conflict between practice managers and district nurses'. Often I would add a degree of context – to express what was in conflict. This prevented me from having a large list of codes that may have expressed what was happening during PLT, but did not reveal who it involved, and why.

Development of codes and themes

Initial 'extended' codes were then copied and pasted into an Excel document for each individual focus group. Each Excel document was then analysed and individual codes were merged into larger encompassing themes. Examples of this are given in the appendix of this thesis. Codes and themes from each focus group were then merged together according to staff groups. I read and re-read these and eventually constructed the research papers that were published (Cunningham D et al. 2006a;Cunningham D et al. 2006b;Cunningham D and Kelly D 2008a;Cunningham D and Kelly D 2008b).

After the initial analysis of the data was complete, I wanted to examine the data as one holistic unit, rather than four staff groups (with four resultant separate research publications). I then examined the transcripts again and checked through the codes that had been developed initially. I re-coded all the twelve transcripts and made changes to my original codes.

Use of mind maps

Mind Genius Ltd mind mapping software was used to connect the different levels of data and coding. Extended codes were grouped together under themes, and codes were also linked to a number of raw data quotes from research participants. Thus, the 'grounding' of what was being constructed could be easily seen. Like a large building, the raw data quotes acted as a foundation that supported the constructed codes, themes and eventual categories. I constructed a mind map for each of the 12 focus groups and printed these out on to A3

cards. The number of focus groups and their participants are given in Chapter Five.

Writing of memos

Memos were written throughout the research process following the advice of Charmaz (Charmaz K 2006). It is of interest that Strauss had later abandoned the use of memo writing himself, preferring instead to read and analyse the transcripts kept from group discussions regarding his research projects. I used both methods advocated in Charmaz' text, often using the quick method to rapidly gather my interpretations of the codes and themes more rapidly (Charmaz K 2006). Initially memos related to the themes that came from individual focus groups and contained significant references to the raw data from the transcripts. I used the constant comparative method to compare the responses from individuals from within the same focus group, made comparisons between different focus groups from the same staff groups, and compared and contrasted the data from different staff groups.

With time, I forced myself to become more abstract and conceptual, aiming to generate a grounded theory from the data. As a consequence I decided to work on memos which contained only the extended codes and themes, and then the subsequent categories. I left the foundations of the raw data quotes behind. In the final stages, I made comparisons and contrasts between the categories that I constructed, eventually reducing the categories down to three.

Construction of categories

I gathered the A3 cards of each of the four different staff groups and displayed them on a large white screen. This allowed me to see the connections, similarities and contrasts between the themes of each of the staff groups. Later I constructed a large mind map developed from the individual transcripts for each staff group, which gave me four mind maps. I gathered similar themes together and saw that what were two different themes was actually a variation of one larger theme. For example, a preference for active learning expressed by A & C staff was merged with another theme which expressed their distaste for inactive lecture based learning. The merged theme was identified as: "Preference for active participatory learning methods".

After some time and contemplation, I began to see that the themes were coalescing into three larger categories of themes. This was helped by discussions with colleagues using generic questioning and interrogation of the data. I presented my findings at NES departmental meetings and asked colleagues for their thoughts and opinions. Open questions such as: "What is happening here? [at PLT], and "What are they saying about their experiences?" allowed me to interrogate and question the data, to identify deeper underlying trends and themes of the participants perceptions and experiences. Ultimately, I constructed three categories of themes, and saw that these categories spanned all the different staff groups involved in PLT, but that some categories were much more strongly expressed by some staff groups compared to others.

4.10. Development of grounded theoretical elements

After the construction of the three categories, I began to consider how to make my work theoretical in nature rather than purely descriptive. To achieve this I wrote memos that looked at two of the categories and tried to identify the common ground between them. I did this in turn for all three categories; comparing and contrasting structural issues with relationships, relationships with learning processes, and finally structural issues with regards to learning processes. With time, I started to see a theory developing from the categories and memos, and my grounded theory of PLT is presented in Chapter Eight.

Chapter Five – Learning processes in PLT

5.1. Details of focus group participants

As this is the first chapter giving the findings of the thesis, I have presented in Table 9, the details of each focus group and given some description of who attended in each group. The three chapters of findings were drawn from their discussions.

Table 9: Focus groups and their participants

Staff group	A & C staff	Practice managers	Community Nurses	Nursing managers
Number of participants	24	21	37	6
Number of Focus groups	3	3	4	2

All those who attended the practice managers' focus groups and nursing managers' focus groups were the relevant managers involved. The A & C staff focus groups were more diverse and some of the participants described themselves as being involved in a number of roles within their general practice. Some had dual roles, for example as a secretary and as a receptionist. Others had one specific role. How they described themselves at the focus groups is detailed in Table 10.

Table 10: A & C staff focus group participants by title

Focus group 1	Focus group 2	Focus group 3
Administrator	Secretary and admin. officer	Receptionist (3)
Receptionist (3)	Receptionist/Dispenser	Receptionist/Secretary
Patient services co-ordinator	Admin. Assistant	Personal assistant/I.T. support officer
I.T. officer	Receptionist (3)	Secretary/receptionist (2)
Secretary	Information Manager	
Head receptionist	Reception Manager	

In a similar manner, community nurses had a degree of skill mix and the fourth community nurse focus group reflected this. Focus groups 1, 2 and 3 consisted of participants either from the district nursing team or health visiting team, and all were qualified nurses. Their roles are described in Table 11.

Table 11: Community nurses' focus group composition

Focus Group 1	Focus Group 2	Focus Group 3	Focus Group 4
District nurses (8)	Health visitors (10)	District nurses (9)	Health visitors (4) Health visiting assistant District nursing assistants (3) District nurses (2)

5.2. Introduction to Chapter Five

This chapter presents the themes of learning processes in PLT. It was constructed from the six themes that were themselves constructed from the perceptions and experiences of all focus group participants from the four staff groups under study. Codes and themes have been combined as described in the previous chapter on the research process.

The six themes are:

- Leadership of PLT

- Planning and preparation of PLT

- Identification of learning needs

- Learning methods and learning environment

- Resources for learning

- Evaluation

Some of these themes were identified by several staff groups, some by just one staff group, and one theme was identified by all four staff groups.

5.3. Leadership of PLT

Within the primary health care team, focus group participants considered that the leader of PLT was the practice manager. He or she was seen as being the natural organiser of PLT, and the person who was responsible for the planning and preparation of practice-based PLT events. Practice managers themselves considered that they were responsible for leading practice-based PLT. Some saw this as part of their duties, consistent with their responsibilities of managing A & C staff, and for development of their general practice. Others were concerned that this additional duty had been imposed upon them, or at least had become their responsibility by default:

> "I think PLT is great but I do feel a lot of it has fallen on our shoulders. I don't think that was the original intention." (Practice manager group 2, participant 5)

Practice managers accepted this PLT leadership responsibility but expressed the view that leading PLT meant they often did not gain much from it personally. Much of their own focus group discussion was taken up with their perceptions of the views and opinions of others, in particular with the A & C staff. Their workload – the delivery of learning at the practice-based PLT event itself - seemed to prevent them from participating and learning during PLT. In their efforts to provide learning for others, they worked during PLT, rather than experienced learning with the team.

"Neither do I, apart from organising lunch and running round like an idiot and making agendas up and chairing it and I mean that is all I do really in the protected learning time." (Practice manager group 1, participant 9)

"Another issue is the managers' training. I don't know about anyone else but I don't tend to participate at all because you have got to organise the thing and quite often there are various sessions running at the same time and you end up spending the afternoon going around seeing what is happening as opposed to actually being educated yourself." (Practice manager group 3, participant 6)

Nursing managers recognised that the practice manager was the main leader for practice-based PLT, but questioned whether this was necessarily required. Some nursing managers considered that the PLT leader did not need to be a practice manager, but should be someone in the primary health care team with the attributes or qualities of an educational leader:

"I'm not sure the onus should be on practice managers." (Nursing manager, group 2, participant 2)

"I think it's the person with the qualities to actually take forward, have visions actually be inclusive. And all of that stuff. So it might be a GP, it might be a community nurse. It's just the person who has those behaviours." (Nursing manager, group 2, participant 2)

5.4. Planning and preparation of PLT

Community nurses were critical of communication issues in the planning and preparation processes of practice-based PLT events. Some participants were critical of not just the lack of identification of their learning needs, but that communications about the proposed practice-based PLT events were ineffective or absent. Their busy workload added to the stress experienced by them on the day of the event:

"At the moment we are running around in the morning asking: 'What is happening, does anyone know?'" (Community nurse, group 3, participant 4)

"We could do that, if we knew ahead, but sometimes you are scrambling about in the morning saying: 'What is it that is on this afternoon?' And then you realise this is a whole three hours that is irrelevant, when you have got tons of work in your head." (Community nurse, group 3, participant 1)

The relative isolation caused by working from different premises affected communication between the general practice and community nurses. This was an example of how physical barriers had impacted on learning processes for some primary health care teams. Community nurses spend a considerable amount of their time in patients' own homes, thus further deterring easy communication with them about PLT events. They found email communication difficult and impersonal, and by its nature, cold and abrupt. They preferred more informal face-to-face meetings and chats with practice managers. Some community nurses had insights into the difficult job faced by practice managers, and also by steering committees at CHP level, which were responsible for large centrally organised events. Some envisaged the appointment of a full-time PLT leader or co-ordinator within the CHP as being a solution for the problems relating to organization and communication:

> "I think that it could be a full time job for somebody, to be a PLT co-ordinator." (Community nurse, group 3, participant 1)

> "I thought they had looked at that [appointment of PLT co-ordinator] at one point, to take that role on." (Community nurse, group 3, participant 1)

There were further criticisms from community nurses of the process of planning and preparing large centrally organised events for A & C staff. Some had an understanding of the scale of work needed to plan and prepare for the large numbers of participants, but they did not feel this excused poor performance:

> "I sympathise that the LHCC [now CHP] have got a big job trying to organise all those hundreds of people but I find it hard to believe that they have ran out of ideas." (Community nurse, group 4, participant 6)

Practice managers were also criticised by A & C staff for the lack of long term and effective planning and preparation, which should have included the identification of their learning needs, for practice-based PLT.

> "We usually think about it two days before, and then they just hope something will come up." (A & C staff group 2, participant 1)

5.5. Identification of learning needs

The four staff groups in this study considered that learning processes were very important factors that influenced their perceptions and experiences of PLT. One theme was strongly identified by all four staff groups: A & C staff, practice managers, nursing managers and community nurses. Indeed, this was the only single theme from the three categories of themes that was identified by all four staff groups. The theme related to the ineffective learning needs assessment process. This was particularly apparent when shared learning needs were not identified to allow the primary health care team to design its practice-based PLT events. The process of identification of shared learning needs by CHP steering committees was also criticised by participants for its inability to provide shared learning at large centrally organised events.

Hierarchy of learning needs

Participants recognised that when shared learning needs were not identified, learning events were prepared based on the learning needs of one or two staff groups in the primary health care team. It seemed a common perception that the majority of practice-based PLT events were focused on a number of staff groups, but not all of them. As will be discussed in my description of hierarchy in the chapters dealing with relationships and structures, it seemed that GPs had learning based on their identified needs, and that community nurses were least likely to have their learning needs met. The more powerful a staff group was, then the more likely that that group's learning needs would be identified and transformed into a learning event. Powerful groups were usually GPs, and practice managers made sure that GPs always had a learning event planned for them. The converse appeared true in that those staff groups with less influence on practice managers were less likely to have a learning event offered that would meet their learning needs.

After several years of PLT experience, community nurses learnt that attending practice-based PLT was unlikely to be productive or useful, as the event was not based on their learning needs. Subsequent meetings were not attended by community nurses, and they either developed their own uni-professional PLT, or simply carried on working as normal.

Their low rates of attendance at PLT events were not only because of an inadequate learning needs assessment. Other factors came into play here, for example, the lack of protection from service delivery for the community nurses. With the failure of nursing managers to provide service cover, community nurses found it difficult to get away from normal work activity, and irrelevant learning offered to them decreased their motivation to postpone work and to attend. In turn, practice managers became aware of their low rates of attendance, and future events were planned by practice managers knowing that community nurses were unlikely to attend. Some of these meetings concerned the general practice's response to the introduction of the 2004 GMS Contract. This compounded the problem further by alienating community nurses, resulting in fragmented and separate learning becoming the norm.

Lack of identification of shared learning needs

It was possible that this failure to provide shared learning, caused by the lack of identification of shared learning needs, was the main factor that resulted in the disintegration of PLT. Again, there was a link between learning processes and structures in primary health care. With two separate management structures of practice managers and nursing managers, there was lack of awareness of the problems experienced by community nurses. Practice managers were unaware of the problems relating to lack of protection from service delivery for community nurses. When community nurses were unable to attend practice-based PLT, or stay to the end of the event, practice managers interpreted this as a lack of interest in the learning topic.

I will now consider this theme of ineffective learning needs assessment for each of the staff groups in turn.

A & C staff

A & C staff complained about the lack of learning needs assessment in two areas: that of practice-based PLT and at large centrally organised events. Some felt that they were rarely asked to suggest learning topics for PLT events, but a further strongly expressed concern was that when A & C staff did provide ideas

they were not acted upon. There seemed to be more criticism for large centrally organised events than there was for practice-based PLT.

> "The LHCC [now CHP] have asked numerous times for us all to give topics for admin staff and we have gave different things, and they have never taken place. So we have gone ahead and done them in house [practice-based PLT]." (A & C staff group 1, participant 3)

> "I can understand now why people are falling away [not attending large centrally organised events]. If they are not getting choices and they don't know there is stuff like this [topics discussed at the research focus group] I think the managers have to be open with the staff." (A & C staff group 1, participant 3)

Power influences learning needs assessment

The second quote here raises the issue of hierarchy and poor communication between practice managers and their A & C staff in the general practice. It seemed that some practice managers were not communicating what was available to the A & C staff at large centrally organised events, and the decision for them to attend was not taken by them personally but by their own practice manager. This was an issue both of poor communication from steering committees to A & C staff which was routed through practice managers, and of power. It was perceived that some practice managers had decided that their A & C staff were not going to attend large centrally organised events and prevented them from knowing what was on offer to them. This did not happen with other staff groups: practice managers did not conceal or prevent GPs or practice nurses from attending large centrally organised events.

In a small but significant number of practices, A & C staff were not being treated as autonomous adult learners. Their ability to choose to attend large centrally organised PLT events was prevented by their practice manager, and this became obvious to some participants at the research focus group. Some participants had thought that large centrally organised events had reduced in number or stopped for A & C staff, only to be told otherwise by fellow participants.

A & C staff were aware that they had no direct communication with those in power outwith their general practice. There was no representation of their staff group at the steering committee that organised large central events. They were

aware that some practice managers and clinical leads attended these meetings. Clinical leads were usually GPs who provided the steering committee with suggestions and information about clinical topics and the perspectives and perceptions of GPs. No such structure or process existed for A & C staff and they had proxy representation by some practice managers.

A & C staff participants felt this was unfair and that the persisting hierarchy of power within primary health care penetrated into PLT:

> "You see, they have all these clinical leads and things, and I always wondered why they don't set up a lead for A & C staff and have that person purely to do with A & C. And then we could be separate you know, you could join up when you need to when there's subjects that involves both of you but other than that just keep us separate and we will do what we want to do. As long as it benefits the practice, we can do the subjects we want to do. I don't know who to tell that to." (A & C staff group 2, participant 6)

Several issues were raised by the above perception. The first was the lack of voice of the A & C staff. They felt they had little independent representation at the level of the CHP as their views were represented by practice managers. The second issue was of equality. There were numerous examples of how A & C staff were aware of their relatively low status in the general practice hierarchy, and their inability to plan and prepare their own learning.

Isolation amongst A & C staff

Some A & C staff were conscious of their lack of communication with their peers in other general practices. As will be presented in the chapter on structures, many A & C staff felt isolated from each other, and they had little or no means to communicate their own voices between teams. They were conscious that practice managers and GPs had well-established fora that allowed them to share ideas and concerns with their peers. PLT had to some extent allowed this to happen for A & C staff, but they wanted more resources and opportunities to network with peers:

> "You find GPs all get together and I know that we get GPs from other practices, even a consultant coming to give a talk in a protected learning afternoon. And other GPs from other surgeries have came

and joined in and we've done that, so I don't see why we can't do the same." (A & C staff group 3, participant 3)

Practice managers

Practice managers said that the identification of shared learning needs was difficult, but they gave a different perception of this compared to A & C staff. Their perceptions were based on their experience that the planning and preparation of practice-based PLT events were difficult tasks and that developing an effective learning needs assessment process was not easy:

> "I find it quite difficult in my own practice trying to organise training that suits every member of the team. I think it is very difficult and I put messages up on the notice board in the tea room and ask staff you know, to put things forward. I've left a folder that they can put things into, but I still get very little feedback." (Practice manager group 3, participant 2)

> "When you have got something really relevant it is good to know that you have got an afternoon that you are going to be closed, to slot it into. But there is not an awful lot of those topics for the amount of sessions that we are doing." (Practice manager group 3, participant 4)

The lack of a systematic, comprehensive and effective learning needs assessment method aggravated this difficulty for them. The staff group that they were most concerned about in the identification of learning needs was the A & C staff. Some practice managers did display evidence of their power, by overriding any learning needs assessment of their A & C staff. They decided which members of A & C staff would be attending at large centrally organised events:

> "Now I have made the decision for them [A & C staff] that they come to the medicines one on the 30th of June [large centrally organised event], simply because I think it will be good for all of them, but I might be proved totally wrong." (Practice manager group 3, participant 7)

This demonstrates that there were some practice managers who decided not to allow their A & C staff to choose for themselves as individuals. This negated the view that as adult learners, participants should have the ability to make a choice and be able to express a preference regarding their learning. This concurred with the evidence from the A & C staff, that practice managers were preventing

or restricting them from attending large centrally organised PLT events and preventing their ability to choose.

However, for some practice managers, the arrival of the 2004 GMS Contract was a resource that legitimately filled up some of the time given to them by the PLT scheme. One practice manager found solace and benefits with the introduction of the 2004 GMS Contract:

> "I actually think last year [2004] was easier because of the new GP contract, we were all working towards that and lots of training issues came out of that." (Practice manager group 1, participant 4)

As will be described in the next chapter dealing with structures in primary health care, the introduction of the 2004 GMS Contract brought considerable changes to PLT, and in particular practice-based events. With the introduction of new work came the arrival of shared learning needs, at least shared by the general practice. As these learning needs were perceived by the community nurses as not relevant to them, community nurses attended practice-based PLT less and less.

Community nurses

The participants from the community nurses' focus groups showed most negativity when learning needs assessment was mentioned in their focus group discussions. They spoke of how practice-based PLT events were rarely based on any of their learning needs, and in particular, how the 2004 GMS Contract had further alienated them from attending:

> "It was just totally irrelevant to our needs." (Community nurse, group 3, participant 4)

Participants described the inadequacy of the learning needs assessment process in detail, and expressed how they felt about their lack of consultation and involvement in the planning and preparation of practice-based events. As a consequence, subsequent PLT events were planned that did not take their learning needs into account. They described how attending these irrelevant learning events made them feel:

"You couldn't afford not to but nobody asks us what we want to do, on the afternoon that we're told to take off." (Community nurse, group 3, participant 1)

"I just don't think they ask us what we want. We are told and we're all, as you say, we're all professional and accountable for your own training and keeping yourself up-to-date and I think we are all very proactive about that." (Community nurse, group 3, participant 4)

"I don't think they have particularly asked us what we need." (Community nurse, group 1, participant 5)

This caused participants to consider that PLT was wasted time rather than useful time. They used up time only to consider that their own work was postponed and not protected. For community nurses there was the additional stress of knowing that on some occasions their work was not protected from service delivery, only postponed to later in the afternoon:

"I had understood that the idea of PLT was that we would all get it, that there would be subjects there that the GP would input, that the nurses would input. Whether they would have something to say, and we would all go away with something that we had learned. Whereas if it is just aimed at one area then that one section may learn something, but I don't know if it is wholly relevant for everyone else." (Community nurse, group 4, participant 4)

"Because a lot of the time I sat through an afternoon thinking: 'What am I doing here?' I could do so much more and I have been told to come here [by the nursing manager] and it was three hours of wasting my time to be honest." (Community nurse, group 4, participant 1)

"That [PLT event] maybe isn't pertinent to you, the hours pass and you are thinking: 'I could have been doing this and that.' This is what is going through your head and you don't enjoy it." (Community nurse, group 1, participant 6)

The last experience emphasized the general feeling of disempowerment. This community nurse has described various issues. One was that of encouragement by the nursing manager to attend and participate in practice-based PLT. The second is of the relative lack of service protection for community nurses. When these two issues were coupled with an event that did not meet their own learning needs, then community nurse participants felt angered by their experiences.

Some felt that occasionally practice-based PLT events had met their learning needs, but this seemed to be related to chance, rather than to any well-informed or well-constructed learning needs assessment process:

> "I don't think that anyone asks the health visitors what we want. You are attached to the practice, so you are a member when the subject is pertinent and sometimes you think: 'Oh! That might be quite good for me.'" (Community nurse, group 1, participant 6)

Condemnation for this ineffective or inadequate learning needs assessment process was not only aimed at practice managers, but also at nursing managers. They too, were considered not to be listening or engaging in a process of learning needs assessment, and of acting on these needs. When community nurses decided not to attend practice-based PLT events and lobbied their nursing managers to arrange alternative uni-professional events, they were disappointed with the outcome:

> "The line managers asked for it [learning needs] and we gave it to them. But that is not what they wanted. They gave us a bit of freedom to make our mind up. We did, and then they said: 'That is not what we want.'" (Community nurse, group 3, participant 6)

> "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.'" (Community nurse, group 2, participant 4)

Again as with A & C staff, there was an underlying theme of power in these experiences. As one practice manager took the decision to send his or her A & C staff to an event chosen by the practice manager, so nursing managers were determining learning needs. Not, it would appear, the learning needs of the participants involved.

Nursing managers

Nursing managers were aware of the inadequate processes of identifying shared learning needs, although they themselves did not participate in practice-based PLT. They had learnt about the inadequacies from community nurses but they

understood the need for the provision of learning that had its foundations on shared learning needs:

> "You would need to find a common theme that would suit the clerical staff, community staff, the GPs, everybody wouldn't it?" (Nursing manager, group 1, participant 4)

> "Where the building of relationships within the teams by learning together, I think that is probably the biggest bonus from the PLT, but you have to get the subject matter right." (Nursing manager, group 1, participant 4)

They appreciated that "getting the subject matter right" did not happen often, or at least in their perceptions gained from feedback from their own staff. As a consequence of various issues, including poor learning needs assessment, nursing managers were aware that community nurses, in general, had withdrawn from practice-based PLT events, and in place had resorted to their own uni-professional events:

> "In ****** Ayrshire, we quite mostly, not all the staff but the vast majority of the staff, health visitors and district nurses, do their protected learning outwith the practices." (Nursing manager, group 1, participant 3)

> "There is still a separate training plan for the PLT sessions for nurses and they are run at different venues from the practice sessions. So it's run very separately or basically you would say there is practice PLT and nursing PLT. Which I don't really think is an ideal, because the whole concept of it was about improving team work and looking at that part of it." (Nursing manager, group 2, participant 1)

The above perception from one participant illustrates that nursing managers were conscious that the current practice-based PLT events were not in keeping with the original aims and objectives of how PLT should be. It was felt that at the introduction of PLT some years earlier, learning should be shared, should unite teams by promoting teamwork and team-learning, and be useful to all in the primary health care team. One participant vocalised her feelings of dissatisfaction with the current separate arrangements:

> "But what I'll say that I don't like the idea of is that you know, the district nurses would go off and do one thing, and health visitors would go to another area and do something else, and the GPs would

be doing something different." (Nursing manager, group 2, participant 1)

The evolution of separate learning events was not seen as being desirable by nursing managers, but this had happened and they struggled to accept it:

> "I quite often get staff saying: 'What's on in the practice today? I really don't feel that it's something that is of relevance to me. Can I do my anaphylaxis update?' Yes, okay but then I think is that what PLT was brought in [for]?" (Nursing manager, group 1, participant 1)

Nursing managers were conscious of similar concerns raised by A & C staff within the general practices. They were disappointed that A & C staff would rather continue with work duties than attend and participate in practice-based PLT events.

> "And then the clerical staff the feedback we constantly get at our local PLT meetings [steering committee meetings] is they would find it would be more benefit if they could do their paperwork because they don't find anything is relevant for them." (Nursing manager, group 1, participant 3)

5.6. Learning methods and learning environment

Participants had opinions about the learning methods adopted both at practice-based PLT and at large centrally organised events.

A & C staff

This group felt strongly about some of the learning methods used during PLT and felt that these did not suit their own preferred style of learning. They had separate thoughts concerning practice-based PLT and for large centrally organised events. They were conscious that learning methods should be participatory and interactive in nature but these features were less likely at large centrally organised events. Perhaps as a consequence of the relatively large numbers of A & C staff, they found these events to be impersonal in nature. As one participant described it:

> "I went to a big event and I just thought it was a waste of time. We just sat there among rows and rows with one person on the stage. And

we were back, back, back, back and I just thought that was a complete and utter…" (A & C staff group 3, participant 3)

Another participant shared this experience:

"We were sitting in a circle and you couldn't hear what the person across was saying. You know, the circle, the groups were huge in that first one! I would have said more than eighty." (A & C staff group 3, participant 4)

A & C staff were aware of the logistical and practical difficulties of arranging learning for large numbers of participants. Their large numbers proved to be a logistical problem for organisers, which resulted in negative perceptions from participants:

"At the bigger events you don't get enough time either, because arranging four hundred people or something in the afternoon, took too long for lunch and the time spent learning or training wasn't enough." (A & C staff group 3, participant 3)

Not only were their large numbers a drawback, their experiences of attending a large lecture made this method of education unpopular with A & C staff at large centrally organised events. Participants did not enjoy this format of learning, finding it dull, sedentary, and with little opportunity for interactions:

"It is awful boring, people speaking at you. And you are just literally sitting there. It is much better if you can get into a discussion in a wee, definitely a smaller group." (A & C staff group 3, participant 4)

"If you felt that you had achieved something, if you came away and have learned something. And not just having sat there, and listened to somebody speaking." (A & C staff group 3, participant 1)

"Just not sitting." (A & C staff group 2, participant 9)

Participants were much more positive about learning methods that encouraged them to discuss, and interact with their colleagues, but that were also light-hearted and fun. There was a strong sense that PLT should be enjoyable and entertaining, as well as being useful learning, based on their learning needs.

"It was good fun and you enjoyed that and learned something. And you think: 'Well, that's helpful.'" (A & C staff group 2, participant 9)

> "Initially they thought the topics were gonna be boring. They actually enjoyed them, albeit not particularly relevant to their job, but they did enjoy most."(A & C staff group 2, participant 7)

A & C staff wanted learning that was fun and enjoyable but they also wanted to be more active and interactive with their learning. This did happen for them at times at both practice-based and large centrally organised PLT events. I will discuss this further in the next chapter on relationships where I will illustrate that A & C staff felt that learning from other primary health care teams and the wider world of the NHS was relevant and useful.

Practice managers

Practice managers echoed some of the perceptions and experiences expressed by their own A & C staff. However, much of what practice managers discussed did not relate to their individual learning, but to the benefits of learning for the A & C staff. They agreed that practice-based PLT was more likely to be welcomed by A & C staff in comparison to large centrally organised events. They acknowledged and echoed A & C staff's perceptions about the impersonal nature of the learning methods offered at these events:

> "I find it, the big events for admin staff have been far too big. I mean the first time we had around five hundred receptionists in the one hall and trying to keep them focused." (Practice manager group 1, participant 1)

Community nurses

This staff group did not comment about learning methods as strongly as A & C staff, but they did have strong feelings about the learning environment or learning atmosphere, especially that experienced at practice-based events. One focus group strongly vocalised how they were made to feel when they attended practice-based events. Participants did not always feel welcomed when they arrived at the practice, and this was usually when community nurses were based in a separate building from the general practice, that is, they were not co-located. Some described having to sign the fire register on arrival at the practice, as a 'visitor to the practice' which undermined their status of being an integral part of the primary health care team. This led to the feeling that they did not naturally belong with the general practice and that they were alien to

the practice building. Others were critical of the way they were treated by the GPs when they were interacting in the learning event itself:

> "Well I find sometimes though, for those of us who are well, used to, if you like, for dealing with GPs it's fine. For some grades of staff who are afraid of them it can be quite difficult. Because I think it can be quite intimidating and I don't always see a great camaraderie there and I think that's very intimidating. I think it's alright for most of us around 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 take annual leave because they feel intimidated by them [GPs]. You're not really welcomed by other disciplines if you like." (Community nurse, group 4, participant 1)

> "They feel intimidated that, perhaps they would be an auxiliary or a very junior nurse sitting with each other. Nurses frightened to open their mouths perhaps when they're asked a question, and they do not have a clue what's going on. And I can ask the others." (Community nurse, group 4, participant 1)

These expressions came from the focus group drawn from one CHP. The nursing manager of this CHP had described in her focus group, her drive to make sure that community nurses were attending practice-based PLT events. She had asked each individual nurse to tell her what they were planning to do on the PLT afternoon in an attempt to discourage working during PLT rather than learning. In view of this action, participants felt duty-bound to attend the practice-based event and not to continue with their normal work. Thus, the only solution to avoid the feelings of intimidation was to request a half day of leave from their annual entitlement. Other senior nurses in the focus group agreed with this comment. It was obvious that participants found that it was not just the learning materials and topic on offer, or the learning method that had encouraged the taking of annual leave, but of the reception and reaction of the GPs at the event itself:

> "I think there is still that chasm between, I can talk from *********, yes we know each other but because we're not on the same premises it can be quite difficult because you're signing [signing the fire register as a visitor to the practice], I'm bringing my team in. The last small event I actually spoke to the girls [A & C staff] 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 more as a

> chore and they feel a bit uncomfortable, going into the practice."
> (Community nurse, group 4, participant 6)

An additional hierarchy was the hierarchy of knowledge. When practice-based PLT events were arranged around the learning needs of the clinical members of the general practice, then community nurses often felt intimidated by the pre-existing knowledge of the general practice in relation to that topic. They felt uncomfortable in saying: "I don't know." Some community nurses suggested identifying topics that were not known by any of the clinicians likely to attend the event so that the previous knowledge of some participants would not be discouraging to others. Community nurses were happier attending events where they felt comfortable. Higher rates of attendance were likely in practices where they had established good relationships with practice managers and GPs. Moreover comfort was also increased when neutral topics such as self-defence and management of violent patients were discussed.

5.7. Resources for learning

Lack of resources

Practice managers were usually the individuals who were tasked by the rest of the primary health care team to plan and prepare for practice-based PLT. Consequently they were the only staff group to identify the theme of available resources for PLT in the focus group discussions. What resources were available to the team, for the provision of practice-based PLT, was a concern for practice managers. Other staff groups did not see this as being an issue, although the primary health care team did see practice managers as being the main leaders of PLT, and that their efforts and attitudes towards shared and team learning had important outcomes for PLT.

Practice managers raised various issues concerning the resources available to them. Some participants were critical of the lack of resources provided for practice-based events by the CHP. Some recalled that the budget for PLT had been reduced and that it had some impact on the quality of learning available. Nevertheless, one participant was grateful for the basic provision of out-of-hours medical cover for PLT:

"I think it is good that it does not cost anything for the practice and it gives everybody a fair chance to get training if they are allowed it." (Practice manager group 2, participant 3)

Influence and resources of pharmaceutical representatives

Other practice managers realised that the limited funds available to them had restricted what could be provided. Thus, some practice managers had asked pharmaceutical representatives to make up this shortfall:

"Well, we were told we had to rely on sponsorship for both speakers and catering. Catering is not really an issue. But if you want to bring someone in [external speaker], it can be very expensive to do that, which is maybe why we tended to go with people with, have sponsored you [pharmaceutical representatives]." (Practice manager group 3, participant 3)

"You end up getting reps [pharmaceutical representatives] to sponsor your day in doing thinks like that, whereas you know if someone from the Trust [CHP] could provide this training for you would take them. But you end up getting reps who provide training for this, that and the next thing." (Practice manager group 3, participant 4)

Other practice managers concurred with these perceptions and experiences, and these views were expressed from all three practice managers' focus groups. It seemed well-established in some general practices, that pharmaceutical representatives were regular providers and planners for practice-based PLT events. The pharmaceutical representatives had learned from some practice managers when the PLT dates were released in a CHP area, and they would call on practices to offer learning:

"I mean as soon as you have got the dates out, 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." (Practice manager group 3, participant 3)

With time, pharmaceutical representatives built up considerable experience of examples of practice-based PLT events that had been well received by other practices. To an extent, this network of pharmaceutical representatives had become an informal resource of knowledge for practice managers. They acted as educational agents offering free learning resources, with advice and feedback about what was available:

"I had one yesterday that brought in a folder and all this different training for everybody really." (Practice manager group 3, participant 4)

"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. So they are saying: 'I did this in practice A and it was very successful.' And obviously the manager can phone them [other practice manager] and get feedback." (Practice manager group 3, participant 3)

"Aye, drugs companies do quite a lot!" (Practice manager group 3, participant 4)

There was a cost involved in this: practice managers knew to have their GPs and other prescribers available to meet the pharmaceutical representatives on or around the learning event. This meeting was an essential part of the informal agreement brokered between practice manager and pharmaceutical representative. Practice managers either arranged for this to happen during or shortly before the event, or in some cases a few days before or after. Other practice managers gave insights into how they would ask their GPs to see a pharmaceutical representative before a practice-based PLT event even if the GPs were leaving the practice premises to attend a separate PLT event. This was often needed, if for example, a pharmaceutical representative was providing learning for others in the primary health care team. It was known to practice managers that pharmaceutical representatives would not readily provide resources, unless they were reimbursed in this way:

"I try to do [have the pharmaceutical representative meet the GPs] in the central events when there is no lunch involved, is try to get the GPs to come in and have their lunch [with the pharmaceutical representative] for ten minutes and I got round it that way." (Practice manager group 3, participant 7)

"I bring them in [pharmaceutical representatives], be it, the day before or be it the following week, the rep to see them as long as I get sponsors for that particular day. And sort it out with them [GPs and other prescribers] when it suits them to come in." (Practice manager group 3, participant 7)

5.8. Evaluation of PLT

Although participants did not comment on the evaluation tools or whether the evaluation processes were informing future learning, some practice managers did consider that the evaluation responses were not always honest or effective. Practice managers were most concerned about the responses from A & C staff. Practice managers had concerns about the process of evaluation: that there was not enough time allocated to this element of learning. As a consequence evaluations were often hurried and not complete, and other staff groups concurred with this:

> "The only way that there is any feedback is through evaluation. But your evaluation form is only as honest as how you are feeling when you are filling it out. And if you are in a rush to go out to see a diabetic, then you will tick the briefest amount, you are not going to spend time documenting." (Community nurse, group 2, participant 4)

Practice managers were concerned that their A & C staff were not honest with their evaluation of practice-based PLT:

> "Well they all fill in forms I think but they have admitted to being not totally honest." (Practice manager group 1, participant 8)

> "The thing is they [A & C staff] are desperate to maybe tick anything really I mean you always get these forms at the end of it and you have not got time to be totally, write what you want to say. I think that people have to be more honest." (Practice manager group 1, participant 3)

One practice manager felt that A & C staff had an informal feedback and evaluation system with each other, but that this was held in private, as if A & C staff had a view for the evaluation form but a more truthful view on the learning event amongst themselves in private:

> "I would have said it would be interesting to hear what the comments were that you got back from the admin staff. I mean what they say outwith, and what they actually say when you actually have meetings is sometimes two entirely different things." (Practice manager group 1, participant 3)

5.9. Summary

There seemed to be many flaws and criticisms expressed about the learning processes involved in both practice-based PLT and large centrally organised PLT events. Nevertheless, when learning based on shared learning needs did occur it was welcomed by many, especially community nurses. Practice managers were given the responsibility of PLT but it was not known if they felt they had the skills and knowledge to perform the planning and preparation of PLT well. They certainly did not mention this in any of the three focus groups held from their staff group. There were additional underlying themes that were identifiable from the data generated from the focus groups. One was of power and the hierarchy that exists in the structures of primary health care. This was noted by community nurses, especially the more junior members, when they attended the practice for practice-based PLT events. There was little sense that they belonged in this setting, nor that they were made welcome to contribute or participate. It is not known from this research whether practice managers and GPs were aware of community nurses' perceptions.

Another concern was the lack of resources for PLT and the assumption that practice managers had the resources available to them for successful collective learning. Although nursing managers suggested any individual from the primary health care team with the relevant skills could be the practice PLT leader, it was not known from any of the participants whether any other staff group member had taken up this role.

The greatest disappointment expressed by participants was the failure to find and collate the shared learning needs of the primary health care team, and of arranging learning that met those needs. Although different staff groups had their own perceptions of the flaws in this process, it was clear that this process needed more research and resources to make it more effective. Teams may want to use the PLT time itself to explore this, or to identify and collate their learning needs, perhaps for the forthcoming year. It may be postulated that funding of the development of shared learning needs tools is needed to speed up and ease this process.

Chapter Six - Relationships in protected learning time

6.1. Introduction

I have structured this chapter according to the various themes from the transcripts of all 12 focus groups. As with the previous chapter relating to learning processes, some themes were identified from only one staff group. The themes are:

- Variable relationships between community nurses and the general practice

- Working in a team where individuals were valued and respected

- Team-building events were valued

- Collaboration between practices was valued

- Practices and the CHP: conflict and difficulties.

6.2. Variable relationships between community nurses and the general practice

This theme was constructed from data from two staff groups: nursing managers and community nurses. A & C staff focus groups did not raise this as an issue of concern. Nursing managers had a wider view of how community nurses related to general practices than community nurses themselves.

Community nurses' opinions

Community nurses were more descriptive, in their focus groups, about the relationships between staff groups in comparison with nursing managers. Community nurses were able to share their experiences, and give examples and details of relationships, both good and bad. Nursing managers based much of their perceptions on their interactions with community nurses, although they did

have some personal interactions with general practices. Community nurses had varied perceptions of general practices, and their attitude to shared work:

> "Each GP practice works differently and you will get really good and really bad. Well I am saying bad, bad ones that don't want to work with district nursing staff, health visitors." (Community nurse group 1, district nurse 2)

The relationship between the general practice and community nurses was of great importance to them. They were strongly in favour of working in a primary health care team where working and learning relationships were good. Relationships varied quite markedly and there were contrasting views expressed in focus groups. Some participants felt so strongly about a bad working relationship that they felt they would ask their nursing manager to move them to a different general practice. In one focus group, a community nurse described her experiences with her attached general practice. When this was voiced in the focus group, all the other participants from that CHP nodded in agreement. They all knew about this general practice and about the problematic relationship that existed there, and had existed in the past. Participants gave further details that suggested that there was a culture within this general practice of not getting on with their attached community nurses, and that this culture had existed for some time and was allowed to continue.

Another community nurse gave a contrasting description of her relationship with the general practice:

> "When I was there you were invited to everything they had. I was invited too, and so they take you along, just like a family. If you've got GPs that really don't have much interaction I think it makes it much more difficult." (Community nurse group 4, district nurse 1)

She felt that the key to this good relationship was that the GPs in the practice worked well with each other, and that this was needed as a foundation for relationships beyond the medical partnership. This close and inclusive working pattern seemed to have transferred to others in the primary health care team. She concluded that this was an excellent example of good team relationships, and was integral to how the team behaved. Others concurred with this viewpoint:

"********** (name of practice) are the same. They invite us to things that are happening in the practice and I think we are working together better. I think we are working together better, over the last year I've been really trying to concentrate on improving communication. And I think it's getting there and people are more at ease with each other, when you're there so I think." (Community nurse group 4, district nurse 2)

Others described more variable relationships with their general practice, and how this influenced what happened during PLT. Some felt that their position in the primary health care team was prone to fluctuations and change. They were recollections of how some learning events during practice-based PLT had given some hope to improved relationships but this was temporary and short-lived for the duration of the event itself:

"It is very sad, and then when everything is all rosy, and everything else, then we do a significant event [analysis] 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 PLT will remove that." (Community nurse group 3, district nurse 8)

"But that is just human nature isn't it? You get on when you need something or you are after something from that other service. And they [GPs] are as nice as nine pence. And then other times, they hear you coming and they close the door." (Community nurse group 3, district nurse 2)

Participants were angered by these experiences. It was felt that the significant event analysis described was performed as part of the 2004 GMS Contract, where quality points were awarded if primary health care teams discussed these together. Thus, the improvement in relationship was perceived as being good only for the life of the event itself, and that this was purely to allow the GPs to earn money from the 2004 GMS Contract. Poor relationships were criticised by community nurses, but shallow or insincere relationships were considered worse. Again, there were feelings that this insincere attitude had been adopted purely to gain further income from the 2004 GMS Contract, and that this was not an authentic desire to create long-lasting change, nor to improve teamwork.

Poor relationships resulting in poor learning environments

Community nurses considered the atmosphere or learning environment that was described in the previous chapter on learning processes. Some recalled how they had not felt welcome in the general practice and as a result did not feel they were part of the primary health care team. Physical structural differences, such as not being co-located, contributed to this:

> "And you have to feel welcome [at practice-based PLT events] but as a nurse they [GPs] don't make you feel welcome." (Community nurse group 3, district nurse 3)

When relationships were poor between general practices and community nurses, this became more apparent during PLT when teams with strained inter-staff group relationships were forced together. It seemed that poor relationships resulted in a poor learning environment during PLT and little was learned. Younger or junior community nurses were considered to be more vulnerable than their seniors and would be reluctant to contribute to any discussions. Other participants commented that they were not present at practice-based PLT as they had not been invited. They gave further examples outwith PLT that illustrated that their working relationship was not good, and that this had led to poor teamwork:

> "Up until a few months ago, they didn't realise I wanted to be in a team. Wanted to be invited. It was an issue that came up and was discussed. It's not very pleasant but we're never included in a team, as part of all the GPs. They went on a team-building exercise and didn't ask the nurses." (Community nurse group 1, district nurse 2)

It was a shared perception amongst participants that relationships varied not only between teams, but that the relationships within teams were subject to change. One of the issues that caused the variation was the attitude of the practice manager. He or she was an important agent in the building and maintenance of relationships across all individuals in the primary health care team. Participants reported that the practice manager would include community nurses when it seemed to suit the general practice:

> "We have a very pro-active practice manager. But she sees that [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 we tag along, and if it doesn't you're left." (Community nurse group 1, district nurse 6)

"In some of the practices it [PLT] is organised for the [practice] nurses, the practice staff. We're attached staff, so it is a second thought if that. So it is just 'link in' and that is you." (Community nurse group 2, health visitor 3)

It was clear in the focus group discussions that the key staff groups that determined the relationships for community nurses were the GPs and practice managers. Community nurses rarely mentioned practice nurses or A & C staff, except to mention that they considered that A & C staff were suppressed by GPs and the practice manager.

Perceptions of nursing managers

Nursing managers reported that relationships with general practices were very variable. There were comments that they found this difficult to cope with and these findings will be described and summarised in the next chapter dealing with structures in primary health care. As primary health care was structured into one CHP serving a geographic area, nursing managers had to develop relationships with between 16 and 21 general practices. They did not find this easy and in essence had to develop distinct and different relationships with each general practice. They were conscious that community nurses also had varying relationships that they deemed were dependent on the general practices involved:

"They [community nurses] are fully embraced within the team and they're full members of the team, and other teams see them as the staff that come and work here [in the general practice] sometimes and you know they don't, they're not embraced in as full members of the team." (Nursing manager group 1, participant 2)

"But there are some practices that work well, and really see the staff [community nurses] as the whole staff." (Nursing manager group 1, participant 4)

Again, like the community nurses they managed, nursing managers were conscious of where there were bad relationships between general practices and community nurses. With similar thoughts to community nurses themselves, they felt this reflected a deeply rooted culture within the general practice. This

culture was dependent on the existence of shared values of working well with each other, and with the wider primary health care team:

> "I think it is people's values. It's how they actually, in terms, because actually you find that they are actually probably quite rude. In every aspect of their life, or have that kind of attitude and I'm not talking just about practices. I'm talking about community staff as well."
> (Nursing manager group 2, participant 2)

The above quote is the only evidence from all participants from the community nursing team, that community nurses had a reciprocal and important role to play in developing and maintaining good relations with the general practice.

Nursing managers shared a further theme with community nurses. They felt that a good relationship was an essential foundation to allow effective learning to occur. They perceived that when a general practice worked well with itself and with attached community nurses, that effective learning was far more likely to occur. This learning would often be interactive and participatory in nature, and occur during practice-based PLT events.

> "The community nurses were working together with the practice nurses to actually see what we needed and helping to generate the agendas for the [practice-based PLT event] and we have seen a significant improvement in it" (Nursing manager group 1, participant 3)

> "It was a mixture of practice nurses and community nursing staff and practice staff and we came up with some ideas but that's where the nurses and the nursing staff, health visitors and district nurses are supporting the practice managers for topics and speakers and different things and organising the PLT." (Nursing manager group 1, participant 2)

Nursing managers want improved relationship with practices

The nursing managers were aware that not only community nurses needed good working relationships with the general practice, but they themselves also required this to be effective in their role. Some nursing managers described good relationships with GPs and with practice managers. However, some reported that a few GPs and general practices were more difficult to deal with and they felt their relationship could be strained at times. Lack of trust was considered an important feature in this conflict:

> "So that kind of mutual respect and working relationship and the history is not really there, so they don't trust you. Trust has a lot to do with it." (Nursing manager group 2, participant 1)

> "I think that's it as well. It's trust. They [practice managers and GPs] don't trust us." (Nursing manager group 2, participant 2)

Nursing managers perceived that GPs thought they held a 'hidden agenda' about what they did and what nursing resources were put in place for each general practice. Some hinted at historical difficulties in their relationship, as if the current nursing manager had inherited a long standing poor relationship with a general practice. One nursing manager gave an example of a frank meeting with a general practice that had resolved some persisting issues with regards to relationships:

> "What is it you're [GPs] here for? What is it I'm here for? So we actually got common ground didn't we? And the respect now it's fabulous, because whenever we maybe want to look at something, I'll maybe email that GP and say: 'I'm looking at this.'" (Nursing manager group 2, participant 1)

Another nursing manager, who had recently moved from secondary health care to primary health care, realised that she knew little about prevalent work cultures and different methods of working that she had found on taking up her new post. She had learned that organizational differences made working in primary health care different from her previous experiences in hospital nursing:

> "I put in my personal development plan was to understand social culture but also to actually understand general practice, because I didn't appreciate that it was a business. I thought they [GPs] were employed by the health service." (Nursing manager group 2, participant 1)

Good working relationships between key individuals in primary health care were reliant on knowledge of this diversity. Knowledge of structural differences was important, and awareness that some staff groups within the NHS were not directly employed by the CHP, but were independent contractors. Several other nursing managers agreed with this opinion that relationships depended on improving understanding of each other and working around the organizational differences, and attempting to make links with people and personalities that mattered, or that could lead to improved relationships.

"It's like, that's what we should be doing. If you sit round the table you get to kind of know, actually most people are nice people you know." (Nursing manager group 2, participant 2)

Practice managers have a key role in primary health care

Nursing managers were aware of the importance of developing effective relationships with practice managers. Community nurses gave examples and details of why practice managers were important, and how their behaviours influenced the success and effectiveness of PLT. There were frequently expressed opinions of positive attitudes towards PLT, but some community nurses had realised that the educational skills and attitudes of practice managers varied considerably, and this diversity had a significant impact upon the quality of team learning, especially for practice-based PLT.

Some practice managers overcame structural problems, and transcended the organizational schism that divided the primary health care team into the general practice, and community nurses who were employed by the CHP. These practice managers tried to identify and uncover learning needs for all those involved in practice-based PLT. Some community nurses described the behaviours and attributes of practice managers who they considered organised successful PLT events:

"They [practice manager] ask us. Our practice manager will ask us [about learning needs]. When the gold standards framework [for terminally ill patients] came out and we seemed to know more about it, and they said: 'How can we find out about it?' And we told them" (Community nurse group 3, district nurse 5)

"But what she [practice manager] 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 clerical and admin. Speak to the GPs. What are we needing? What do we need to work with?" (Community nurse group 4, district nurse 2)

Identification of shared learning needs

In the perceptions and experiences of community nurses, those practice managers who included them at the very beginning of the learning process with the identification of shared learning needs, were considered to provide more effective learning. This contrasted with other practice managers who arranged

learning based on the general practice's learning needs, and then invited community nurses after that part of the learning process had been completed. Thus, community nurses appreciated practice managers who involved them from the beginning and who included their learning needs and preferences into the design of the PLT event.

Some community nurses perceived that other practice managers involved them at a later stage in the learning process. However they were still made to feel welcome to attend the event, often taking place in the general practice's premises, and that they belonged there:

> "Our practice manager does let us know, but what he will say is: 'We are doing an update on GPASS' [clinical care software program], or 'We are doing an update on contract work', or 'We are doing this and I really don't think that it is relevant for you girls to come along. You are welcome to come along to lunch.' But there is not really any point." (Community nurse group 3, district nurse 2)

> "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 go to do? Has the CHP done something else?' And then there are other ones who will not let you know what is going on." (Community nurse group 3, district nurse 9)

The involvement of community nurses was determined by the pre-existing relationship that the practice manager had with them. If relationships were good, it was natural for the practice manager to develop a practice-based PLT event around the needs of the whole primary health care team. If relationships were not as close, then community nurses would be invited to the event, but this event was less likely to be based on their identified needs.

Other practice managers not only did not identify learning needs, but also did not invite the community nurses to the practice-based PLT event. Some community nurses realised that the agenda of the 2004 GMS Contract, or the learning needs of the general practice had dominated the practice managers' planning and preparation of PLT.

> "They [practice managers] are not interested in the bigger picture anymore. They are interested in their own group." (Nursing manager group 1, participant 1)

"I honestly look at it that he [practice manager] is detrimental to the communication and the camaraderie between practice, practice staff and community staff. I know my job well and I can tell him that I know my job well and he knows that. But I think he is extremely detrimental and I think you only need to take one person and that person is the practice manager." (Community nurse group 4, district nurse 2)

Practice managers as key agents for the team

Participants were disappointed about the behaviours of some practice managers, as it was perceived they had a duty not only to plan and prepare practice-based PLT, but also to lead the primary health care team and to involve everyone.

"They [practice managers] should be because they are there, to sort out the, as far as I'm concerned they are supposed to put a lot into it. A lot into the team, making sure that everybody is working together and seeing what people do. But not all practice managers are like that." (Community nurse group 1, district nurse 7)

"They [practice managers] actually help the practice to focus and help to put the whole package together. Their awareness needs to be raised, that if we don't have these people and these people [participating in PLT] it doesn't work for the practice. That's what's lacking, I think in some of the practices, because they don't look outside the door." (Community nurse group 1, district nurse 4)

Some community nurses saw the practice manager as being the agent who held the primary health care team together and who worked between different staff groups to do so. To do this effectively meant that the practice manager had to work beyond the interests of the GPs, and to see the wider perspective of the different staff groups who contributed to the team. Much of this work was done by maintaining good working relationships with others, and many participants saw this as being a key component of the practice manager's duties.

A & C staff's view of practice managers

A & C staff also held strong views of the role and responsibilities of practice managers. Like the community nursing team, they saw practice managers as having an influential role in what happened during PLT, and in particular during practice-based PLT. For some A & C staff, working during PLT occurred rather than learning. They perceived that their own practice manager did not consider

them worthy or a priority in the organization of learning during practice-based PLT.

In contrast, other practice managers seemed to have adopted a more enabling stance to A & C staff and their learning. Some participants from A & C staff focus group said that they had gained responsibilities for planning and preparing PLT for their staff group. Others felt that although they did not necessarily do this, they could if they wanted. There was a growing sense amongst the focus groups, that if they were to fully benefit from PLT then they would have to do some of the preparations themselves. Some saw this as a challenge that they were prepared to undertake if it meant that their own learning was to be more relevant and useful. However, for others in the group this was not deemed possible:

> "No, I just phone up and ask them [potential presenter] would they like to come along and talk." (A & C staff group 1, participant 5)

> "We don't get any of that; we don't get to make the decision. It's just what I say [practice manager] goes." (A & C staff group 1, participant 6)

Experiences were contrasting. Some A & C staff seemed able to put forward ideas, and progress that idea to an actual practice-based PLT event that would benefit them and their team. Others from different practices were strongly controlled by practice managers, and to them, the former approach seemed very unlikely to occur in their general practice. Certain participants in the A & C staff focus group concurred with this disabling approach to practice-based PLT:

> "We normally get told it's protected learning time next and it's going to be on such and such." (A & C staff group 1, participant 4)

There was however, a minority view that their PLT experience was not like that. Some participants belonged to general practices where practice managers were responsive to learning needs of all of the team and had enabled the A & C staff to progress their own learning. Some participants described themselves as being senior receptionists or team leaders. As they were the head of a component of the A & C staff team within the practice, the planning and preparation of PLT had been delegated to them by the practice manager:

"We always ask the girls [fellow A & C staff members] every now and again. I maybe email them all and ask them if they have any ideas or any suggestions and if it is something that is relevant then I shall take it to my manager and if we get it, we get it for them." (A & C staff group 1, participant 5)

6.3. Working in a team where individuals are valued and respected

Community nurses' perceptions

The concept of work being valued and respected by others was identified by community nurses. A strongly voiced issue for them was of being valued and respected by the general practice. By this, they most often meant the GPs and the practice manager. Having their work recognised by the general practice meant a great deal to them but they also wanted that work to mean something to the rest of the team. They wanted their efforts to be recognised and appreciated by the primary health care team. As one participant expressed:

"I think GPs being, appreciating you, you feel part of the team and appreciating what you actually do. And realising what you do. I think taking on board what you are saying, and you've been there for a wee while taking on what you are saying." (Community nurse group 3, district nurse 9)

As I will describe in the next chapter, some community nurses felt their work was invisible to the GPs as it was performed either in a separate building, if they were not co-located, or at times in patients' homes. They needed to feel that their work was valuable. Some perceived this did occur and it usually strengthened relationships as a result:

"I think where you are all valued for yourself and you are all equal, that is important, and good communication." (Community nurse group 2, health visitor 6)

"It is involving everyone as a team. I think I work in quite a good practice, but I don't know as they say. If I was excluded then I wouldn't be very happy. I am happy with my workload in the place but they don't involve me for some of the practice days [practice-based PLT]." (Community nurse group 2, health visitor 1)

> "I went to ******'s [name of focus group participant] practice when I was a student, and it was really good, because everyone got to appreciate one another's roles and listen to what, and it just made everyone think that it takes everyone within the team." (Community nurse group 1, district nurse 4)

Other community nurses were aware that despite their best efforts, they were not always considered part of the primary health care team by the other members. It was their perception that the GPs, and to a lesser extent, the practice manager had the power to decide whether they were included in the team or not:

> "We have asked on various occasions to be included within the team and things that they do, and only a couple of months ago they went and had a team-building exercise, and, and didn't think to ask us. And as I said, you know, we are not part of the team." (Community nurse group 3, district nurse 6)

This phenomenon of separate and isolated working and learning practises alienated the community nurses, and some had less of a sense of belonging to the team than others. This was similar to the perceptions of the community nurse who had not felt she belonged to the practice when she was asked to sign the fire register, in essence to record her status as a visitor to the practice.

Community nursing awareness of practice hierarchy

Community nurses were, to a degree, outsiders to the general practice and looked in on it. As a consequence they had developed opinions and perceptions of how the general practice was structured and some had perceptions of the hierarchy that existed there. They had two concerns: how the A & C staff were treated, and that GPs had a great deal of power.

Status of A & C staff

There were several comments that hinted at the low status of the A & C staff. Some community nurses alluded to the phenomenon that it was not uncommon for A & C staff to work during PLT rather than attend a learning event. Community nurses perceived that this was related to several issues. One was that the GPs and practice manager did not consider that A & C staff were worthy of formal learning or education. The second was that A & C staff did not have

any power or authority to do anything about the lack of resources for them. In contrast to their own position, some senior community nurses were sure that they would be able to resolve such an issue with their nursing managers:

> "That unlike us, many of these girls [A & C staff] would not go to the practice manager and say: 'This is PLT, this is where we should have protected learning time. This isn't the time for filing.' Whereas we would easily go to our bosses and say: 'Wait a minute! Protected learning time is not for whatever!'" (Community nurse group 4, district nurse 1)

> "Particularly for the admin staff. I feel quite sorry for them because I think that I am in quite a good practice. But I know that quite often if there is nothing organised for the admin staff, they are working they are catching up. Quite regularly they are catching up, and they don't have the confidence to turn around and say to their line manager: 'Excuse me, but this is protected time for us as well.' Maybe CPR [mandatory cardio-pulmonary resuscitation training] is organised for an hour or something, and the rest of the time they are back at their desk doing their catching up." (Community nurse group 1, district nurse 1)

That some of the A & C staff were fearful of the practice manager's reactions to their protests about lack of PLT was identified by another community nurse:

> "But I feel some of the wee girls [junior members of the A & C staff], some of the grade twos that are working in the practices. There is just no way that they have, that they would go to their manager, sorry but this simply isn't happening. Because what they say is: 'They pay my wages.' They don't have unions, they don't believe in unions at work." (Community nurse group 4, district nurse 1)

Their perceptions reflect the different structures within primary health care and the CHP, which is explored further in the next chapter on structures in primary health care. Community nurses' perceptions were that they worked in a safer employment environment compared to A & C staff that worked in small businesses and were employed directly by the GPs and managed by the practice manager. They considered that A & C staff were fearful of losing their jobs and that to complain about the lack of PLT may result in them being dismissed - that they would lose their job. In another focus group, this issue of job insecurity was identified by a community nurse:

> "Because these girls [A & C staff] can't say anything, because I am not suggesting that they are brilliant but because it is a business, like lots

of small businesses out there. They function within their own regime. And it is very difficult for them to speak up, because they find that if they do, then they are out of the door pretty soon one way or another." (Community nurse group 1, district nurse 2)

This perception has some similarities to the issues voiced by the nursing managers. Community nurses worked within the tightly regulated structures of the CHP and there was a uniform system that governed and managed all community nurses within the CHP. However, the community nurses perceived that the general practices were separate and autonomous organizations: small businesses that were able to create their own rules and operate accordingly. This 'organizational schism' between a large CHP and smaller general practices caused problems for the relationships between community nurses and the practices. Nursing managers found it difficult to work with between 14 and 20 different general practices as each general practice had developed its own working patterns and methods.

Perceptions of GPs and their power

Community nurses were distressed to recall the issues raised above. They did not like to see that some A & C staff had little in the way of PLT and that their job security was under threat should they complain about the lack of planning and preparation of PLT. Although community nurses perceived that it was the practice managers who were responsible for the lack of planning and preparation of PLT events that did not include the A & C staff, the nurses considered it was the GPs in the practice who held the power regarding these decisions. These decisions were considered by community nurses to be related to money and power. They saw that practice managers had prioritised learning at practice-based PLT around the individuals who employed the practice manager – the GPs in the practice.

One community nurse was accepting of this:

> "But I think as you say, the lead person within most of the practice is the practice manager, and his wages are paid by GPs. He is not really responsible for your [nursing] 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 specific [targets within the 2004 GMS Contract]." (Community nurse group 1, district nurse 4)

This community nurse had reflected on the duties of the practice manager and considered the new learning agenda that had arrived with the 2004 GMS Contract. She saw that the practice manager only had operational responsibilities for the general practice. The significant numbers of people working within the nursing team, with different learning needs and varied job titles, did not help practice managers with learning processes. Again, the structural differences between individual general practices and the much larger CHP had caused differences in the relationships between the practice manager and community nurses. Although community nurses were attached to the practice, some did not perceive they were integral members of it. Community nurses realised that it was a difficult task for one practice manager to plan and prepare learning for all in the primary health care team. Thus, they realised that the foci for the practice manager were the learning needs of the GPs, the people who employed the practice manager, and the need to perform well in the 2004 GMS Contract.

The power to decide on what happened at practice-based PLT filtered down from the GPs to the practice manager was recognised by another community nurse:

> "I suppose that the GPs have the final clout, but the practice manager, depending on how structured they are, can make an awful lot of the decisions. It does involve the health visitors as well. But it is so inconsistent across the board, but that is a personality issue, that is not… It is like health visitors as well. We all work doing most of the stuff, but we do some things different. In each practice we do the same and in some practices, personalities and GP personalities are quite different." (Community nurse group 2, health visitor 4)

6.4. Team building events were valued

This theme was identified by two staff groups: community nurses and A & C staff. Team-building events were generally welcomed by numerous focus group participants from these two staff groups.

Community nurses and the learning environment

Community nurses were keen to get to know the general practice better. There was a strongly held perception that good working relationships were worth having and that work was needed to maintain them, and to develop them further. PLT gave an ideal opportunity to do this, whereby both the general practice and community nurses had PLT to enable this to happen. It appeared that a number of primary health care teams did use this time for the purpose of team-building.

Some participants felt that the ideal team event was when the practice had an afternoon away from the general practice's premises or shared building and invited community nurses to participate. When teams looked at everyday work and how this could be developed and improved upon, then community nurses felt this was worthwhile and enjoyable.

> "I think there was a team building one, at the ******hotel 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. The working of the practice and what the problems are and I think that that is what it was about. Not just hearing about MS [Multiple Sclerosis] but how you function as a practice, how you gel together and things like that." (Community nurse group 1, district nurse 2)

This community nurse clearly valued the concept of not just working in a team, but working as a team, where individuals can learn collectively, examine what they do in a safe and secure environment and make changes to processes in their work that may improve services for patient care. This is in marked contrast to the learning atmosphere described by the nurse who recalled how she signed herself and her team into the practice on the fire register. It also contrasted markedly with the senior nurse who told her focus group that her junior nursing colleagues would prefer to take the afternoon off as annual leave because of the intimidating atmosphere generated by the GPs. Some importance was stressed by the community nurse on the need to have an independent or external facilitator at team development, perhaps to reduce the hierarchy within the primary health care team and to allow all opinions and views to be expressed.

She gave more details, when asked by others in the focus group to explain, why such team-building events were such a good use of time:

> "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." (Community nurse group 1, district nurse 2)

This quote displays the sense of involvement and collaboration that is needed if primary health care teams are to learn together and make effective changes. She described high levels of commitment amongst the primary health care team, and that all the team contributed. Participants in the team-building event felt secure and safe enough to challenge others and then to make changes in their working lives. There was also the perception that the hierarchy, both structural and learning, had been reduced, at least temporarily.

However, another community nurse who had positive perceptions of team-building events had also mentioned that an away-day was perceived by some as being a waste of time and money:

> "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." (Community nurse group 1, district nurse 5)

She highlighted another issue constructed from this research: the concept of legitimate learning. There were examples whereby others were able to criticise a team for what occurred during PLT and that some events were not considered to be legitimate learning events. Again there is a theme here of power. As will be mentioned later in this chapter, this was an issue raised by practice managers, the main organisers of practice-based PLT and was voiced at times by members of the PLT steering committee. Outsiders to the team were able to be critical of what a team chose to do during their events.

Team-building events also touched on a second theme identified by community nurses. They were keen to attend practice-based PLT events that were fun and not associated with a hierarchy of learning. Community nurses at times could feel uncomfortable when there was learning on offer that was not based on their needs, but on the needs of the GPs. They would then feel uncomfortable with

their relative lack of knowledge on that topic. When there was a learning topic that was new to all the primary health care team, they felt very comfortable and would usually enjoy the event. Examples of this were events which involved practical self-defence training.

> "But it was fun! [Self-defence demonstration]. It was just fun and the person who was kind of teaching us the moves wasn't too serious. He was showing us what we were doing but it was just a fun session and everybody was laughing. We all just laughed. But we were still learning something that was still valuable to our job." (Community nurse group 4, health visitor 1)

> "You're not having to strike a balance between the GPs who have got their medical knowledge and admin. staff don't have that knowledge. It was everybody was learning from it." (Community nurse group 4, district nursing assistant 1)

There was a reservation here about enjoying learning. The participant is almost defending her opinion that this was a fun event and reinforcing the value of this by stressing how she was learning, in addition to enjoying the event itself. It seems there were perceptions of guilt about enjoying time spent together, and that learning should not be enjoyable. Just as the team who went to the hotel and tried to make improvements to their work had been criticised, team members felt vulnerable to criticism, and their ability to select learning based on their own needs was at risk.

Fun events were also considered useful even if there was no obvious learning topic. Community nurses felt they wanted to learn about their own primary health care team and get to know individuals better. This in itself was considered a legitimate use of PLT.

> "Team-building exercises, for example, something like ten pin bowling for example, where you are mixing up the teams, like mixing the GP team in with the district nursing team, health visiting team, but you are working in a team to try and beat. Do you know what I mean? It's something, fun, I think sometimes people need that downtime and you need to be able to, people get to know each other better that way." (Community nurse group 4, district nursing assistant 1)

This nurse had perceived that purely getting the team together and doing an activity collectively was not only fun, but a useful and valuable activity. She valued mixing the team up and being with other professionals in an environment

where community nurses got to know the others better. As one nurse succinctly put it:

> "You can get behind that professional face and get to the real person." (Community nurse group 4, health visitor 3)

As with the perception regarding self-defence, community nurses saw that there were practical learning events, often involving some degree of physical activity that the team enjoyed. The learning hierarchy was reduced and that some element of learning took place for everyone:

> "In some you can get some very, very good [learning events]. Our practice manager has arranged some very good, and very diverse subjects actually which everybody has been interested in. Self-defence and all sorts of things. And what was it, we had Pilates one day. You get interesting things that brought everyone together." (Community nurse group 2, health visitor 10)

As with the previous issue, their pre-existing relationship with the practice manager and the attitudes held by that practice manager towards teamwork and team-learning were considered fundamental to the success of such events. Some practice managers were able to see the learning event at PLT as being a substrate or reason for the team to get together. This was the primary aim, and the learning topic was secondary to this. Some practice managers saw the learning aim as being about teamwork and team-building, and the practical topic was used to enable this to happen. It worked like glue, bringing the primary health care team together to allow them to meet and bond with each other.

A & C staff and learning environments

Many A & C staff participants saw team-building events in the same way as community nurses. They viewed it as an opportunity to improve relationships, learn about other people in the primary health care team, and be involved in changing how the team worked. Having good relationships with the rest of the team, and spending time to develop them further were considered to be positive aims of PLT. Similar to the experience of the community nurses, A & C staff saw the person behind the job title or role:

"You're not seeing them [GPs] as the doctors all the time. You are managing to socialise with them and see them as people." (A & C staff group 2, participant 3)

"It gave us a chance to be people together, not just doctors and receptionists, and the nurses came as well." (A & C staff group 2, participant 3)

These perceptions and experiences related to fun team-building events, in particular where the primary health care team had left their normal building and went away for the afternoon. Some A & C staff had participated in events as described earlier by the community nurse, where the team had examined their daily workings and tried to make changes and improvements to how they functioned. There was some surprise when the GPs allowed this to happen and that they had stayed to see the event through:

"It [practice away day] was really good cause they didn't see things from the girls' point of view. And we were surprised that they [GPs] did actually stay. No it was beneficial to all, 'cause it did mean we got to sort things out." (A & C staff group 2, participant 8)

Another colleague described a similar event to the one experienced by the community nurse who found team-building PLT events to be beneficial:

"We wanted an afternoon where we had everyone in the practice: GPs, midwives, and health visitors. The whole team in the one afternoon. And they all got to say what annoyed us about each other!" (A & C staff group 2, participant 3)

There were other views on the need to involve all the team with changes, and it was clear that they perceived that GPs had to be active participants and collaborators in these changes if the proposed actions were to be put in place, and to work:

"If it's something that we are trying to educate the GPs about, you know. It's of real value if it's a procedure that we want to have changed. And they [GPs] won't come and it's just us, then what use is that?" (A & C staff group 2, participant 3)

6.5. Collaboration between practices was valued

This theme was identified by two staff groups: the A & C staff and practice managers.

A & C staff

For A & C staff the theme of collaborative learning seemed to be a very strongly expressed view: in fact at times it overtook the agenda of PLT during the research focus groups. Frequently in the three focus groups, participants would digress from discussions around the topic of PLT and move to discuss other topics such as 'Advanced Access' and computerisation of patient records with software such as 'Docman'. A & C staff were keen to learn from other participants during the focus groups: it was as if the focus group had given them an unforeseen opportunity to learn from their colleagues. As focus groups were arranged into CHP areas, participants may have met some individuals before their focus group took place. They were keen to learn about the topics chosen for practice-based PLT by other primary health care teams, but also what these topics were actually about.

> "See listening to you! You have got a lot of things we never thought about!" (A & C staff group 3, participant 6)

> "What is Advanced Access?" (A & C staff group 3, participant 7)

Thus, in the focus groups, A & C staff would start to discuss how large projects such as Docman and Advanced Access worked, and how these significant changes for the practice were put into operation. The structures in primary health care had prevented this collective learning opportunity from happening readily in the times before PLT. A & C staff explained that up until then, they had limited opportunities to get in touch with each other and learn about common problems. Many appreciated the opportunities that PLT brought, and it was one of the few advantages of large centrally organised events that A & C staff could sit and chat informally over lunch with contacts from other teams. Some described this as being the best element of PLT, the coffee and lunch breaks that enabled informal learning between different A & C teams.

"It is good when we get into small groups with other practices. Because that's really where it is probably beneficial." (A & C staff group 7, participant 3)

"Kind of linking up and just chatting." (A & C staff group 3, participant 2)

As they were used to working in their own practices, in relative isolation from others in primary health care, A & C staff valued the chance that PLT had given them. They wanted to discuss the details of practice activities, and to look at the everyday working challenges that they faced and shared with each other.

'We could all meet together, find out how somebody did something and how you did it, and then decided if there was a better way to do it.' (A & C staff group 1, participant 1)

'It was all about things that have happened in other people's surgeries that you then discussed. But again it was just like we got together with everybody and although we're all doing the same job we don't [ever meet up]' (A & C staff group 1, participant 3)

Practice managers

Practice managers valued the effect of having good learning relationships with colleagues from other general practices. Many commented on the benefits for their own A & C staff. Learning from other practices was often valued either at practice-based PLT when nearby practices could get together, or at large centrally organised events.

"You know for practices, well 'Oh! They do it that way that might be easier you know'. You can learn from it that way from other practices. It [large centrally organised event] is the only chance you get to be all together." (Practice manager group 1, participant 2)

"We have actually joined with one other practice, and we've got that feeling of inter-mixing with another practice and learning things from them." (Practice manager group 1, participant 2)

Practice managers had another learning source that was not open to the A & C staff: that of the practice managers' group or forum. This seemed to have been facilitated by the CHP, and it was clear that many saw this structure as being an easy and convenient opportunity to learn. Practice managers described how they

obtained new ideas for practice-based PLT at the practice managers' forum, and learned about an array of topics there:

> "We are relying on each other aren't we? 'Who's had that training? Oh good! Give me the number.'"(Practice manager group 1, participant 6)

> "There is a pretty effective working group of managers anyway in the North." (Practice manager group 1, participant 8)

Some voiced their perceptions about how beneficial this group was, and described how information from other practice managers validated ideas for PLT, and a personal recommendation from another practice manager was a clear indication that this source would be offered to another practice. The opinion of a colleague from the forum was very valuable, and as described in the earlier chapter, was the method used by pharmaceutical representatives to pursue contacts with prescribers in the practice. If one practice manager in an area recommended a resource from a pharmaceutical representative, then it was likely that some of the other local practice managers would follow in this regard and use this resource.

Although practice managers were keen that A & C staff were able to learn from their colleagues from other primary health care teams, they were also aware of negative consequences of one A & C staff team meeting another. It was clear that when this learning opportunity had happened in the past, A & C staff returned to their practice and recalled how workloads, and terms and conditions of employment differed amongst practices. These comments irritated practice managers and they felt that the comments detracted from the main purpose of the interactions. As nursing managers highlighted, the general practice were able to decide themselves how A & C staff were employed and ultimately how much they were paid. Unlike the CHP and other staff that worked for NHS Ayrshire and Arran, there was no fixed pay scale structure: each practice decided itself on these arrangements.

An unforeseen consequence of the mixing between A & C staff was that staff discussed other concerns that were not on the initial learning agenda. Practice managers found this difficult and it was an issue that discouraged them from allowing this learning resource to be used.

"It sometimes can be difficult when staff do go to other practices and then they start talking about: 'Well what grade are you on, you're on that grade and I'm on grade three.' And then they come back to the practice and say: 'That other secretary at the other practice is a grade four!'" (Practice manager group 3, participant 6)

"'What's your terms and conditions?' You know the things they are really interested in! Or 'What bonus did you get? How many holidays have you got?' It's certainly a double edged sword." (Practice manager group 3, participant 7)

6.6. Practices and the CHP: conflict and difficulties

Practice managers were the staff group that identified the relationship between the general practice and the CHP as being difficult. When they thought of the CHP in the context of PLT, they considered the PLT steering committee and nursing managers. It was common for practice managers to describe poor relationships with the PLT steering committee and this involved several issues: lack of leadership in PLT, criticism over legitimate learning and poor communication and lack of representation on the PLT committee.

Legitimate learning

Participants were angered over the criticisms from the CHP about the nature of some of the learning that practice managers had prepared for their teams. Some CHP managers and members of the PLT steering committee considered that some practice-based PLT events were not legitimate learning. Practice managers were hurt by these remarks. They considered that many of these events had taken some time in planning and preparation, and quick critical statements from others outwith the team were very unwelcome, and perceived as being unwarranted. Some saw this criticism as an example of hierarchy, similar in a way to being disciplined by a superior colleague. This was particularly damaging when it was done in public rather than in private:

"I was in a meeting with other managers when a representative from the LHCC [CHP] really gave me a row in front of other managers because we had never attended a session [large centrally organised event]. And we had moved into new premises and a lot of the PLTs at that point were really relevant to…" (Practice manager group 2, participant 4)

> "There was certainly one practice went off and did something they regarded as team-building and somebody [from the CHP] came down on them like a ton of bricks and said: "No! That is practice away-days, not PLT!" So we need some kind of guidance as to, is going climbing Goat Fell [mountain on the Isle of Arran] seen as a team-building? Or is that a nice afternoon out?" (Practice manager group 2, participant 1)

Thus, some practice managers were aware that the CHP had an opinion on practice-based PLT events that they themselves had planned and prepared and for some, they wanted to have more guidance about what was considered legitimate and what was not.

Communication problems

Poor communication between CHP and practice managers was another issue for practice managers. Some saw that poor communication was disruptive to the practice's preparations for PLT. A common complaint from practice managers was that of slow and delayed communications regarding large centrally organised events. They felt that the notification of what events were available to their team members came too late. Sometimes, as a consequence, some practice managers arranged a practice-based PLT to compensate for late information from the CHP. They then faced accusations of poor attendance at large events.

> "I had a problem that the trusts [CHP] couldn't tell me what was in the big training session right at the end of the year." (Practice manager group 3, participant 3)

> "I mean to be sitting here on the 22nd of June and we don't know in eight days from now what is going to be provided for the clinicians. That is not good planning." (Practice manager group 3, participant 4)

6.7. Summary

The strength of relationships between individuals and between different staff groups within the primary health care team was an important factor for the effectiveness of learning. Most staff groups perceived that the practice manager and his or her attitude towards the team and its functioning was the most important element to relationships. Some practice managers adopted an ambassadorial role within the team, approaching individual staff groups to

negotiate a learning agenda that involved as many as possible. What was clear in the analysis of the practice manager's actions was that the approval of the GPs was necessary. Few practice managers persisted in behaviours that did not gain the ultimate approval of his or her employer.

Some primary health care teams suffered from poor relationships, compounded by highly hierarchical general practices, and distant community nurses, both in a physical and functional sense. For these teams relationships were shallow, impersonal and business-like. In such teams practice-based PLT disintegrated into separate learning events for each individual staff group. Staff groups with less power, such as A & C staff, had fewer opportunities to learn and much of the practice manager's efforts were aimed at benefiting GPs.

Chapter Seven - Structures in primary health care

7.1. Introduction

I have structured this chapter into the various themes that I identified from focus group transcripts. Some themes were identified by several staff groups and others by only one group. In contrast to the other chapters of findings, I have divided this chapter into two sections; one pertaining to the community nursing team and the other pertaining to the non-clinicians of the general practice. This division reflects the strong sense of boundary between these two groups within the primary health care team.

Perceptions of different structures

Different types of structures were identified and considered by participants. Some saw the differences in how primary health care teams were structured in a functional sense and the varying influences of hierarchy amongst different general practices was one example. Others saw structures as a physical concept, for example, the structure of the practice building, and awareness that the A & C staff rarely left that building in their daily work.

Some participants talked about the differences in the organizational structure of primary health care including the differences in the functions and structures of the general practice in contrast to the community nursing team. The concept of structure was seen in many ways, and was dependent on the person, and usually related to the staff group to which they belonged. Thus, their view or perspective of the structures in primary health care was determined by their own position within that very primary health care structure.

7.2. The community nursing team

The following themes were identified from the community nursing team:

- Dominance of PLT by the general practice

- Physical structures influence how teams work and learn together

- Lack of protection from service delivery for community nurses

- Lack of support from nursing managers

- Team-based learning prevents flexible learning across practices

- The organizational schism between the CHP and general practices

- Dual management structure – practice managers and nursing managers

- Practice nurses are isolated from the nursing profession in primary health care

Dominance of practice-based PLT by the general practice

Nursing managers and community nurses identified that the 2004 GMS Contract had a strong influence on what was learned during practice-based PLT and that this was a consequence of the domination of practice-based PLT by the general practice.

Perceptions of nursing managers

Nursing managers recognised the influence of the 2004 GMS Contract on practice-based PLT. They saw it as one of the main reasons that resulted in community nurses withdrawing from practice-based PLT. Their nursing staff worked independently of the 2004 GMS Contract and they were not remunerated in the same way as the general practice was, so its introduction did not directly affect their ways of working:

> "I was finding my staff weren't getting involved, [in practice-based PLT] they weren't being included because the GMS contract also started to come out and people started to focus in on using that time." (Nursing manager group 2, participant 2)

> "But I think if it's [practice-based PLT] only looking for the contract and stuff, that's the problem. And I think that's right enough. It probably was, that's when it changed, when the new GP contract came in." (Nursing manager group 2, participant 1)

Some nursing managers did perceive that the 2004 GMS Contract had brought positive changes to health care. They saw that it was a drive by the Government to improve the quality of health care being delivered for patients and did not

see that all the issues relating to it were negative. They did perceive that community nurses had mixed feelings towards the 2004 GMS Contract, and in general, those sentiments were negative:

> "Yes, it feels like a lot like box-ticking." (Nursing manager group 1, participant 1)

> "You've got some people [community nurses] who can see what the bigger picture, you've got some people that see that it's actually patient care that's going to benefit." (Nursing manager group 1, participant 3)

Nursing managers occupied a high position in the hierarchical community nursing team. They saw that some of their nurses had negative reactions to the 2004 GMS Contract and that community nurses were being asked to deliver tasks in health care that seemed not to be beneficial to their patients, but were creating income for the general practice. A culture of 'ticking boxes' was suggested by nursing managers and by community nurses, and they suggested that health care was process-driven and that work was done not for the benefit of patients, but for the benefit of the GPs' income. Other nursing managers disagreed, or at least did not agree entirely that the 2004 GMS Contract was a waste of time for community nurses. They perceived that patients received improved care, particularly with care relating to chronic disease management within the community. These nursing managers understood that community nurses resented the 2004 GMS Contract and were not always happy when they were asked to perform tasks by the general practice.

Separate learning

The 2004 GMS Contract had, in many cases, acted as a barrier to joint learning and to joint working, and was an example of how different organizational structures influenced collective learning. Nursing managers perceived that the care delivered by community nurses was wider than the Contract. They felt that their nursing teams had to work with many other different teams in the community, not just the general practice. Because of these issues, the nursing managers and senior nurses started to deliver their own education and learning events whilst practice-based PLT events took place:

"District nurses and the health visitors didn't feel as if they were included and we had actually started to draw them out and set up events ourselves." (Nursing manager group 2, participant 1)

"For a start, community nurses feel that the job is much broader than say the work they get in the practice, things like the contract doesn't actually help." (Nursing manager 2, participant 2)

Community nurses' perceptions of the 2004 GMS Contract

Community nurses perceived the 2004 GMS Contract and the domination of practice-based PLT by the general practice differently from their own nursing managers. They became wary and suspicious of practice-based PLT events that dealt with contract work and were cautious when they received an invitation to attend. They saw their involvement as being concerned with increasing income for the GPs and they viewed learning at practice-based PLT events as preparation for them to be involved with more contract work. It was not that by attending they would be learning about improving health care, but that contract-related work would be delegated to them with a strong expectation from the general practice, that this work would be delivered. Some community nurses felt that their relative isolation made their existing work invisible to the rest of the primary health care team. Contract work would then compete with other duties such as child protection and they considered that their child protection work was unnoticed by the general practice.

Community nurses increasingly saw the general practice as being a private business owned by the GPs and managed by the practice manager. Moreover the contract had sharpened this contrast between the two organizational systems within the NHS:

"And that is the unfortunate thing, because they are kind of looking at business managers, accountants and you get some wonderful accountants but some of them, it's purely as a business and it takes the kind of emotive side away from it, If you like. It's money, money, money, money, money, money." (Community nurse group 4, district nurse 1)

"I know the contract was set up and that's how it works but it's just a … Certainly it's put your back up, and I must say you know you think to yourself: 'Wait a minute, when did we ever get any extra money?' We seem to be doing increasingly huge amounts of work, ticking a huge amount of boxes." (Community nurse group 4, district nurse 1)

Senior community nurses were especially critical of the 'new breed' of practice managers, some of whom had gained employment because of previous business and financial experience. Often these practice managers had been recruited from commercial businesses, and some had accountancy training. This was in contrast to other practice managers (mostly female) who had been promoted from the ranks of A & C staff.

Organizational schism

Some community nurses were able to see that their organizations differed, and that the general practice was organised to bring in income to the practice, based on what services were available to patients and that payment was to be made according to the quality of these services. Others did not understand the fine details of these differences, but they were aware of the two separate ways of working, and how this difference influenced practice-based PLT.

> "I think people are excluded by the contract work, because it's all points and it's not very… And I know it's a business etc. But we don't work like that." (Community nurse group 4, health visitor 2)

> "Because it is all down to how many points, and that gets prizes, and then that gets money, so yes it does." (Community nurse group 4, district nurse 1)

There were perceptions that the contract acted as a structural barrier in issues outwith PLT. Some felt that team meetings were at risk of being cancelled if the meetings did not meet the criteria set by the contract.

> "One of the reasons that we feel that we don't get team meetings anymore is that we did have a meeting with the GPs, but one of the things in their contract was if there were not enough bodies on seats, then the meeting was cancelled. So they kept putting more appointments on [consulting with patients rather than participate in a meeting] and it kept slipping." (Community nurse group 1, district nurse 7)

Perceptions of lack of power

Community nurses felt powerless to protest about their experience of practice-based PLT, and they considered that they were under-represented at two key positions in the structures within PLT. They felt unable to influence the general

practice in selecting the topics for practice-based PLT, and unable to influence or change large centrally organised meetings. They considered they were under-represented at the PLT steering committee. This issue existed before the introduction of the 2004 GMS Contract, but community nurses did feel that the contract had exacerbated the power imbalance of practice-based PLT.

> "So all of that has fragmented and it has lost its impetus, and I think that there needs to be a group, and certainly some of the nurses have agreed to go on it, but not just nurses. It needs to be a CHP group that thinks really about what they are doing with PLT, or whether we do all do it differently, and we do all have separate programmes." (Community nurse group1, district nurse 2)

The comment above refers to many of the issues discussed in these three chapters. The differences in structures between the larger CHP and the many different and smaller general practices resulted in a fragmented and variable experience for community nurses. They were used to one system of working and found it difficult to manage with the individual variations of each general practice. As practice-based PLT was arranged mostly by the general practice, it was controlled by them too. As a consequence each general practice decided on its needs and arranged learning to suit. Community nurses had little authority or power to be involved in these arrangements and were invited to attend after planning and preparations had been made.

This raised concerns regarding democracy and fairness within learning during PLT. Community nurses realised that others in the team had a more powerful voice than theirs, and that learning had been centred on the whole team, but was now focused on the requirements of the general practice. Thus, some either went along with what had been planned by the general practice or decided to work, or they learned independently of the rest of the primary health care team.

> "It wasn't relevant or they didn't consult you, or the doctors were doing their appraisal thing, and so they were spending time doing that, so there was nothing, you were doing your paperwork, catching up which kind of makes a mockery of the whole thing." (Community nurse group 1, district nurse 8)

> "And the GPs had made other arrangements so there was nothing organised within our practice and again it is knowing what is available

and what is out there, and whether we are allowed to attend, and whether there is places for us. And again, if it is appropriate to our discipline." (Community nurse group 1, district nurse 8)

Physical structures influence how teams work and learn together

Invisibility of the community nursing team

Many community nurses perceived that they worked in isolation from the general practice. The structural barriers for some meant that they were based in different buildings from the general practice that they were attached to. Many felt that their work was invisible to the general practice, and in particular to the GPs and to the practice manager. A number were very frustrated by this and some were insulted:

> "I think it is disgusting! Really! That a GP doesn't know what we are doing! Come on!" (Community nurse group 2, health visitor 8)

Participants felt undervalued. Many alluded to numerous and repeated house visits to the elderly and chronically ill, which took up a lot of their time. Health visitors in particular described extensive dealings with at-risk families where children were being protected and monitored to prevent harm. It was not surprising to hear their anger when one participant raised her concerns that GPs did not know what her post involved. Being situated in different buildings had resulted in poor communication about workloads and work had become invisible to the separate parties:

> "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! 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 up front and all of the rest of it. But I really thought that these days were long gone." (Community nurse group 2, health visitor 8)

This lack of visibility compounded the issue of lack of power. Not only were community nurses relatively powerless, they were unnoticed by those with power and had little voice. Some recalled taking steps to make their work more obvious to the general practice at a practice-based PLT event:

"I actually produced a booklet, and left it after the practice talk. I left it with the practice manager and the next time I looked at it, it was untouched. It was amazing! There was a lot of discussion come out, actually after the presentation to discuss our role. The GPs weren't aware of how much we actually do, out there in the community, and that kind of thing." (Community nurse group 2, health visitor 5)

Benefits of co-location

Some community nurses realised that working in different buildings was a significant barrier, and considered that co-location was likely to produce benefits to team-working and to communication. Those who worked separately were interested in changing this, and had insight into the problems caused by working in separate premises. For community nurses who were co-located, the descriptions of team relationships were generally better:

> "We're based in our practice and there is a huge difference when you're based in the practice. A huge difference when you're next to the GP. And you can see the difference it makes, you know, it's definitely a closer primary care team." (Community nurse group 3, district nurse 4)

They considered that working relationships were closer and teamwork was better when primary health care teams were co-located. Community nurses felt they could meet informally and call in to see GPs and practice managers and discuss issues face-to-face. They preferred this method of communication over email, which they perceived to be abrupt and impersonal. Some had made an association between email communications and the evolving business nature of general practice:

> "I worked in both [co-located and not co-located]. I've worked based for the GP where we are now. When we are based with the GP it works, much, much better. You know our GPs have always said to us: 'Half past eleven is coffee time; come in if you need us, come in if you've having problems. Open the door.'" (Community nurse group 3, district nurse 4)

> "We are supposed to move into the same building, but just now we're in a separate clinic but we are going to be moving into the surgery fairly soon. But our practice manager's idea of communication is email and I think that that, I would rather pick up the phone." (Community nurse group 2, health visitor 7)

Other participants echoed these experiences, suggesting that working in the same building led to improved communication. Informal exchanges with other staff groups on a daily or weekly basis meant that relationships were stronger and work that was invisible in some locations became visible:

> "They [GPs] can see a bit more clearly what you are doing, because you are so involved. You go into the tea room, they are there. You walk down the corridor and you bump into one, and there is always an exchange of words." (Community nurse group 3, district nurse 4)

Improved and closer working relationships were enabled by co-location. Team members became aware of each other's workload and the changing tasks and priorities for each staff group. Team members were learning informally and opportunistically from each other by exchanging news and information when they met. The formal learning of PLT was therefore easier in such circumstances as teams had good pre-existing relationships and knowledge of each other, and had learnt what was relevant for their colleagues:

> "I don't think it is essential that you are in the same building. I mean I'm saying that and I am in the same building as my GP practice, whereas ******** and ********** aren't in the same building. I don't think it's essential but I certainly think it makes it a wee bit easier, you know because I think they tend to include you more if you're actually in the same building." (Community nurse group 4, health visitor 4)

> "I think it's just the informality you know working side by side, helps people. It sometimes just makes it that wee bit easier because I mean ******** [name of co-participant] has put a lot of work into the energy of the whole team on both sides. Have to keep those communication channels open and it is difficult when you are in separate locations. But I think if you work at it hard enough, you can maintain it." (Community nurse group 4, health visitor 1)

Practice managers were seen by community nurses as important agents to build relationships with and make connections. Much of the expressions relating to closer working and improved visibility and role recognition related to the GPs and practice managers. Little was said about the other members of the primary health care team: A & C staff or practice nurses.

> "I must admit the practice that I am covering at the moment in *************, the practice manager to me is absolutely wonderful, and you can go to her door...but there is always that bit of rapport here and if there is anything else happening that she knows about from the

> front of the house as she calls it, she always comes and lets you know. And most people have lunch together in the lunch room which gives us a bit of rapport as well." (Community nurse group 2, health visitor 2)

There was recognition that the common spaces in the health centre or practice were the spaces that promoted teamwork and team-learning. Corridors, coffee-rooms and kitchens were where team members could mingle informally, and chat. A policy of 'open doors' where team members could call in and informally discuss problems relating to patients and to the practice, encouraged communication and improved the sense of teamwork in that building. It was difficult to see how primary health care teams that were not co-located could compete in the sense of communication.

Lack of protection from service delivery for community nurses

Community nurses felt that there were numerous hurdles and barriers to overcome before PLT could become a valuable resource for them. Perhaps the biggest problem they described was their lack of effective protection from service delivery during PLT events. PLT had become available because of the growth nationally of out-of-hours services (OOHS). This service had the infrastructure of telephone lines and computerised communication systems as well as call handling staff and on-call GPs. The OOHS was designed for the provision of cover for the general practice.

The OOHS for community nurses was not so well organised or resourced. In general, health visitors did not need any OOH cover, but district nurses did. Their rotas had changed in recent years and had been replaced with separate evening and overnight shifts of community nurses. Some of these nurses had been used by the nursing managers to provide cover during the afternoons of PLT. For various reasons this cover did not work very well, and the 'bank nurses' who provided it were not always available. As a result the protection from service delivery for the GPs was considered better than it was for community nurses during PLT.

Many community nurses were disappointed by this, and felt let down by their nursing managers, who were responsible for organising their cover. They also

held the perception that the level of protection was unfair compared to their medical colleagues. Lack of cover led to logistical problems during PLT:

> "Well I am in the position where I have hardly ever go to it [PLT] because I can't actually get the time to get away." (Community nurse group 2, health visitor 9)

> "Yes, but they [bank staff] have to be there, so if there is not availability, there, then there is no cover, and then you are covering your own bases." (Community nurse group 2, health visitor 9)

Some perceived that the work they were doing was different from the urgent or emergency house call requests received by the OOHS for the GPs. Community nurses, and in particular the district nurses, had different types of calls. Some were needed to administer drugs to patients such as insulin to patients with diabetes and eye drops to infirm elderly patients. As a result, each team had a few of these patients each, and when multiplied through the CHP meant that there were a large number of visits needed at certain times in the afternoon. This would often peak when a significant number of patients requiring insulin injections could not be covered by a small number of bank staff of community nurses. The structures of workload and OOH covering staff were different from the GP to the community nurses, but the model used was one that suited the GP service.

Because of lack of cover, community nurses knew that their time was not truly protected, at least not protected to the extent experienced by GPs. Participants knew, from past experiences, that they had to do some of their afternoon calls in the earlier part of the day, and this created a significant amount of stress which was detrimental to learning:

> "You tend to have PLT at lunchtime, or just after lunchtime, you are in a flap and you're harassed because you have been chasing your tail all morning and you have a list of what you have still to go and do at the back of your mind, so you are not getting a kind of relaxed, fresh…" (Community nurse group 1, district nurse 2)

> "And I think as well, we have the same problem as **********(co-participant), you are condensing your day's work into a morning, so you need to have a service there that is able, and enough people that are able to pick up anything that you have to leave." (Community nurse group 1, district nurse 5)

"I sometimes feel we are chasing our tails!" (Community nurse group 1, district nurse 2)

Interrupted learning

If community nurses were able to condense some of their day's work into the morning preceding the PLT afternoon, then there was still work that had to be done after the PLT event had finished. They knew this work could not always be deferred to the bank staff. Thus for community nurses, work encroached on learning at PLT. Many found that they were sitting during PLT contemplating when they would need to leave, and as a result, the learning atmosphere for them was far from relaxed. Some did not know until the morning of the PLT event whether there would be cover provided and available for them:

> "You have to phone in the morning if you don't get an email to see if there is cover, and you are lucky, more than the rural girls. Because we sometimes get a bank nurse and we know the times that she is on. And if she is one nurse and she could have six diabetics, sometimes more and she can't do them. I leave a wee note saying: 'Phone me if you're inundated. Phone and I will do the diabetics.' " (Community nurse group 1, district nurse 3)

> "You are there [at PLT event] and you have done all of your outside stuff in the morning. And the, with protected time, you are watching the clock all day to get there. And it is fine if it is suitable if it is what you want to learn about. But we find that a lot of the time when things are arranged for us, that they are the wrong things for us and it is a waste of time to be honest." (Community nurse group 1, district nurse 3)

It is clear that participants were prepared to work harder in the morning and to have some duties to complete at the end of PLT if they were learning something useful during the PLT event. However, they were not willing to condense a day's work into a morning if the learning offered was irrelevant, or if the events were dominated by activities provided to benefit GPs.

Attendance at large centrally-organised events

Attending large centrally organised PLT events was also a problem for community nurses. Lecture formats did not always mean they could discretely leave the learning event to attend to their patients:

"And it is rude to get up and leave when people are talking, no matter whether it is interesting or not. It is rude and people do leave and it is unfortunate. And sometimes I don't think that there is an awareness of why people are leaving because they are having to go and do something. And the next minute all you see is that half of the tables are empty. People are spending time and money to do that regardless of what we are learning from it, but you can't help it." (Community nurse group 1, district nurse 5)

"Going back to what you said earlier as well, I was fortunate or unfortunate to be at the same table as the speakers yesterday for PLT, and yes at four o'clock there was an exodus and you could see the look on these people's faces: 'What is going on here?', kind of thing. And it is quite rude [leaving the event early]." (Community nurse group 1, district nurse 8)

Community nurses were concerned about how their actions would be construed by others at large centrally organised meetings, both by fellow participants and by the organisers and presenters of the learning event. Their need to leave the meeting, to deliver patient care, was rarely communicated to anyone. They perceived that others thought they were bored with the proceedings and were leaving early. Rather than be considered rude, some decided not to attend the event in its entirety, or left in the coffee break.

Some participants found that attending practice-based PLT in the practice building was distracting and not relaxing. Some alluded to not being protected from work and that GPs and patients would try to engage with them with issues relating to work rather than learning:

"But I don't think that in the practice you can relax. It is your workplace. 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 be out of the room and you have patients speaking to you. It is quite distracting." (Community nurse group 2, health visitor 6)

"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]." (Community nurse group 2, health visitor 1)

Lack of support from nursing managers

In relation to attendance at PLT, community nurses did not feel there was sufficient support from their managers. These perceptions were divided into two main issues: the lack of support to allow protection from service delivery, and the lack of action after learning needs were identified. The latter topic has been presented and explored in the chapter concerning learning processes. Community nurses felt their managers had withdrawn their interest about what happened during PLT:

> "I noticed that if I didn't find something for us [community nurses] to do then there was nothing." (Community nurse group 1, district nurse 2)

With the protection from service delivery being variable, community nurses were not always sure that they would have their own uni-professional PLT, or that they would be able to attend large centrally organised events. With a lack of leadership from their managers, as well as insufficient resources, it seemed that many felt abandoned and isolated on the PLT afternoons. Some were critical of their managers, especially with the lack of progress in providing service cover and protection:

> "Our nurse managers know because they are the ones who ring and say: 'We don't have cover.' So our nurse managers know it, but obviously we need to provide a service and we do. But you can't make the nurses appear either [provision of bank nursing staff] but there is no alternative arrangement." (Community nurse group 1, district nurse 7)

> "Our nursing managers need to speak to the nursing managers in the north side so that we have a reciprocal arrangement, so that we cover like the GPs do. Or if it ran through ADOC [Out of hour's service] that your emergency calls come in. What we did have before in this part of **** Ayrshire was contract nurses [bank nursing staff] who worked protected time." (Community nurse group 1, district nurse 8)

It was clear that some community nurses saw the solution as being similar to what was provided for the GPs to allow them protection from service delivery. They considered that their own managers needed to arrange reciprocal arrangements with the two other CHP areas and provide a small team of bank nurses who could allow them to have PLT. Thus, in the perceptions of the

community nurses, part of the problem relating to the lack of protection was the attitude of nursing managers towards the importance of PLT.

Team-based learning prevents flexible learning across practices

The structural differences between general practices and the CHP were highlighted by both staff groups within the community nursing team. They perceived that the team-based learning that took place during practice-based PLT was unnecessarily restrictive and inflexible. They wanted learning events to be available for any community nurse to attend. Practices usually arranged practice-based PLT around the needs of the general practice and if relevant invited their attached community nurses to attend. In contrast, community nurses wanted to be able to go to any general practice and to be able to see what was on offer across their locality and not be restricted to what their own general practice had elected to do:

> "If there was themes across the area [CHP area] you know, people can't dip in and out if it's relevant to them. It's kind of if: 'Well if you're attached to that practice, that's where you go'. Whereas another practice might have something that you think is more relevant and you haven't done so much work on. You don't have access to that." (Nursing manager group 1, participant 1)

> "I would like it to be not based around the GMS contract the learning. I would like it to be based around the needs of the population we serve and that would be a geographical need. It wouldn't be a separate practice and it would mean that, within that locality people could actually choose." (Nursing manager group 2, participant 2)

The benefits of learning with their attached team were less of a concern for community nurses. Nursing managers saw primary health care as being organised and delivered by a CHP. This was the organizational size and structure that they understood and recognised. They did not value the general practices' opinion that learning should be undertaken by one specific primary health care team. As one nursing manager expressed:

> "Then people could actually fit into where they felt [attend another practices' practice-based PLT] but it would need to change the culture within the practices. It's not about your business, and actually it's about the health care of the area that you serve, that population." (Nursing manager group 2, participant 1)

This perception connects to the theme of organizational size and the perceptions of what each individual regarded as the fundamental organizational unit of primary health care. It was perceived by nursing managers that practice managers and GPs regarded individual general practices and primary health care teams as being the basic organizational unit. In contrast, nursing managers regarded the CHP as the basic unit, with practices being sub-units. Nursing managers also wanted any member of their staff to be able to go to any practice-based PLT event. It was the learning topic that they were concerned with, not who they were learning with. Community nurses echoed this statement.

Organizational schism and differences between the CHP and general practices

Size differences

Nursing managers realised that there were many contrasts between the working patterns of the CHP and those of individual general practices. There was of course a considerable difference in size. Practice size varied; some had small list sizes of 2,000 patients, with larger ones ranging up to 16,000. But CHPs were much larger and looked after patient populations of approximately 135,000 patients. Therefore nursing managers perceived the scale of each organization differently in comparison to practice managers. Nursing managers considered that their practice manager colleagues were dealing with much smaller organizations than themselves, and that they had a responsibility for a much smaller list of patients. This contrast in size and resultant responsibilities had caused some problems in the past and nursing managers recalled earlier conflict with GPs and with practice managers:

> "We don't use this against each other but my letters usually do write back to GPs explaining to them the size of my service and my responsibility, but they may have a practice with 15,000 patients but unfortunately there are 136,000 patients in ***** Ayrshire that we are responsible for, delivering care for. You don't like to say that, but sometimes it helps to remind." (Nursing manager group 2, participant 2)

Some nursing managers considered that very small practices might not be able to host practice-based PLT events on their own. There were similarities with some

of the perceptions and experiences of practice managers and A & C staff who agreed with this problem. Participants from small practices had mentioned in their own focus groups that they felt small and relatively isolated, and would be happier merging with a larger practice for practice-based PLT. Nursing managers concurred:

> "Because if you've got a practice team for instance we've got one. You've got small teams where there are only three members of community staff, and one or two GPs. How do you organise, you know, training around about? They very often tap into other practices." (Nursing manager group 1, participant 3)

Autonomous general practices

The difference in size was not the only issue related to the contrasts between CHP and general practices. The community nursing team found the autonomy of practices difficult to cope with. They were used to dealing with one large CHP that had standardised rules and regulations that covered the entire organization. In contrast, general practices were fairly autonomous small businesses in contract with the NHS health board, and could, within limitations, run their organization as they saw fit. This caused problems for the community nurses. Some nursing managers had problems with the business aspect of primary care and general practice. They perceived that they personally had, little knowledge of this aspect of primary health care:

> "Everybody is employed by the health service. It should just be a matter of moving resources like we do" (nursing manager group 2, participant 1)

> "Obviously you've to. It's your business, people to employ but I think it's a huge barrier. It really is, and I'm sure you [GPs] would like to get up some day and go into your work and just do your medical bit and not have to worry about finances." (Nursing manager group 2, participant 2)

> "I think it's to do with private practice versus NHS organization, are you employed by…" (Nursing manager group 2, participant 1)

Nursing managers had some insights into these differences. They could see that the differences in remuneration method between the two components of the primary health care service could lead to problems and that nursing managers had to have some knowledge of what was different:

"And I think people in our position [nursing managers] we actually do think like that. Because at the end of the day I still lift my wage. I don't have to worry about how it will affect my income or bank statement. But actually practices will have to think about that, so we can go: 'Oh! Am I going to spend two hours at that?'" (Nursing manager group 2, participant 1)

Nursing managers held perceptions of general practices and felt they were a different type of organization than their own. Nursing managers regarded themselves and community nurses as being truly within the NHS organization, and that general practices worked within the NHS, but had some features suggestive of private health care. Frustrations were also expressed about cultural differences between the two organizations. Some saw GPs as being too independent from the NHS and not accountable to the organizational hierarchy that was above them. Some nursing managers felt this led to disputes and feuds over attached district nurses and health visitors:

"Sometimes you don't always have, people [GPs and practice managers] don't always have a healthy respect for, other people [community nursing team] are bound by the rules and regulations of the organization that they work for, you know." (Nursing manager group 2, participant 2)

"You know if you work within a practice, you can choose to make your own rules for your own practice but we don't. We can't do that and sometimes that is a difficult one for people to understand. That you know no matter whether we or anybody agrees to it, it's maybe not the best way. It's the rules of our organization and we are bound by them and that sometimes happens doesn't it?" (Nursing manager group 2, participant 2)

Nursing managers found the organizational differences difficult, however, they had to negotiate around many different ways of working with each separate general practice in contrast to the one set of rules and regulations that governed the CHP.

Dual management structure

Nursing managers were aware of the dual albeit contrasting management structures in primary health care. They also realised that nursing teams were influenced and to a degree managed, by two sets of managers: the nursing managers and practice managers. One remarked on this dual system pithily:

"Who manages them?" (Nursing manager group 1, participant 4)

She had questioned who had overall control and responsibility for community nurses, thereby raising a controversial issue which had comparisons with other data found in this study: the conflict between two sets of managers and the uneasy alliance at times which affected the daily work of community nurses. Ultimately, the nursing manager did have the responsibility and task of managing community nurses, but there was an acknowledgment from them that practice managers had some responsibilities for the day-to-day running of the duties of community nurses. As one community nurse stated, she held various clinics and performed various activities for the general practice in their building, and this had to be organised and co-ordinated with the help of the practice manager.

Conflict was recognised. The workload of planning and preparing PLT was seen as considerable by practice managers and the fact that this work involved the needs of community nurses, caused some frustrations amongst practice managers. Nursing managers saw this but were reluctant to get involved in the planning and preparation of PLT.

> "Then at one point the practice managers actually said to us it was our responsibility to take our staff for the half days [practice-based PLT] and that just became: 'Oh no!'" (Nursing manager group 2, participant 1)

> "I wasn't involved before, was the fact that the practices wouldn't organise the PLT, or they wouldn't involve the nursing staff and that just became problematic. And I think it was maybe just the way it was set up. Whereas you know other areas, it was just the practice managers were very much involved with it." (Nursing manager group 2, participant 1)

Nursing managers recognised the resentment that practice managers held about the burden of planning and preparing practice-based PLT. They felt they did not have the time or resources themselves to plan and prepare PLT for community nurses. They perceived that their involvement would not meet the aims of PLT because it was meant to be team-based learning, not uni-professional learning for one staff group in isolation:

> "There is some resentment from some practice managers that they should, they feel they are organising training for our staff and though

they see them working as a team, or even someone based within the practice. They don't do their PDPs and appraisal, so how can they organise the training? For starters, they don't have any management responsibility for… (Nursing manager group 1, participant 1)

Professional isolation of practice nurses

Nursing managers perceived that practice nurses were isolated from the rest of the nursing profession in primary health care, and that they lacked any form of voice in their own general practices. They felt that practice nurses were at risk of exploitation by GPs in a variety of ways.

They recognised that they did not have any authority over practice nurses. As nursing managers they were in charge of between 15 and 20 teams of district nurses and health visitors attached to general practices. They also had responsibilities for specialist nursing staff who looked after chronic medical conditions e.g. heart failure specialist nurses and diabetes community nurses. However, practice nurses were a group of nurses who worked in primary health care that they had little or no influence over.

Some nursing managers expressed concerns that these practice nurses were 'sole workers', with some working on their own in small general practices, with little sense of camaraderie with community nursing colleagues, and little voice to represent or protect them. This, they perceived had an impact on what resources were available for learning for practice nursing:

> "Which again I go back to the practice nurse. Because we look at the nursing profession. What actual access to training and development does that practice nurse get? Our staff is not a problem. They get!" (Nursing manager group 2, participant 1)

Some nursing managers recalled previous contact with practice nurses. Practice nurses had approached them, as senior nursing colleagues in the health board area, about difficulties they had experienced in their work:

> "Because I would say that at least here, after they were here for a wee while, they [practice nurses] started to come on a few professional issues but they wouldn't tell the GPs. And I had two or three who made contact with different things and a few things that I actually had to speak to ******** ******** [local medical director] about

at that point in time. Things like that." (Nursing manager group 2, participant 2)

Other nursing managers had contrasting thoughts about practice nurses. They did see themselves as being learning resources for them and they felt that they had some responsibilities, not for their line management, but for their education and development:

> "I personally think for practice, nursing is what we do, and I feel that practice nurses can be very isolated. And it really depends who you are employed by, as to what the opportunities you get to learn and for personal development." (Nursing manager group 2, participant 1)

> "I send the chair of the practice nurses' meetings lots and lots of information. That goes out to practice nurses and I don't think I have had many practices come back and say: 'Stop dong that!' Because they actually see the benefit." (Nursing manager group 2, participant 2)

> "Because I say practice nurses should be part of the nursing team as well. I don't mean part of as a line manager. I'm just talking about shared learning." (Nursing manager group 2, participant 2)

Nursing managers showed some insights into the structural differences and barriers between their nursing team and the practice nurses situated and employed within the general practice. Some had made efforts to reach out to them by providing confidential support for employment or service issues, or by providing some learning resources. However, there was further recognition of the organizational schism in primary health care, that two separate systems of organization and of employment existed and those differences had to be reconciled.

7.3. A & C staff and practice managers

There were four themes that were constructed from the data from the six focus groups from A & C staff and practice managers.

- PLT allows A & C staff to learn out with the general practice boundary

- Practice manager's influence and leadership of the A & C staff.

- Isolation from the community nurses and from the CHP

- The hierarchical structure of the primary health care team

PLT allows A & C staff to learn out with the general practice boundary

A & C staff and practice managers identified one theme in common with each other. They saw several advantages of PLT, and one of the most important advantages was that it gave an opportunity for A & C staff, and others, to meet up with peers from different practices. This allowed A & C staff to talk informally with their peers, learn about their organizational and functional systems and ways of working, and to introduce some of these changes in their own practices. The A & C staff saw this as a wider opportunity. PLT also gave them the time to learn from other agencies within the NHS and from the wider community. They valued this and many talked about how meeting others from these organizations had made improvements to their work:

> "We've had people coming in talking about abusive behaviour. Teaching us how to read body language and things like that." (A & C staff group 1, participant 3)

> "There were two of them [police officers] a chap and this girl. And that was good and showed us how to protect ourselves if somebody did attack us." (A & C staff group 1, participant 5)

Learning about wider community services

A & C staff spoke about the benefits of visits to other agencies within their own community. Some went to see a funeral director's office, or had visits from representatives from charities, drug workers and people that they would not have reason to meet during the their normal working day. It was clear that for A & C staff, the practice building was the structure that they worked and operated in almost of all the time. It was a structure they were very familiar with, but few of them had legitimate reasons in their daily work to venture beyond the practice building. This structure restrained them to a certain extent, and it restrained their learning before PLT had commenced.

> "We had meetings with forensics. It was so, I mean it was clinical really. But it was so interesting. It was great. You know it was brilliant we seen actually like real slides and everything. It was somebody from some university who came in-house." (A & C staff group 1, participant 3)

Boundaries of learning

A & C staff also learned about not just the services provided by the NHS and other agencies, but also what their patients experienced. Some A & C staff described learning events with drug workers who explained to them about the daily lives of their patients who were addicted to drugs such as heroin. Others learned about the impact of poor health, and the complicated and long journeys made by patients on their way to partial or full recovery from serious injuries or illnesses. Some participants felt that PLT allowed them to extend their own boundaries as far as learning topics, and to extend the boundaries of their job. They were able to know more about the challenges faced by their patients, and learn about the problems affecting their lives. Some found the topics helped them with difficult situations experienced whilst working in reception:

> "And he [visiting speaker] did confidentiality in young people and it was all about your average 13 or 14 year old pregnancies and the choices they have to make about TOP [termination of pregnancy]. Or do their parents get involved? It was really good because we have a lot of school children at the desk with a worried look on their face. Some of the girls [A & C staff] are not experienced enough to deal with them so he was really good. We've had a lot of good topics." (A & C staff group 1, participant 8)

There were various perceptions of these learning topics. Some considered them to be illegitimate learning: that the themes were beyond the boundaries of A & C staff. Some participants reacted by saying: "That's clinical!" as if this was an area for them not to enter, that they did not need to learn about this to do their daily job. At times, the word "clinical" was used in a negative way, as though it represented a symbolic barrier to their learning, one that was inappropriate for them to breach. An exchange between two A & C staff members in one focus group highlighted this contrast. One participant described in positive terms how she had enjoyed meeting drugs counsellors:

> "Well I found it really good, she [drugs counsellor] answered any amount of questions she even, I have absolutely no inkling of what people did with drugs and some people break down their drugs and mix it with the brick dust, which I never even knew about. It's amazing some of the things they will do to eke it out and that, she went on to say that's why they end up with no legs, walking with sticks and things." (A & C staff group 1, participant 1)

However, this description was responded to by a quick retort from another participant:

> "You feel as if you need to know that though? That's more the clinical side." (A & C staff group 1, participant 2)

A & C staff differed in their views on this. Some were happy to learn beyond their own jobs and position within the structure of their primary health care team. Others saw this as being inappropriate. Participants also talked about examples that demonstrated that for some, PLT had allowed a change in attitude. Some patients were not deemed worthy by A & C staff of needing valuable attention and time from clinicians. People addicted to drugs were a group that many A & C staff had very mixed feelings about, and some of these views were based on their interactions with them at the reception desk or on the telephone. Moral viewpoints came under strain during the focus group, and from what participants said, during the PLT learning events also.

Practice managers' perceptions of A & C staff

In general, practice managers shared the enthusiasm for PLT events that allowed A & C staff time to go out of the practice, or enabled the primary health care team to invite outside agencies in to the practice. The practice managers recognised that among the A & C staff, there were individuals with varying levels of motivation for these learning topics, and for formal learning in general. Some described how individuals were reluctant to learn beyond their normal work:

> "My staff would rather sit in the surgery and get on with their work. It is a terrible thing to say, but there is certain staff eh, in fact yes, you will get a member of staff that maybe wants to learn and develop. There is a lot of staff who just want to go in, do their work, get paid and go home. Do their job well, but they are really not interested in getting development. But they are quite happy just to come in and do their job and as long as they are getting trained to do their job they are quite happy." (Practice manager group 3, participant 5)

> "You have got girls [A & C staff] who would rather stay at home [work in the practice and not attend large centrally organised events] and file! You know what I mean. That says it all!" (Practice manager group 3, participant 5)

Practice managers appeared frustrated with some attitudes of A & C staff. They recognised that for some of their staff, there was a preference to work rather than learn during PLT. They could not understand this, and the practice managers found it puzzling. They felt these staff members were blinkered in the view of work: that learning was only about doing the immediate tasks that they were responsible for, and that they could not use this time to learn about patient experiences and the wider and complex world of the NHS and social agencies.

> "It's all motivation because they don't want to. As you say they like their job. They have been trained how to do their job and they are not interested in going any further and I know that's true." (Practice manager group 3, participant 6)

Practice managers felt that PLT gave A & C staff the chance to meet other neighbouring practices that allowed the staff to learn from peers based in other practices. In contrast to community nurses, the A & C staff from one team were employed solely in that practice. They did not move between general practices unless they resigned and were employed by a new general practice. Thus, many A & C staff had spent most of their career in one team and in one building. PLT had allowed them to escape from the team and from the building, at least for the afternoon. Practice managers saw the gain from this:

> "We work in the same area, but I think for the first time, we have opened a lot of dialogue like how does ******** deal with this situation? And it was quite good because while there is maybe contact between managers there isn't or there wasn't the same contact between senior receptionists at surgery one and senior receptionists at surgery two. And that I thought was quite a useful dialogue at the start." (Practice manager group 2, participant 1)

Learning from other teams

Large centrally organised PLT events provided further opportunities for teams to mingle and chat informally, outwith the confines of their own practice structures. There was a chance to exchange ideas both formally at small group learning events, but also informally during coffee breaks and at lunchtimes:

> "It is a way of sharing and a way of learning from each other. That's what it is all about. There is good systems in other practices in things that you don't even know about until someone talks about it. 'Oh!

That's good! We can take that back.' It's good for that." (Practice manager group 2, participant 1)

Small group learning events were particularly useful for A & C staff to meet others from different teams. They could work on problem based learning scenarios and with time, would be comfortable in sharing and learning from each other:

"I was a facilitator with a couple of the girls [A & C staff] and they broke into groups and they had discussion groups. That was quite a good day, quite a positive day." (Practice manager group 2, participant 2)

"You went into groups and you had sort of scenarios to discuss and it was like different receptionists and people from different surgeries together." (Practice manager group 2, participant 4)

"And everyone seemed to gel, and they all spoke and they all had a good bit to say and it was good." (Practice manager group 2, participant 2)

Practice manager's influence and leadership of the A & C staff

For some A & C staff, the influence and attitudes of their own practice manager were important to their experiences of PLT. He or she was the most important person in the general practice with regards to PLT, and the practice manager's attitude determined to a considerable extent the opportunities of learning for A & C staff.

Exclusion from attending PLT

A & C staff had various experiences of how often and to what degree they were included into the learning events, particularly at practice-based PLT. Even for large centrally organised events, practice managers were influential. Some knew that their practice manager had prevented them from attending large events by simply excluding them from the arrangements made by the CHP. As practice managers were the main contact points for general practices, the CHP used them as a method of communicating with A & C staff. However, if a practice manager did not relay this information to A & C staff, then those staff members might not attend the large events.

"I think that is quite bad if you're not getting told what is available [at large central events]. So who is deciding?" (A & C staff group 1, participant 3)

Importance of practice managers for practice-based PLT

It was perceived that the practice manager clearly had a position of considerable power over A & C staff. He or she was able to determine whether the A & C staff attended or not, and in some primary health care teams, determined what topics were chosen for practice-based PLT events. Not all practice managers behaved in this manner. A number of A & C staff participants recalled that their practice manager tried hard to identify their learning needs and to provide practice-based PLT events that met these learning needs:

> "Our practice manager is good; she listens to what we want. Like we have asked for the self-defence so you know we're getting it. And it's important that they sit down and listen and take on board what we want to get out of it." (A & C staff group 1, participant 3)

> "Oh! I don't know. We get asked what we want to do and he does ask us what we want to do, then we'll say." (A & C staff group 1, participant 4)

Practice managers were also able to veto events that they themselves considered were inappropriate for the practice to undertake. Few people had this power: GPs shared this, but the practice manager was one of the few individuals who could prevent others from organising PLT events. In one focus group a participant talked excitedly about how her team had spent an afternoon cycling around Cumbrae Island. This physical event had led to considerable improvements in relationships between individuals, and A & C staff had got to know more about the others in the team, especially GPs and senior community nurses. Another participant envisaged what her practice manager would say if it were suggested that her team copied this idea for practice-based PLT:

> "If I had to say to him: [practice manager] 'Do you fancy a trot round Millport [Cumbrae Island] on a bike?' I know the response I would get!" (A & C staff group 1, participant 7)

Some focus group participants considered this imagined response, and in a tentative example of independent thinking suggested that her A & C colleagues

may not always need the leadership, or permission of the practice manager, to enable PLT to provide learning:

> "So I think part of the fault's ours as well. And we should maybe say: 'Well this is what we want.' And if he [practice manager] says: 'Well I don't know to deal with this'. I suppose we're all capable of picking up the phone and say: 'Well we can do it'". (A & C staff group 1, participant 3)

In the three focus groups, this was a rare occurrence. In general A & C staff did not feel able to plan and prepare their own PLT learning and they were very dependent on practice managers to do this for them.

Isolation from the community nurses and from the CHP

Isolation from the CHP

Although practice managers perceived that PLT had helped their A & C staff move out from their usual structures and meet peers and others from the wider NHS, practice managers themselves felt that PLT had not helped them to develop relationships with others in the area. They felt that they had personally poor relationships with the CHP, notably the steering committee and with the community nursing team. As mentioned in the chapter on learning processes, practice managers had already had confrontations with the PLT steering committee on the subject of legitimate learning topics, usually at practice-based PLT.

Isolation from the community nursing team

The practice managers' biggest problem was with the nursing managers. They had a low level but ongoing dispute concerning who provided learning for the community nurses during practice-based PLT. Practice managers did not feel responsible for arranging learning for community nurses. Relationships between the two groups of managers were variable, but clearly not strong enough to overcome the structural and organizational differences within the CHP and the general practices.

> "Well I mean there are PNAs [nursing managers] that should be able to organise something for them [community nurses] if they are not

> wanting [to come to practice-based PLT]. I mean it is a hassle really." (Practice manager group 2, participant 2)

Some practice managers decided that if community nurses wanted to attend a practice-based PLT event, then they were welcome to do so, but it was more through chance, rather than systematic planning and preparation, that the learning arranged would suit them. Some practice managers perceived that if they did not like the event, then that was not going to cause any significant concerns for the practice manager. They considered community nurses to be out with the general practice and thus outwith their responsibilities.

> "I know what the doctors are doing and if they [community nurses] are interested in it then they are welcome. And if not they have got their own personal development plans to do." (Practice manager group 2, participant 3)

> "Well, we've reached an agreement that the district nurses do their own thing on protected time afternoon and it is up to them." (Practice manager group 2, participant 4)

Some of the negative perceptions about community nurses were also conveyed about nursing managers. They were feelings expressed that practice managers were doing the job that nursing managers should be doing, and that by extension, the community nurses should not really be at practice-based PLT, but should have learning that was separate from the remainder of the primary health care team.

The hierarchical structure of the primary health care team

This theme was identified by practice managers and by A & C staff focus groups. Both staff groups considered that the hierarchical structure of their primary health care team was one of the most important factors that influenced their experiences of PLT.

Worthy of learning

One of the most obvious phenomena that illustrated the hierarchy of the primary health care team and the dominance of the GPs and the practice manager was the lack of learning made available for the A & C staff. In some practices, it seemed that the A & C staff did not merit PLT. Events were planned and

prepared for the clinicians and the practice was closed to patients, but A & C staff did not have any learning. They worked instead:

> "Well I remember one time in training [practice-based PLT] we went through our entire filing system, looking for missing files. And that's what we did the whole afternoon." (A & C staff group 2, participant 3)

> 'It's work, it's work and you're not learning any particular thing." (A & C staff group 2, participant 4)

> "We don't have the time for learning! If we feel that we need this or that there is always someone off sick, or someone on holiday. And we just have not got the time to do that training [practice-based PLT]" (A & C staff group 2, participant 3)

As these perceptions and experiences illustrated, for some teams, not learning at PLT was a common occurrence, it seemed some to be their norm, rather than a rare event:

> "And we have certainly not got anything organised for next week. So that looks as though it will be the same again. [Working rather than learning during PLT]" (A & C staff group 2, participant 4)

Other participants in the focus group who listened to this were disappointed and upset to hear that their peers were treated in this way. They questioned how this was allowed to happen. One participant said that her practice manager would have been furious to hear this, and that for their A & C staff to work during PLT was forbidden:

> "We've never been allowed to work in an afternoon [PLT] no matter what we do. We've always got to do something. I think that's the way it is. Dedicated protected time." (A & C staff group 2, participant 8)

It seemed that there were different cultures and attitudes towards learning within practices, although some were geographically very close to each other. Cultures influenced what happened during PLT, and in particular what happened during practice-based PLT. It was clear that some practice managers saw their A & C staff as deserving of PLT, whilst others were not prepared to invest in the planning and preparation for an event that would include A & C staff.

Thus, for some teams, practice-based PLT meant that they had protected time to catch up with work, or to perform tasks that were outstanding. With the practice closed to visiting patients, and the telephones diverted to the OOHS, A & C staff were able to catch up with work and to undertake tasks that they had not got round to doing. Thus, for them PLT meant protected work time. The person who was most influential in allowing this to happen seemed to be the practice manager.

The power of GPs

GPs also held substantial power in relation to events at PLT. Some A & C staff participants recalled that like practice managers, one single GP could veto an idea that a group of individuals had proposed for a learning event at practice-based PLT:

> "Well we wanted to do something like that [informal practice away-day] and everyone was up for it. And, but one of the GPs said: 'That that was not what PLT was for'. So that got, you know, we didn't do it." (A & C staff group 2, participant 3)

> "He's the boss so we did'na do it." (A & C staff, group 2, participant 4)

There were varying perceptions of authority and power amongst the descriptions relating to GPs. Some A & C staff participants recalled that PLT had given them the opportunity to challenge well-established work practices. Some primary health care teams had undergone team-building events, and had discussed everyday work patterns, often with an external independent facilitator. Humour was useful in such situations, and it was used to build on good relationships between GPs and A & C staff. One participant recalled a light-hearted event where the team had analysed their work patterns and tried to improve on it:

> "One of the doctors is really bad in going to the reception when he has got nothing to do and pulling prescriptions of the machine before the girls [A & C staff] have split them up. He has done it for years so that afternoon [practice away-day] that was the first thing, was to say 'process'. So he did for a while but he reverted back so he got another warning at that last team meeting. 'The last time and told!' So he's got a warning again. It was a good afternoon!" (A & C staff group 1, participant 3)

The humour is intertwined with mock disciplinary action (the warning) and with mock overtones of being dismissed by the organization. Nevertheless, this quote has illustrated how some teams can use PLT to look at behaviours and work patterns of individuals with power, and perhaps for the first time others in the team can make suggestions that may change these behaviours. Other participants disagreed with this temporary suspension of hierarchical behaviour at PLT as they felt that ultimately the hierarchy would persist and that individuals such as GPs would not make lasting changes:

> "At the end of the day you can sit and discuss with them. But at the end of the day, they think: 'You're staff, we're physicians, we're doctors'. They don't take it on board." (A & C staff group 1, participant 1)

This sentiment has similarities with the community nurse who alluded to the temporary improvement in relations with GPs during the discussion of a significant event analysis at practice-based PLT. She had recalled that the GPs were friendly and interested, but this was not a long term change. It lasted purely for the life of the event itself, and the next day the GPs had returned to their normal ways. Thus for some participants with low power within the primary health care team, they were sceptical of whether changes at team-building events during PLT actually resulted in authentic changes for the long-term.

A & C staff realised that it seemed acceptable for GPs to differ amongst themselves within the primary health care team. They recalled that there were unwritten rules that governed how they all had to behave, but GPs could behave and operate as individuals and not as one body:

> "Like one doctor is different from the other doctor and that one is different. So to get them to agree and then to, is quite a difficult task. If they can't agree then I have never ever known a profession that doesn't agree. Sorry that do agree you always find that you maybe only get one that thinks that way and the senior partner will completely, you know quash it. It is difficult some times to get them to agree so." (A & C staff group 1, participant 3)

Senior partners, or more established doctors who had worked in the practice for longer had a high degree of authority and autonomy. GPs in general were much more autonomous than other professions or staff groups within the primary

health care team. It was permissible for them to disagree on policies, or ways of working, and the A & C staff would have to learn this, and work around it.

Participants on occasions were surprised at how their individual general practices contrasted with each other. Whether A & C staff felt able to address the GPs in their team by their first names, varied from practice to practice. In some practices hierarchy seemed to very steep and strongly embedded in what the practice did. Others reflected that that was how it was in the past, but that relationships had changed and that the practice was less hierarchical than before. Others also recalled how this had lessened over some decades, with a number of participants having worked in the same practice for ten or twenty years. Social events were a marker of this. Some teams enjoyed a number of events together throughout the year and regarded each other as colleagues and friends. This extended to their families too:

> "We do go for barbecues with the doctors and their wives and we took
> our partners and children, and their [GPs'] children. We all meet to
> play bowls, barbecues at ******* country park and the whole family
> went. It wasn't just the staff and the doctors. It was their wives as
> well, and their kids and ours. It was a good….that was a good laugh! I
> mean at work, they are professional at work, and we have our
> moments with them…" (A & C staff group 1, participant 3)

This recollection of a happy social event contrasted sharply with another participant's views. She recalled the practice night out at Christmas. The GPs merely being there spoiled the evening for her:

> "Apart from Christmas time, and that's how the night is terrible!
> Because you don't know the people, you don't know the person. You
> don't know the employer" (A & C staff group 1, participant 7)

Lack of representation of A & C staff

Practice managers were also aware of the influence of the hierarchical structure of the general practice, and the effect this had on practice-based PLT. They realised that their efforts in planning and preparing for PLT were centred more on the needs of the clinicians, and in particular the needs of the GPs:

> "You have to cater for what the doctors want. Uh-huh, that's what
> you have to do." (Practice manager group 2, participant 2)

Others emphasized that planning and preparing for the A & C staff was more difficult. The learning processes chapter has given more details of this, as well as the perceived difficulties in identifying the learning needs of the A & C staff, and the need to find learning methods that fitted in with their preferences. However, practice managers were less critical of themselves but were critical of PLT steering committee that planned and prepared large centrally organised events:

> "'What can we [the steering committee] put on for them [A & C staff]?' And there was not much thought put into it." (Practice manager group 3, participant 4)

> "I think some staff felt that a lot of time had gone into organising the training for the clinicians and that receptionists were like... tagged on." (Practice manager group 3, participant 3)

One A & C staff member had also identified this hierarchy when related to the actions of PLT steering committee:

> "We have got good GPs, but the other places [educational steering committee] that are doing all the organising never want to listen to what admin has got to say. A&C is always a way down the bottom when it comes to the topics and the training. There is always a lot of gripes on [evaluation] forms about that." (A & C staff group 2, participant 7)

Some A & C staff felt that there were various fora for practice managers and GPs to meet and exchange ideas about PLT and other topics, but for them this was not possible. They had no representation of any strength on any of the three PLT steering committees, being represented in a proxy sense by practice managers. There were perceptions that this was unfair and unjust and that it resulted in the continuing hierarchical nature of primary health care organization. One participant felt strongly that each CHP had various leads for clinical care, practice managers and nursing staff, but that no CHP had a lead A & C staff member to represent staff on issues, or to represent them and put their view forward at PLT steering committee meetings. One focus group agreed that this was further evidence of their lack of status and power. This was paradoxical, as many of them considered they did a very worthwhile job within their general practices, and were instrumental in arranging and organising patient care within the quality and outcomes component of the 2004 GMS Contract.

"You see, they all have these clinical leads and things, and I always wondered why they don't set up a lead for A & C staff and have that person purely to do with A & C. And then we could be separate, you know, you could join up [at PLT] when you need to, when there's subjects that involves both of you. But other than that just keep us separate and we will do what we want to do!" (A & C staff group 1, participant 3)

7.4. Summary

A number of structural issues resulted in PLT not achieving its full potential. To a degree, PLT had exposed how some primary health care teams were not working in the sense of a team. This was most apparent with teams who occupied separate sites, and where working practices meant they did not have shared working. Strongly hierarchical practices found shared learning difficult at times, and staff groups with little power often worked rather than learned during PLT. Physical and non-physical structures were seen to influence relationships between individuals and between staff groups. Some 'enlightened' teams were able to overcome these barriers. They had endeavoured to build and maintain close working relationships and regarded each other as colleagues and friends. Usually the practice managers or GPs had leadership in this area, and their approval for team-building events and social events encouraged these behaviours in the rest of the team. In contrast, staff groups in other teams regarded each other as adversaries or different tribes to engage with only when necessary.

Structural issues also affected learning processes. Teams who were close to each other knew about each other both in a professional and personal sense. Identification of learning needs was easier. Practice managers had a pre-existing knowledge of different staff groups' issues and concerns. When groups of colleagues and friends got together for learning, it was relatively easy as well as productive. Other primary health care teams struggled when they spent an afternoon of PLT together and it resulted in an uncomfortable event. An unpleasant learning environment resulted in poor attendance at future events, or fragmented learning in separate staff groups. The potential to bring about learning for the whole team was lost.

Chapter Eight – A grounded theory of PLT and theoretical comparisons

> "Theorizing is a practice. It entails the practical activity of engaging with the world, and of constructing abstract understandings about and within it." (Charmaz K 2006)

8.1. Introduction

This chapter presents my grounded theory of PLT and gives descriptions of the three elements from which it is constructed. The chapter will explain how the theory was constructed from the research findings. I will illustrate how the three elements connect with each other and with the three categories of findings from which they are derived. The constant comparative method is intrinsic to grounded theory and therefore I will compare and contrast my grounded theory with the works of two others: Pierre Bourdieu and Etienne Wenger. I selected the work of Bourdieu as a result of his reputation as a philosopher and sociologist, and his publications on the sociology of education. Analysis of my findings showed that power was an important consideration in PLT. Bourdieu published extensively on the issue of power in relation to education and educational opportunities. I selected Wenger because of his work on the educational theory of collective learning. My findings relating to proximity had considerable similarities to Wenger's thinking on Communities of Practice.

As I have adopted a Charmazian grounded theory approach to this research, it is important to emphasize the social constructionist foundations to the development of my grounded theory. My interpretations of the social processes and interactions between individuals and different staff groups during PLT are an integral part of the theory construction. Charmaz considered that the role of the researcher is central to the development of theory. Charmaz stated:

> "The theory depends on the researcher's view; it does not and cannot stand outside of it. Granted, different researchers may come up with similar ideas, although how they render them theoretically may differ." (Charmaz K 2006)

Wider implications of theory

Charmaz considered that the construction of a grounded theory that helps with understanding can also illustrate deeper social processes and tensions that operate outside of the research field, and that analysis and theorising can develop wider and deeper issues than were initially apparent. She stated:

> "The logical extension of the constructivist approach means learning how, when, and to what extent the studied experience is embedded in larger and often, hidden positions, networks, situations, and relationships. Subsequently, differences and distinctions between people become visible as well as the hierarchies of power, communication, and opportunities that maintain and perpetuate such differences and distinctions." (Charmaz K 2006)

This quote is relevant to my grounded theory. It has become evident to me that Charmaz's perceptions and predictions were useful when exploring my own experience, research findings and grounded theory. What happened during the practice-based PLT events and my subsequent analyses of these events led to a deeper understanding of both the primary health care team and of primary health care. What happened during PLT was a consequence of what happened outwith PLT: primary health care teams, staff groups, and individuals behaved during PLT in similar ways to their normal working behaviours and social processes. It was clear that participants did not become different individuals for the purpose of PLT and revert back to their normal selves at the end of the PLT event. The unique background and context of every primary health care team were constructed by individuals before the PLT event started. These factors significantly influenced what happened during the PLT event. Ultimately, analysing and theorising on the events within PLT also informs us of how the primary health care team operates outwith PLT.

8.2. The process of grounded theory development

Introduction

This section seeks to demonstrate how my grounded theory was constructed from the research findings.

Method of theory construction

Following construction of the three categories of themes: physical and organizational structures, relationships in primary health care, and PLT learning processes, I began to think how these categories could be connected with each other and how I might construct a grounded theory from them. I asked myself various questions, interrogating the data to see if it could generate answers. Questions were open and generic in style and are included in Box 4

Box 4: Questions used to interrogate the data

- How and when is PLT effective for all in the team?

- How is PLT effective for some teams and not for others?

- When was PLT appreciated, valued and well received by participants?

- What are the structural and organizational barriers that prevent PLT from being a useful resource for the team?

- What happens to PLT when teams are affected by barriers?

- What connects the three categories of findings and what are the gaps?

- What is not said by participants, but was hinted at, in the transcripts?

- What concepts span across the categories and connect them?

Development of proximity

After a period of reflection, aided by the writing and reading of memos that became increasingly conceptual and abstract, the most prominent concept in my mind was that of proximity. I noticed that primary health care teams that worked in the same building or worked closely together with each other usually considered that they had successful practice-based PLT. The presence of the element of proximity was a good indicator or predictor that practice-based PLT would be valued by the team. In order to develop this further, I then considered the opposite of proximity. I thought of the participants who had described how

their team colleagues were strangers to them, or those staff groups that had distant working and social relationships with each other.

I then identified and considered the various structural barriers that prevented individuals and staff groups from learning from each other at PLT. Community nurses were beset by two barriers that worked together to exclude them from practice-based PLT. One barrier was that they often did not work within the same building as the general practice. This prevented them from mixing and interacting with the general practice, and in particular the GPs and the practice manager. The second barrier that prevented learning for community nurses comprised organizational differences. I concluded that physical and organizational structural issues had a great deal of influence on the ability of primary health care teams to learn from each other at practice-based PLT. By reading the transcripts again, I realised that some teams were able to overcome these barriers. Thus, the element of proximity was constructed mainly from the categories of structures and relationships in primary health care.

Development of power

It seemed that many of the problems underlying the negative experiences and perceptions of the participants related to that individual's own position within the hierarchy of the primary health care team. I was already familiar with hierarchy as it was a theme within the category relating to structures. Nevertheless, issues of power pervaded all three categories of themes and I saw it as being one of the keys to the development of my grounded theory.

Development of authenticity

Lastly, I thought about the lost opportunities of PLT. There were many expressions of disappointment by participants in their unhappy reflections on PLT. The scheme had not met their expectations, and it had not achieved the aims and objectives that many thought were made when PLT started. Much of the failure was caused by the struggle of different staff groups within the primary health care team to wrest resources from others. By reflecting on the themes that were included in the learning processes, and in particular, learning needs assessment, I saw that much of the efforts that went on before and during PLT were not team activities. The scheme was not authentic to the initial

aspirations for PLT, nor to the concepts of team-learning. I realized that the ability to have useful and effective PLT was determined by power, and although PLT had been introduced to help teams improve their services, with time it had not become a team activity based on the learning needs of all the team, but rather it was based on those who welded power and could control others. This element of authenticity was constructed from the category of learning processes, and was strongly connected to the element of power as well as to proximity.

Visions of diverse types of practice-based PLT

After thinking about these three elements of my grounded theory, I then imagined what both effective and ineffective practice-based PLT events would be like. I drew on all the descriptions, perceptions and experiences from the participants in the research. I read through the 12 transcripts and began to draw contrasting scenes of what these PLT events would be like, and how participants would perceive them. I thought of their attributes, of who would be involved in the afternoon, and what the learning interactions and atmosphere would be. This helped me in considering how my grounded theory could relate to the realities of the participants, and their reflections of practice-based PLT events.

I will now present my grounded theory of PLT, followed by more detailed description of the three elements showing how each was constructed from the research findings.

8.3. A grounded theory of PLT

For collective learning to be effective in the long-term for teams who use PLT, a number of factors are necessary. Teams must function in an authentic manner rather than in a nominal sense. Individuals and staff groups need to have shared work and should have shared outcomes with regards to the aims and objectives of the work. Staff groups should depend on each other to further the goals of the team, and team-members benefit from having a high degree of trust with each other.

Teams will struggle to learn from each other when the everyday work of separate staff groups is markedly different from others in the team. The processes of shared learning must reflect the learning needs and preferences of the team and not just specific staff groups within the team. Learning needs assessment and learning methods must originate from all within the team and incorporate the preferences of the team, for shared learning to be valued and effective in producing change and improvements.

It is necessary for teams to be conscious of the degree of proximity that operates within their team. Awareness of proximity is particularly important for the team's educational leaders, and leaders should be individuals who are working for all of the team, rather than a specific staff group. Teams which have low levels of proximity will have difficulties identifying shared learning needs. Unless shared learning needs are identified from all in the team and acted upon, learning events will tend to favour those individuals and staff groups who have power. Powerful individuals and staff groups will tend to dominate shared learning unless this factor is identified and the team learns to modify or restrain the powerful. High levels of proximity can act as a restraint on those individuals with power, and can result in shared learning that is fairer for all within the team. Those teams who are strongly hierarchical in nature will likely have low levels of proximity and this will result in low levels of authentic team-based learning.

8.4. Three elements of the grounded theory of PLT

Proximity

The degree of closeness in which primary health care teams worked with each other was an important factor in the success and effectiveness of PLT. Proximity influenced how PLT was perceived by the practice-based non-clinicians and the community nurses within the primary health care team. Teams that had proximity appeared to find PLT valuable and useful for their everyday work. The converse of this appeared to be true. When participants described their relationships with other staff groups as being poor, PLT was perceived as being difficult to plan and prepare for, irrelevant to the participants' learning needs, and wasteful of time. The degree of proximity of a team influenced the team's

learning processes during PLT and thus, the ultimate usefulness of PLT for the team.

Structural factors

Proximity was influenced by a number of structural factors: physical, functional and organizational, within primary health care. Physical factors included co-location, whereby different staff groups who worked together were more aware of each other's work, their work challenges and to a degree, their learning needs in comparison to teams who worked separately. Structural factors also influenced relationships within primary health care teams. Teams with proximity were aware of each other as individuals, and some saw colleagues as friends. Friendships usually resulted in improved working relationships. This consciousness of others and of the work of others, impacted positively on the effectiveness of learning needs assessment. Primary health care teams who had proximity were more aware of learning needs throughout the team, or involved all the team in a systematic and comprehensive inquiry into learning needs. This was integral to the way they worked. These teams, and in particular the practice manager, tended to involve others in various plans and other developments, and therefore the planning and preparation of PLT was conducted in a similar fashion. Teams with proximity were more likely to be involved in collaborative working, thus the foundation was in place to have collaborative learning. Such teams with a high degree of proximity had developed a culture of working and thinking as a team. The individual and his or her viewpoint were important, but not as important as the perspective of the team.

Shared legitimate spaces

The potential benefits of physical co-location often depended on the availability of common legitimate spaces within the physical structures of primary health care. When primary health care teams had shared common spaces that they could use to meet informally, communication became easier. Participants remarked that these areas were where anyone in the team had a legitimate right to be, and that they did not need permission to be there. This contrasted with other more private spaces such as consulting rooms, or practice managers' offices. In these spaces, team members who did not normally operate from

these rooms, might find that their right to be there was less than others in the team. This would affect their confidence in these locations, and their ability to learn from such interactions and experiences. Formal meetings, that involved different staff groups, and were concerned with patient care were further manifestations of collaborative practice.

Organizational structures

Organizational structures influenced proximity. Many of the community nurses were very aware that their work and learning straddled two teams: the primary health care team that they were part of, and the larger and wider community nursing team. Community nurses had to work in both situations and contexts. They alluded to the sense of self-determination that practices enjoyed, and they described how practices could construct their own system of rules and conventions. Their perception was that practices were semi-autonomous organizations with a high degree of control and enablement. This contrasted with their opinion of their employer - the CHP. Nursing managers also had similar perceptions. They were higher up in the nursing hierarchy and appreciated that the CHP had developed rules and conventions of working that had to span the whole of the community nursing team, no matter which practice or geographical areas were covered. Teams who had proximity were able to work around these organizational barriers. They were aware of its existence and made strategic plans accordingly. In contrast, teams with low levels of proximity allowed the barriers to determine and shape their working relationships.

Learning processes

Practice managers from teams with a high degree of proximity were able to identify the learning needs of the team. They did not see the team's learning needs as being simply a collation of the learning needs of the individuals in the team. They were aware of the potential new challenges that the team faced as an organization. Thus, proximity had an influence on the learning processes adopted by teams before and during PLT. Practice managers from these teams adopted a longer term strategy, and had a wider perspective. They were able to plan and prepare PLT for the primary health care team, rather than just for

themselves or for the GPs. Such practice managers valued PLT highly and saw it as a useful resource that would maintain good team relationships as well as help the team to meet the challenges of the future. As a consequence of good and honest feedback from staff groups within their team, these practice managers felt empowered and authorised to try new learning topics and their educational endeavours were wide in the context of learning topic and learning method. The team gave these practice managers the legitimacy they required to act. As learning events were improved with effective feedback, these practice managers had increasing confidence with experimentation during practice-based PLT and developed immunity to negative comments from CHP managers.

Relationships

There were contrasting experiences and perceptions relating to practice-based PLT when community nurses came to the practice building to learn. Some participants found this to be an emotionally charged event. They described how they had to sign themselves into the practice's building so that the fire register would be correct. They were perceptions that they did not belong in this building and that they were a guest to their primary health care team. Belonging in the sense of being a team member, and in the sense of physical territory such as a building, became an important finding and one that illustrated different reactions especially from community nurses. Some community nurses seemed to be strangers to the general practice: their relationships with the GPs were weak. They were also strangers with regards to the A & C staff and this had a very negative effect on practice-based PLT. Signing the fire register became symbolic of poor relationships and of low levels of proximity within the primary health care team.

Strained and distant relationships resulted in very formal learning methods being used at PLT. These PLT events often lacked interaction and dialogue between individuals as these teams preferred passive learning, rather than employing methods involving interactive discussion. Those primary health care teams that had high levels of proximity operated their PLT in a more informal way. Participants felt enabled and encouraged to speak out and challenge current working systems, and there was mutual engagement with all the members of the primary health care team. In general, teams with proximity had more

imaginative practice-based PLT events that seemed to be more engaging and enjoyable for participants.

Agents of proximity

The agent of proximity was the practice manager, who built up long-term strategic relationships with all staff groups. Levels of proximity were improved by the development of close relationships between some practice managers and the attached community nurses. The educational skills and attitudes of practice managers were crucial to the quality of practice-based PLT for community nurses. Some practice managers considered that arranging PLT for community nurses was a legitimate task for them to be performing, but the majority did not. Practice managers who did work for the whole team, and not just the general practice, were perceived as being the learning leaders of PLT. These practice managers forged and maintained strong working relationships with all staff groups: a role for some with comparisons to that of an ambassador. They connected with different individuals in the team and aimed to maximise the potential of team-working and team-learning. They saw collaboration, team-working and sharing as being important and as a result, other staff groups valued the PLT learning leader, and praised him or her for their approach.

Practice managers who acted in this enabling way were acting with the consent of the dominant group: the GPs. Few practice managers had the confidence to act in a way that would go against, or contradict the policies of the GPs. Participants felt that the GPs were behind the PLT leader, supporting him or her, and that few practice managers defied the views of their own employers for very long.

Although few participants discussed the impact of PLT on improving proximity, it was clear from what was said that simply having PLT did not necessarily improve or cause closer working. Indeed for some teams it made it more obvious how little team-working there was. Teams that had little proximity found PLT to be an uncomfortable experience or chore, and events were endured rather than enjoyed.

Authenticity

For participants, there was a distinct perception that PLT for all of the primary health care team had not become what it had set out to be. The initial aspirations and hopes for this project had not been achieved, and much of this disappointment related to lack of authenticity.

Participants described when PLT had started and how, in the early days of the scheme, it seemed to be a welcomed project that would allow teams to learn together and implement changes for the benefit of patient care. With time, the PLT scheme evolved and drifted away from these earlier ideals, and team-based learning changed into fragmented learning, or for some staff groups, to no learning at all.   Some participants considered this morally wrong as it was not the outcome for which they envisaged PLT had been created. They believe that some team members, notably GPs and practice managers, had altered the aims, objectives and processes of PLT for their own benefits. There were strongly expressed opinions about inequality, and some felt betrayed by the organisers and leaders. Dominant groups were able to exert their power and control over PLT, and there seemed to be few constraints on these actions.

A & C staff

The lack of learning particularly affected the A & C staff. Although attendance at practice-based PLT by community nurses had declined considerably, it appeared that some of the community nurses had arranged their own learning to compensate. They either learned as individuals, or in their own small team, or learned as part of a much bigger group of district nurses or health visitors. In contrast, if A & C staff were excluded from practice-based PLT, then they had no learning of their own to compensate. The absence of learning resulted in them working in the general practice rather than learning.

Surprisingly, at least to me, some A & C staff preferred this to attending learning events. Some had discovered from previous experience that learning offered to them would be irrelevant because their learning needs had not been identified or acted upon. They also realised that they did not have protected learning time but postponed learning time. In contrast to the GPs in the general practice,

their work was not undertaken by an out-of-hours service, but remained on hold until the next working day. The concept of 'protection' was not legitimate or authentic for them, and was compounded by their frustration at attending events that did not help them with their work.

Much of their concerns about authenticity related to their experiences of learning processes. Participants saw that the various processes of learning were not authentic methods for team-based learning. They perceived that learning needs assessment either did not extend to them, or if it did, the learning offered as a consequence did not relate to the identified learning needs. Thus, they felt neglected and ignored and it seemed that learning was planned and prepared that was independent of their needs and wishes. Experience had taught them that the learning was based on the needs of others in the primary health care team who had the power to control and dominate what happened.

Learning methods did not always suit the A & C staff within the team. They had frequent expressions in their groups for learning that was fun, interesting and that would help them improve the quality of their work. They were disappointed that the learning planned for them did not employ the learning methods that they preferred.

Community nurses

Community nurses wanted to learn with the GPs in the team, and they considered that GPs were needed to be there to make sure that decisions made at PLT events would result in actual change happening. They were aware that GPs had considerable influence in the team, thus their absence at PLT meant it was unlikely that authentic change to working practices would take place.

Another irritation experienced by the community nurses was that their invitation to attend practice-based PLT was a concealed expectation to take on further work on behalf of the GPs. Some felt overpowered at practice-based PLT. Their relatively small numbers, compared to the general practice, meant that some agreed to provide and deliver services that on reflection they did not think they were able to do in the long term. Thus, they considered this learning to be not authentic, perceiving that their presence at practice-based PLT was not to

learn, but to be given more work. This was particularly felt by those community nurses who observed that their current work was invisible to the general practice, and in particular to the GPs and practice manager. Adding further work to this resulted in extra stress, and resulted in declining attendance.

Practice managers

Practice managers were aware that the evaluations of practice-based PLT events were not always honest. They had concerns that feedback and evaluations given to them tended to consist of comments that it was felt others would want them to hear, rather than the truth about the quality of the educational event at practice-based PLT. They were keen that evaluations returned to them were honest, but many had misgivings about whether this was possible.

Power

Structures and power

Some individuals in the team could be prevented from learning by other team members because of their structural position in that team. Primary health care teams have a hierarchical structure and individuals who are higher up this structure might exert control and dominance over other individuals in the team. This has an impact on learning, both for the topic selected for shared learning, and the learning methods chosen. Power may prevent or discourage learning and especially for groups or individuals who have little or no power in that hierarchically structured team. Indeed, for most of the teams that participants were drawn from, the GPs determined whether the whole team would participate in the PLT scheme or not. They were usually the only individuals who decided on this policy while their employees had little to say in the introduction, or to the ending, of PLT for their team.

Practice managers in strongly hierarchical teams behaved differently from those who had more democratic views of teamwork and team-learning. Strongly hierarchical team practice managers worked as agents of the GPs. Their employers' learning needs and wishes were met first. When the planning and preparation of these events were secured, practice managers then arranged learning for the A & C staff. Often these learning events would be held

separately from those of the practice-based clinicians. If resources allowed it, practice managers then arranged learning for community nurses. Some, however, only offered them learning that was already arranged for others in the team.

Power influences learning processes

Power was revealed through learning methods and learning topics chosen for practice-based PLT. The GPs' dominance and power was used to control the learning needs assessment, and by doing so influenced what topics were chosen. Pre-existing knowledge of a chosen topic was hierarchical and this was illustrated by the GPs, as seen through the perceptions of the community nursing team. Community nurses who had little involvement in planning and preparing learning events would find that a chosen topic at practice-based PLT would be one of which they had little knowledge. Learning methods that were perceived as being interactive made the community nurses conscious of their lack of knowledge. They were reticent in showing this knowledge gap, and would often be passive during such events, anxious not to appear lacking in knowledge to the remainder of the team. This was more likely to occur in those teams that had low levels of proximity.

Powerful staff groups were more likely to dominate the learning agenda during team-based learning than groups with less power. Those groups that had the organizational resources to dominate learning would tend to do so. They perhaps felt a sense of legitimacy in these efforts, for example, work which related to the Quality and Outcomes Framework of the 2004 GMS Contract. They may have had the ability to influence their sub-ordinate staff, to plan and prepare learning for them, or they may have had a dominant agenda that they sought to persuade others to agree to. The learning topics suggested by the dominant group may have been ones that they saw as being the priority for the whole team but this would usually not have been assessed in any systematic way.

Power is altered by proximity

Some teams demonstrated that their organizational structures had a flatter hierarchy than others. Although the same employment structure and conditions were used throughout the NHS area studied, how this hierarchy influenced

behaviours between staff groups varied considerably amongst teams. Proximity influenced power and could have a tempering effect. Flatter teams seemed closer to each other. There were symbolic representations of this in the transcripts. It was noted that those teams that called each other by their first name behaved more informally with each other. Another symbol of proximity modifying power was the careful use of humour especially by A & C staff.

It was clear that staff groups with less power either acquiesced to the dominance of the powerful staff groups, or they withdrew from the learning opportunity. They worked at their normal duties rather than learned at practice-based PLT, or they learned separately in uni-professional groups. This was against the main aims and objectives of team-based learning when PLT was first proposed. It was assumed that PLT was for all of the primary health care team, and that teams would learn with each other.

8.5. Comparisons with Bourdieu's theory

Introduction to Bourdieu

Pierre Bourdieu was an important French sociologist, anthropologist and philosopher whose work has had considerable influence on a range of academic areas (Grenfell M 2008;Swartz D 1997) These areas include sociology, education, culture, and in recent years, health care. Brosnan emphasized the relevance of Bourdieu's theory within the field of medical education, particularly where sociological factors such as power are strong (Brosnan C 2010). In addition, Luke examined the training and growing professionalism of junior hospital doctors, using the theoretical lens of Bourdieu (Luke H 2003). It is Bourdieu's prominence in the philosophical thinking of education, and particularly in relation to the concept of power, that influenced me in selecting his theory for comparison with my grounded theory. Like Luke, I was able to gain a deeper understanding of my theoretical element of power by exploring Bourdieu's thinking on power. His concepts of habitus and capital help to explain the mechanism of how power affects learning.

Swartz interpreted the complex language of Bourdieu, and his work is helpful in the application of Bourdieu's conceptual thinking with regards to the sociology

of medical education. Grenfell with others offered similar interpretations of Bourdieu's key theories (Bourdieu P 1984;Bourdieu P and Passeron J-C 1977;Bourdieu P and Wacquant LJD 1992;Grenfell M 2008;Swartz D 1997)

Bourdieu's theory of practice includes three main concepts: *habitus, capital* and *field*. Each of the three concepts is described below and their relevance for PLT is discussed. Bourdieu stressed that each concept needs to be considered to be inter-related with the other two, and none can be considered in isolation. Bourdieu has described the inter-connections between the three concepts using an equation:

[(habitus) (capital)] + field = practice. (Maton K 2008)

 Maton explains this equation:

> "Practice results from relations between one's dispositions (habitus) and one's position in a field (capital), within the current state of play of that social arena (field)."

I will now define and analyse the three conceptual elements of Bourdieu's theory of practice and illustrate the connections with my grounded theory.

Habitus

Definitions of habitus

My interpretation of Bourdieu's concept of habitus is that it is a self-view which can determine the reactions of individuals. Habitus is derived from various influences on a person: their background, social class and upbringing are examples of the various factors that determine individuals and their thinking. Habitus can act as a restraint on development and change. Swartz described and interpreted Bourdieu's concept of habitus as:

> "Habitus tends to shape individual action so that existing opportunity structures are perpetuated. Chances of success or failure are internalized and then transformed into individual aspirations or expectations; these are in turn externalized in action that tends to reproduce the objective structure of life chances." (Swartz D 1997)

Maton interpreted and summarised habitus, and suggested that: "structure comprises a system of dispositions which generate perceptions, appreciations and practices." (Maton K 2008) Maton described habitus further:

> "Simply put, habitus focuses on our ways of acting, feeling, thinking and being. It captures how we carry within us our history, how we bring this history into our present circumstances, and how we then make choices to act in certain ways and not others." (Maton K 2008)

Habitus and practice-based PLT behaviours

My interpretation of habitus within the context of my grounded theory of PLT is that it enables the understanding of why different individuals and staff groups behaved with each other and collectively. Habitus is one component of how power within the team was maintained, and controlled what happened at practice-based PLT. Habitus suggested that some of the behaviours were constructed from the foundations that influence each of us: our background, our upbringing and our thoughts of how we ought to behave in certain circumstances.

The concept of habitus helps to explain and understand my theoretical element of power within PLT. In practice-based PLT, the GPs in the general practice tended to dominate what was planned and prepared for learning events. As time progressed this seemed to be an increasingly common situation with primary health care teams. Practice managers acted as the agents of the GPs in the learning processes of practice-based PLT, including the learning needs assessment and learning methods adopted. However, for many primary health care teams, the end result of what happened during practice-based PLT was similar. The power of the GPs in deciding and controlling the normal everyday events of the practice was replicated in the hours of PLT. The dispositions of the different staff groups within the primary health care teams continued to influence behaviours of each staff group during practice-based PLT. Thus the way that the different staff groups behaved outwith PLT continued into the educational and social processes of PLT. Few individuals or staff groups from these teams re-invented themselves into agents that behaved in a different fashion or manner during PLT compared to their normal habitus.

The habitus of A & C staff

The A & C staff's view of themselves affected how they perceived opportunities provided by PLT. They held contrasting opinions about their roles and what they considered they should be doing, during PLT. Some A & C staff participants described to others in their focus group how they were becoming more involved in patient care than had traditionally happened. For example, one participant described how she had set up a folder of advice and contacts for carers in the locality, and that her efforts had become a resource for the primary health care team and for patients. Responses to this during the focus group were divided, reflecting the habitus of the A & C staff, and their perceptions of their place in the team, especially when considering the role of clinical contact and care. Some participants felt this was an admirable task to have performed. They also saw it as a useful career development that provided practical help for colleagues and patients. Others examined it from the context of their own position in the primary health care team and felt that this A & C staff member was leaving the traditional boundaries of their usual duties and moving into clinical work. They perceived that she was becoming inappropriately involved with patient care. Some envisaged this as being wrong. Their own habitus restricted the development of the A & C staff into the arena of direct patient care and they were not interested in learning about it.

There were other examples of how habitus discouraged A & C staff from learning about topics not traditionally within their normal learning. Some talked about how practice managers and GPs in their team had presented clinical audits and reviews of how the team was performing in areas related to chronic disease management. Again, responses were divided. Some regarded this as being irrelevant to their work: "That's clinical!" and they did not see these topics as being appropriate for them to learn about at PLT. Others disagreed and valued seeing the relevance of their own efforts in the administration processes of chronic disease management. They considered that it helped them see the point of their work in a wider context.

Habitus restricts learning and development

Swartz also emphasized the restrictions and negativity of habitus. In the context of PLT this was apparent in the development of some staff groups within the primary health care team:

> "Habitus adjusts aspirations and expectations according to the objective probabilities for success or failure common to the members of the same class for a particular behaviour. This is a practical rather than a conscious adjustment." (Swartz D 1997)

A number of A & C staff participants felt very angry at the lack of planning and preparation for them at practice-based PLT. They saw that they were not a priority for learning and that commonly, events that took place would offer irrelevant learning as they were based on the learning needs of those with power. In contrast to the anger displayed by some, others from the A & C staff participants were not unduly disappointed. Their restricted view of their work developed from their own habitus meant that they had little aspirations towards learning. They expected and predicted that this outcome would happen and that PLT would not be a resource for them. They were not overly surprised when this was their experience. Some saw PLT as being unnecessary and unwanted and claimed they would not miss it if the PLT scheme ended. The habitus of some A & C staff acted to disable any ambition they had for further learning and development. They perceived that formal training was not needed for their job, and a few considered they did not merit this time. Their in-grained self-view or habitus restricted their development and made this group accepting of the reality of PLT and its demonstrated inequalities. Habitus disabled A & C staff and reduced their power.

The influence of habitus in maintaining power in primary health care teams

Power to control what happened during PLT, in essence who learned what and with whom, was increasingly in the realms of GPs and practice managers. Their dominance was aided to an extent by the habitus of the A & C staff. There was a degree of agreement of this phenomenon by some practice managers as well as managers from within the CHP. Some practice managers made choices for the A & C staff without their involvement – in particular when deciding which events that A & C staff would attend at large centrally organised PLT events. CHP

managers also decided that A & C staff did not need to attend learning events at large centrally organised events. They perceived that A & C staff did not require further training or learning events, and that this staff group did not deserve such resources. As one CHP manager stated:

> "To be honest I think it [PLT] works well for the clinical staff. I think it is just a case of looking at how or what we deliver to the A&C to bring them back in for them to enjoy it. But I think if you can think of A&C as a whole not just as practice-based staff, you have to sit and think. You know, just how much can they learn?" (CHP manager and administrator of PLT committee)   (Cunningham D & Kelly D 2007)

Habitus was obvious with other interactions between different staff groups. The learning relationships between GPs and community nurses was variable, but was frequently strained by issues relating to underlying control and power in the primary health care team. The community nurses' traditional perceptions of their roles and views of their relationships with GPs meant that they adopted a passive role during practice-based PLT, and did not challenge those with power.

Capital

Definition of capital

Bourdieu considered capital as being a wider social concept than just money or financial assets. He envisaged capital as consisting of a variety of forms of assets or resources that increase an individual's personal worth. Moore interpreted Bourdieu's concept of capital as follows:

> "Hence Bourdieu's purpose is to extend the sense of the term capital by employing it in a wider system of exchanges whereby assets of different kinds are transformed and exchanged within complex networks or circuits within and across different fields." (Moore R 2008)

Bourdieu stated that capital exists in a variety of different forms. Financial capital is relatively easily defined as the financial worth of individuals or groups. Social capital reflects the connections of individuals within the social world. This term captures our social networks and contacts that we may use to further our own aims. Brosnan described social capital as "being associated with the right people" (Brosnan C 2010). Luke argued that medical practitioners have

significant capital in comparison to nurses as they are able to attract the attention and interest of pharmaceutical representatives who are interested in modifying the medical practitioners' prescribing (Luke H 2003). Capital also exists in the form of cultural capital or symbolic capital.

Capital and power within PLT

Capital, like habitus, has connections with my grounded theory element of power within PLT. The GPs in the primary health care team have considerably more capital in all its forms compared to those with less power in the team. This was one of the mechanisms in which some GPs dominated practice-based PLT. Some of the capital was financial in that it related to ownership of the business and of the premises where much of practice-based PLT was held.

Capital also consisted of the social networks that GPs and to a lesser degree practice managers had. GPs had links to providers of education and learning, for example, they knew hospital consultants and specialist nurses from secondary health care centres and could use their connections to such providers. By suggesting and volunteering social contacts, GPs made sure they had relevant learning opportunities.   Practice managers had a social network with other practice managers and they may have known other educators who could provide learning for practice management and administration. Both GPs and practice managers were known to pharmaceutical representatives who had a financial interest in providing learning events for practice-based PLT. These displays of social and financial capital contrasted with the capital of the A & C staff. They did not own the premises or business where they were employed, and their social networks were much smaller. A & C staff had far fewer connections with individuals in other teams locally, or with other teams within secondary health care compared to GPs and practice managers.

Interactions of habitus and capital

Capital and habitus together were influential for some primary health care teams in determining what happened during practice-based PLT. Some community nurses perceived that learning events that centred on the 2004 GMS Contract showed that community nurses had little influence on what happened during PLT. They saw that learning events were arranged to increase the

practices' performance in the Quality and Outcomes Framework (QOF) component of the 2004 GMS Contract. Some even perceived that the motivation behind the invitation extended to them to attend such practice-based PLT events was to increase the financial capital of the GPs. For some community nurses, attendance at these events meant they left with agreements that they would perform home visits or other duties that would improve the practice's performance in the QOF.   The habitus of the community nurses suggested that it was difficult for them as individuals to refuse or decline the orders or requests of the GPs. This conflict resulted in the declining attendance of community nurses at practice-based PLT.

Field

Definition of field

Field is the last of the three intertwined concepts of Bourdieu's theory of practice. He himself described it as:

> "A structured social space, a field of forces, a force field. It contains people who dominate and people who are dominated. Constant, permanent relationships of inequality operate inside this space, which at the same time becomes a space in which various actors struggle for the transformation or preservation of the field. All the individuals in this universe bring to the competition all the (relative) power at their disposal. It is this power that defines their position in the field and, as a result, their strategies." (Thomson P 2008)

Field and the element of power in PLT

In the context of the primary health care teams, PLT events themselves functioned as the field. The struggle for the resources needed for PLT involved the members of the primary health care team. The time at PLT is in itself a resource, as is the ability to command learning resources such as speakers, learning materials and so on. The time and working efforts of the practice manager were further examples of field. Some staff groups had more power and were able to influence the practice manager about how much of the practice manager's time was spent on planning and preparing practice-based PLT for the different staff groups. Their struggle, in some practices with each other and with different staff groups, was influenced by their habitus and capital, but took place in the field of PLT.

8.6. Comparisons with Wenger's theory of a Community of Practice

Introduction

> "Our institutions, to the extent that they address issues of learning explicitly, are largely based on the assumption that learning is an individual process, that it has a beginning and end, that it is best separated from the rest of our activities, and that it is the result of teaching. Hence we arrange classrooms where students – free from the distractions of their participation in the outside world – can pay attention to a teacher or focus on exercises." (Wenger E et al. 2002)

Etienne Wenger, with Jean Lave and others, wrote extensively on the concept of Communities of Practice (Lave J and Wenger E 1991;Wenger E 1998;Wenger E, McDermott R, & Snyder W 2002). Wenger theorised that much of what we learn from each other whilst working in a team or within an institution is informal in style and takes place when we are working. He did not visualise learning as being separate or isolated from working, but as an active process that was related to teaching, but not dependent on it.

Wenger proposed that some individuals and staff groups who work together in a team may become, or are already operating in the style of a Community of Practice. He also stated that not all teams work in this way, arguing that teams did not automatically develop or evolve into being a Community of Practice. Wenger suggested that different attitudes to collective working and learning are needed before a team could claim to be like a Community of Practice. Wenger described his perceptions of what a Community of Practice would look like:

> "Communities of Practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an on-going basis." (Wenger E, McDermott R, & Snyder W 2002)

Fundamental elements

Wenger claimed that there are three fundamental elements of a Community of Practice, and that these three elements need to be present before a team can be considered to be a Community of Practice:

- A domain of knowledge

- A community of people who care about this domain

- The shared practice that they are developing to be effective in their domain.

It would be useful to consider how these three elements help with understanding the arena of PLT and the primary health care teams studied in this thesis.

A domain of knowledge

Primary health care teams effectively work and operate in a knowledge-based culture. They rely on their specialist skills and knowledge to provide health care for patients. Different individuals and staff groups have different skills and knowledge bases that have a degree of overlap. When combined together primary health care teams work in this domain of knowledge.

A community of people who care about this domain

Focus group participants in this study described stable teams with low levels of turnover in their team, other than that of individuals undergoing fixed term training. The domain of knowledge was held within the individuals of the team. This included staff groups who had responsibilities for improving and continually updating their own skills and knowledge in line with their professional responsibilities. Many individuals involved in primary health care held positions where continuing improvement was mandatory. It was part of an obligation to their professional regulatory body to remain up-to-date and fit for practice. In addition, numerous participants from the focus groups reflected on their desire to provide quality services for patients and to continually meet the needs and requirements of their practice population. Therefore, there is evidence of the positive attitudes of these individuals and teams relating to 'caring about this domain'. The most likely area of strain for this element of Wenger's theory, in comparison with my grounded theory, is whether every primary health care team had formed themselves into a community that cared about their domain, or whether they were best described as individual staff groups that acted in the way described by Wenger.

The shared practice that they are developing to be effective in their domain

This element is related not to the 'practice' as a building or other physical identity, but to the concept of shared working and co-ordinated activities that help to provide quality health care. Shared practice suggests working together to enable this, rather than the unco-ordinated work of disparate and separate teams or staff groups. Ideally, primary health care teams should be operating in such a manner to be effective and also efficient with resources. The term 'domain' suggests two relevant areas in the situation of this study. First was the clinical area of health care practice: that of primary health care. The second was of the geographical area: the distinct area, or patient list served by the primary health care team.

There are similarities with my grounded theory of PLT. In some respects, Wenger indicated that the physical proximity of teams is important if they are to aspire to operate in the system he described. This is in agreement with my element relating to proximity. In addition, Wenger maintained that teams do not necessarily need to be co-located to work in the manner of a Community of Practice. Teams who are not co-located but who communicate readily with each other and who work jointly in a co-operative sense, on a project can be seen to work as a Community of Practice.

> "Sharing a practice requires regular interaction. Naturally, therefore, many communities start among people who work at the same place, or live nearby. But co-location is not a necessity. Many Communities of Practice are distributed over wider areas. Scientists have long been forming Communities of Practice by communicating across the globe."
> (Wenger E, McDermott R, & Snyder W 2002)

This is similar to my concept of functional proximity, of which some teams gave examples. Teams that worked closely with each other in providing primary health care did not necessarily have to be in the same building, although co-location can facilitate and enable proximity.

Wenger emphasized the need for regular interactions between those who constituted a Community of Practice:

"Interacting regularly, members develop a shared understanding of their domain and an approach to their practice. In the process, they build valuable relationships based on respect and trust. Over time, they build a sense of common history and identity." (Wenger E, McDermott R, & Snyder W 2002)

There are clear comparisons with my findings related to relationships and structures that have informed the theoretical element of proximity. Those primary health care teams that worked together got to know each other better and built up trust and mutual respect. Staff groups who interacted with trust and mutual respect were evident in this study. Wenger predicted that teams made up of different components or different staff groups could operate in the sense of a Community of Practice:

"Homogeneity of background, skills, or point of view may make it easier to start a Community of Practice, but it is neither a required condition nor is it a necessary result. In fact, it is not even an indicator that a community will be more tightly bonded or more effective. With enough common ground for ongoing mutual engagement, a good dose of diversity makes for richer learning more interesting relationships, and increased creativity." (Wenger E, McDermott R, & Snyder W 2002)

Wenger stressed the need to cultivate Communities of Practice. Indeed this is the main theme of his third text on the subject of Communities of Practice. He argued that in order to maintain a Community of Practice, it is important that there is leadership in this endeavour, and that those who control resources in large organizations needed to understand and appreciate the educational requirements of such communities. A further comparison to my grounded theory of PLT was possible here with relation to the element of proximity. Practice managers were deemed by many to be the leaders of PLT for primary health care teams. The proximity of the practice managers to all of the different staff groups in the team was one factor in the success of PLT. Practice managers who were available to others and interacted informally with these groups then found that learning needs assessment was easier. This was especially important for those staff groups likely to be more distant in a physical or functional sense from the rest of the primary health care team. Community nurses valued practice managers who attempted to include them in practice-based PLT. A & C staff were separated from some within the team by hierarchical structural barriers, rather than physical ones.

Participation and collaboration

In his earlier work, Wenger stated that in the case of individuals and staff groups, simply being in a team does not mean that the team or that individual team members will work or learn in the ways of a Community of Practice. He considered that the term 'participation' required further clarification:

> "First, participation as I will use the term is not tantamount to collaboration. It can involve all kinds of relations, conflictual as well as harmonious, intimate as well as political, competitive as well as co-operative." (Wenger E, McDermott R, & Snyder W 2002)

It can be imagined that those who participate in the world of football or other team-based sports are participatory, but are not collaborative in their endeavours. Footballers in opposing teams can be seen as participating in a game, but cannot be seen as collaborating with the other team in this venture. Indeed their very actions are often competing against the aims of each individual team, that of winning the match.

> Second, participation in social communities shapes our experiences and it also shapes those communities; the transformative potential goes both ways. Indeed our ability (or inability) to shape the practice of our communities is an important aspect of our experience of participation." (Wenger E, McDermott R, & Snyder W 2002)

This has resonance with my theoretical element of proximity. Teams can be physically close with each other but do not always work in a collaborative sense with each other. Such a positive outcome is not guaranteed by proximity, and this was recognised by the nursing managers. They identified that co-location was often useful and helpful to promote and sustain effective team-working, but by no means did it guarantee that individuals and staff groups would collaborate with each other. Some primary health care teams in the study worked in the same small area and looked after the same patients; they participated with each other in the arena of health care within a locality, but did not collaborate. It was usual for such teams not to be able to learn from each other, mirroring their inability to collaborate.

Wenger further described the attributes of collaboration in a community of practice, stating:

> "Membership in a community of practice is therefore a matter of mutual engagement. That is what defines the community. A community of practice is not just an aggregate of people defined by some characteristic. The term is not a synonym for group, team, or network." (Wenger E, McDermott R, & Snyder W 2002)

Wenger was also conscious of the different types of people who make up a Community of Practice, and that such communities were not homogenous: they had diversity in the roles and skills within the team. He stated:

> "More generally, each participant in a community of practice finds a unique place and gains a unique identity, which is both further integrated and further defined in the course of engagement in practice. These identities become interlocked and articulated with one another through mutual engagement, but they do not fuse." (Wenger E, McDermott R, & Snyder W 2002)

The different staff groups within some of the primary health care teams in the study were examples of this. With a strong sense of value and respect for each other, and for each other's specific roles in the team, they were able to collaborate in health care and provide services to patients. Some of the teams developed and increased proximity with each other by developing and maintaining friendships and promoting social events leading to increased understanding. Proximity shifted from being not just a description of physical closeness, or close collaboration in a team-working sense, but closeness in the sense of socialisation and, to a degree for some individuals, of friendship. This was most noticeable in terms of the general practice. Some primary health care teams were examples of this, whereby although the entire team was not a Community of Practice, the general practice was. In this regard the community nurses were seen as being part of a distinct and separate entity. This was further emphasized by the feelings expressed in relation to belonging. Wenger related this to concepts of identity and expressions from individuals that they were strongly connected to individuals within a team, and also to the buildings or premises occupied and used by a Community of Practice.

Wenger identified that within large organizations, Communities of Practice could exist. Thus, although a larger primary health care team does not function in the ways he has described, separate elements or components of the team may exist as a Community of Practice. Hence, in relation to this study, in some

instances the general practice operated as a Community of Practice although the larger primary health care team did not.

Wenger has also described and defined his term of a looser Community of Practice as "a constellation". This was an analogy based on the perceptions of astronomers and astrologers in past times. Just as distant stars were perceived as being close and forming elements of the Zodiac, for example, more careful study showed that they were not proximal to other stars at all. As Wenger stated:

> "A constellation is a particular way of seeing them as related, one that depends on the perspective one adopts. In the same way, there are many different reasons that some communities of practice may be seen as forming a constellation, by the people involved or by an observer." (Wenger E, McDermott R, & Snyder W 2002)

Wenger envisaged some key recommendations for future Communities of Practice to continue to flourish:

> "1. Construe learning as a process of participation, whether for newcomers or old-timers.
>
> 2. Place the emphasis on learning, rather than teaching, by finding leverage points to build on learning opportunities offered by practice.
>
> 3. Engage communities in the design of their practice as a place of learning.
>
> 4. Give communities access to the resources they need to negotiate their connections with other practices and their relation with the organization." (Wenger E, McDermott R, & Snyder W 2002)

8.7. Chapter Summary

There are comparisons with my grounded theory of PLT and with Bourdieu's work on education, and with Wenger and colleagues work on learning. My element of power had significant comparisons with Bourdieu's theory on how education is controlled by groups with power and how the ability to achieve education is socially based. Those primary health care teams who were able to suppress power, even just for the PLT event, seemed to have more successful PLT. When the power linked to opportunities at PLT was shared with other

groups such as when less powerful groups were able to determine the learning agenda or topic, then there were positive outcomes for the team. When power at PLT was focused on the pre-existing structures, only powerful staff groups benefited from PLT. It was as if power itself replicated itself as those staff groups with power used this energy to continue to benefit from PLT.

Wenger's work on Communities of Practice had considerable comparisons with my thinking about proximity. It seemed that a number of teams worked in the ways that Wenger described but from what participants said, these teams were not in the majority. Such Communities did not seem common, and their practice-based PLT activities acted as markers of this.

Chapter Nine – Comparisons of research findings with the literature

9.1. Introduction

The chapters of research findings have been presented earlier in this thesis. As mentioned in Chapter Two, the literature search for this thesis was not undertaken until the grounded theory was constructed, in keeping with the tradition of grounded theory. Chapter Eight presented my grounded theory and compared my theory with the theories of Bourdieu and of Wenger. This chapter aims to compare and contrast, using the constant comparative method, my research findings with the literature review presented in Chapters Two and Three. It would seem logical to broadly structure this chapter into my three categories of research findings: structures in primary health care, the relationships between individuals and staff groups, and the learning processes involved in PLT. I made comparisons with the literature of Chapter Three when it seemed appropriate in relation to the above three categories, and I will also refer to further literature identified after the initial literature searches.

9.2. Structures in primary health care

It was clear from my research findings that the structural composition of the primary health care team, and of primary health care itself, had a very significant impact upon what was learned and by whom at PLT events. The chronology of development of the primary health care team presented in Chapter Two has shown how the 'teams' of 1948 were remarkably different from today's primary health care teams. The vision of the Department of Health in 1920 was that GPs and district nurses would work collaboratively, and from primary health care centres (Ministry of Health - Consultative Council on Medical and Allied Services 1920). It was evident from my own research findings and grounded theory, and from other studies undertaken throughout the lifetime of the NHS, that this vision had not been realised consistently in the NHS.

Although primary health care teams of today are much larger than before and contain new staff groups (for example, practice managers and practice nurses)

that did not exist in 1948, some employment arrangements still persist. The partnership model of GPs who work under contract with the health board, in general, continues in NHS Scotland. Community nurses continue to be directly employed and managed by health boards.

The dominant position of the GPs, and their use of power in deciding, the learning agendas at practice-based PLT were clearly expressed by research participants. The chronology of the primary health care team helps to explain why this happened, and the dominance of the GPs can be traced back to the inception of the NHS in 1948 (Rivett G 2011). With the establishment of the GP as an independent contractor within the NHS, and thus the main provider of primary health care, GPs remained the business owners of general practice. The other staff groups, except for the community nursing team, were recruited and employed by the GPs. Thus, an employment hierarchy was created and continued by this employment arrangement. This has enabled the GPs to profit from PLT more than other staff groups as their power has enabled them to control PLT, and as a consequence their capital, in all its forms, has increased.

Sheaff and colleagues reviewed partnerships and non-hierarchical organizations in a variety of countries and occupational settings (Sheaff R et al. 2012). Professional partnerships are relatively common in the UK and can be found in other countries such as the United States. In the UK, pharmacists, dentists and optometrists can work together, in the format of professional partnerships.

In their report, Sheaff and colleagues studied partnerships of GPs within primary health care in the UK. They found that the structure of general practice had evolved since the inception of the NHS, with partnerships of GPs coming together and in addition, employing A&C staff, practice managers and practice nurses. Sheaff and colleagues described such professional partnerships as hybrid structures, with a partnership of (generally equal) partners, and with the partnership functioning as an employer of the rest of the practice. Sheaff's report also studied other forms of partnership in UK primary health care, for example, where practice managers, practice nurses, or pharmacists were partners, or where partnerships consisted solely of community-based nurses.

The report's conclusion was that professional partnerships (such as general practices working within a contract) could be effective providers of health care. They called for further research which would compare the effectiveness of partnerships with other organisational structures such as the direct employment of GPs and other primary health care staff.

Organizational structures

Introduction

It is important to define what I mean by the word "organization" and in what context I will use the word in this chapter. The word "team" was defined in Chapter Three. There are a number of definitions of "organization". For example, the Collins English dictionary defines "organization" in five ways:

1. the act of organizing or the state of being organized

2. an organized structure or whole

3. a business or administrative concern united and constructed for a particular end

4. a body of administrative officials, as of a political party, a government department, etc

5. order or system; method (Various 2011)

Organizations and teams in NHS Ayrshire and Arran

Within the definitions of teams as described in Chapter Three and that of organizations above, a team can be seen as being one form of an organization. Organizations exist in many forms, and there are examples of these different forms within primary health care in NHS Ayrshire and Arran, and in the NHS in general. In the context of NHS Ayrshire and Arran, where this research is situated and in the context of this thesis, I will clarify what I mean by the use of these words and their relevance to the structures apparent in the health service. I also wish to consider how teams and organizations are related to each other.

It was clear from participants that many felt they were part of a team, or were employed or allocated to a team, but did not function or operate in the sense of

a team. The definitions and attributes of a team, and of teamwork described in Chapter Three meant that the use of the term "team" came under strain for some of the teams in NHS Ayrshire and Arran. This was most obvious when considering the working relationships between community nurses and the general medical practice. Some community nurses saw themselves working for two teams: the larger community nursing team providing services to one CHP, and also for the primary health care team, providing community nursing services for the list of patients registered with one general medical practice. Thus, some community nurses worked with a distinct team (the primary health care team) but also with a much larger organization – the community nurses of one CHP. For other community nurses, the concept of the primary health care team was a much looser arrangement, to the point that the authors of the definitions of teams in Chapter Three would not regard them as being part of a team, or of demonstrating teamwork.

Historical perspective

The research work of Hockey, and Sweet and Dougall illustrated the perspective and perceptions of community nurses from before and from around the time of the establishment of the NHS (Hockey L 1966;Sweet HM & Dougall H 2008). Their research showed the isolation and fragmentation of the providers of primary health care, and the separate working structures and poor communication between staff groups. In addition, research from various GPs, and other medical practitioners confirmed the lack of collaboration and lack of teamwork in primary health care in the 1950s and 1960s (Backett EM, Heady JA, & Evans JCG 1954;Crawford JCC 1954;Elder AT 1953). The organizational schism in the primary health care team, separating the general practice from the community nursing team, was clearly present in some teams in NHS Ayrshire and Arran.

Variable states of collaboration

In 1987 Bond and colleagues showed that although primary health care teams had formed and that more of these teams were working in shared premises, it was clear that these factors did not automatically result in closer working relationships or team-working (Bond J, Cartlidge A, Gregson B, Barton A, Philips P, Armitage P, Brown A, & Reedy B 1987). Their study focused on GPs and their

relationships with district nurses and health visitors, but did not include practice nurses, practice managers or A & C staff. The research showed that only 27% of pairs of GP-district nurse and 11% of pairs of GP-health visitor were working in a close collaborative sense. Bond's survey showed that 40% of respondents were located in shared premises. This was a significant difference from the early 1950s when co-location was not found to any extent. There was growing evidence that simply placing individuals and staff groups together into a team, even when co-located, did not result in teamwork necessarily happening.

Isolated working practices have continued

Judging by the strength of expressions from research participants, it seemed that the structural barriers within primary health care that were prevalent and presented in the literature in the 1950s through to the 1980s to an extent are still detrimental to team-working today. A number of community nurses in the focus groups complained strongly about being isolated from the remainder of the primary health care team, and also were unhappy about the lack of knowledge that the general practice held about them and their work activities. They also felt that they, and their work, were invisible to the GPs, and that their work was not valued by them. It seemed that for a significant number of community nurses, isolated working patterns have continued through the decades since the inception of the NHS. PLT with its regular practice-based events had failed to improve team-working for some of these isolated staff groups. Indeed, in some instances it had made community nurses more aware of their working isolation, and lack of power and importance, within the team.

Managerial dualism

There exists an organizational conflict with regards to the management of community nurses. My findings have shown that some community nurses at times were being pulled in two directions - by the practice manager and by their own nursing managers. There was a conflict between what was expected of community nurses by the nursing managers and by the practice managers. Community nurses were aware that they had to operate within this dual management system.

The Cumberlege report from 1986 recommended the complete detachment of the 'attached' community nurses from general practices, but it seemed clear that most health authorities had ignored this recommendation (Department of Health 1986). Hockey emphasized that it would be preferable to have one nursing manager situated in the community nursing team, who would be responsible for both the management of community nurses and for practice nurses (Hockey L 1984). Hockey rejected the current structure where practice managers managed practice nurses. The GP contracts of 1990 and of 2004 gave practice managers the perception of more authority over the community nursing team as they attempted to achieve health promotion and chronic disease management targets for the practice.

Wood and colleagues did describe a primary health care team where community nurses were managed by the practice manager, but no further research could be found to show that this experiment had been replicated elsewhere (Wood N, Farrow S, & Elliott B 1994). The study showed that communication between the community nursing team and the general practice was improved, and that there was a blurring of roles. Community nurses undertook training that allowed them to perform tasks and services for patients that had previously been reserved for practice nurses or for GPs.

Practice nurses

The introduction of practice nurses, usually under the direct employment of GPs and managed by practice managers, became a way of defusing the conflict between the community nursing team and GPs. Studies from the 1960s and 1970s had showed an increasing demand from GPs to be able to refer ambulant patients to nurses in primary health care. The lack of fluidity of the community nursing team in allowing for this provision resulted in the rise of practice nurses. The expansion in practice nursing posts was accelerated by the 1990 GP Contract with its emphasis on screening, health promotion and targets for childhood immunisation and cervical cancer screening (Department of Health 1990;Hannay DR, Usherwood TP, & Platts M 1992a;Hannay DR, Usherwood TP, & Platts M 1992b;Peter A 1993). GPs were now able to delegate significant amounts of work to practice nurses and patients were able to consult with nurses within primary care at a venue other than their home.

Unmet learning needs of practice nurses

In my findings, nursing managers expressed their concerns about the working lives and learning opportunities of practice nurses. They mentioned how a few practice nurses had approached them for help because they felt dominated and controlled by their employers – the GPs in the general practice. Some had expressed concerns when encouraged to perform duties and tasks that they perceived were beyond their competence. This finding bore similarities to earlier studies which showed that practice nurses were often expected to undertake duties that they considered they were not prepared for, and had been offered little formal training to address their learning needs (Hibble A 1995;Mackereth CJ 1995;Ross FM, BowerPJ, & Sibbald B 1994). New GP Contracts in 1990 and in 2004 placed emphasis on the development of new and increased services for patients and it was noted that much of this work was expected to be delivered by practice nurses, with variable investment in the education and learning needed for them to provide such services.

Earlier research showed that the learning opportunities of practice nurses were strongly influenced by the GPs in their practice. Studies in the 1970s and 1980s revealed that there were concerns about the lack of learning experiences available to practice nurses, and the lack of opportunities for them to learn formally (Hasler JC, Greenland AS, Jacka SM, Pritchard PMM, & Reedy BLEC 1972;Mourin K 1980a;Mourin K 1980b;Peter A 1993). Swanwick drew attention to his research findings illustrating that little had changed for practice nurses by the year 2000 (Swanwick T 2005).

Shared purpose and goals

Grumbach and Bodenheimer, Wiles and Robison, and Mickan and Rodger stressed the importance of shared purpose and shared goals as being necessary drivers for team development and team-working (Grumbach K & Bodenheimer T 2004;Mickan SM & Rodger SA 2000a;Wiles R & Robison J 1994). They collectively stated that teams would naturally form when work was shared, or when work was targeted towards the same endpoints. Grumbach and Bodenheimer also argued that team-building events were unnecessary for true teams. They stated that individuals who were appreciative of the need to work closely with others

and who respected and trusted one another would become a team without the need for team-building. Molyneux, in her study of one successful team has stated that this team had no team-building events but that the team was constructed by working closely together in an appropriate manner (Molyneux J 2001).

My findings have illustrated that where work is not shared, or where endpoints are significantly different, teams may not find it easy to work together. The 1990 GP Contract and 2004 GMS Contract created organizational differences which have resulted in different endpoints for some of the primary health care teams in the study. The Audit Commission has raised concerns about the different structures within primary health care and the resultant differences in pay and reward for work undertaken (Audit Commission for Local Authorities and the National Health Service in England and Wales 1992). Many of the focus group participants found the system of reward, brought about by the introduction of the 2004 GMS Contract, was inherently unfair. A&C staff felt their contribution was not seen and unrewarded, a perspective shared by community nurses.

The 2004 GMS Contract

PLT started in NHS Ayrshire and Arran in 2001 and the GMS Contract was introduced in 2004 (Cunningham D & Kelly D 2005;Department of Health 2003). The focus groups for practice managers, and A & C staff were held in 2005, and focus groups for the community nursing team were held in 2007 (Cunningham D, Fitzpatrick B, & Kelly D 2006a;Cunningham D, Fitzpatrick B, & Kelly D 2006b;Cunningham D, Stoddart C, & Kelly D 2006c;Cunningham D & Kelly D 2007;Cunningham D & Kelly D 2008a;Cunningham D & Kelly D 2008b). Research participants were thus exposed to some of the changes brought about by the introduction of the 2004 GMS Contract, and their perceptions and experiences of this were discussed and raised in the research focus groups.

It is clear from the literature presented in Chapters Two and Three that the GP Charter and Contracts which came into being in 1965, 1990 and 2004 had a significant influence on the functioning of the primary health care team. These contracts influenced the structures within primary health care and working and learning processes needed to adapt to such widespread changes in practice

(British Medical Association 1965;Department of Health 1990;Department of Health 2003). These were contracts for GPs, and had been negotiated between the leaders of the general practice profession and the Government. These contracts, however, had implications and consequences for others in general practice and in primary health care. The contracts greatly influenced the working lives of practice nurses, practice managers and to some degree A & C staff, however, they had less impact for the community nursing team (Checkland K 2004;Laughlin R, Broadbent J, & Willig-Atherton H 1994;Morrell DC 1991).

Influence of the 2004 GMS Contract on practice-based PLT

The 2004 GMS Contract had a significant influence on PLT, and in particular on practice-based PLT. Practice managers to some degree welcomed the 2004 GMS Contract within the context of PLT, it provided them with ready-made and legitimate topics for practice-based PLT, and such topics were judged by practice managers as being useful topics for learning. Practice managers judged that having contract topics for practice-based PLT would gain the approval of their employers - the GPs. As the questionnaire undertaken in 2005 showed, practice managers did not feel it was their responsibility to arrange practice-based PLT for community nurses (Cunningham D, Stoddart C, & Kelly D 2006c). Community nurses were perceived by practice managers as having less power than the GPs, and as a consequence practice managers were less concerned about the community nurses' opinions if contract topics did not meet with their approval.

A number of practice managers mentioned the considerable workload of the 2004 GMS Contract and the number of team-members involved in the delivery of the contract, in particular to the Quality and Outcomes Framework (QOF) and chronic disease management. The introduction of the 2004 GMS Contract was predicted to create significant amounts of new work for the primary health care team (Shekelle P 2003). Despite this predication, general practices in the United Kingdom were able to achieve high levels of performance in the QOF and a significant increase in payments to GPs (Doran T et al. 2006).

Checkland and Harrison and others have emphasized that much of the 2004 GMS Contract workload was delivered by practice managers and practice nurses

(Checkland K and Harrison S 2010;McDonald R et al. 2009). These findings echoed the changes experienced in the 1990 GP Contract, Hibble commented that the changes brought about by the contract were delivered primarily by practice nurses and practice managers. (Hibble A 1995). Few of these staff groups gained as much financially in comparison to GPs. This was a point raised by community nurses in my study who expressed concerns that some of the practice-based PLT meetings were focused on the performance of the practice in the QOF component of the 2004 GMS Contract. Some had complained that their invitation to attend such meetings was a method of coercing community nurses into visiting housebound patients at home to collect data that would improve the practice's QOF scores. Not all community nurses felt that the 2004 GMS Contract had resulted in divisions within the primary health care team. Some participants alluded to the GPs' reliance on their efforts in data collection and chronic disease management for those patients unable to attend the practice nurses. For these community nurses, this reliance had strengthened their working relationships with GPs since their work was seen to be valuable and visible to practice managers and to GPs.

The 2004 GMS Contract as a barrier to shared learning

It is apparent that the 2004 GMS Contract acted as a barrier for collective learning for some teams during practice-based PLT. A number of research studies identified the impact of the 2004 GMS Contract on the primary health care team, and how for some teams it resulted in divisions within the team (Checkland K et al. 2008;Edwards A and Langley A 2007;Grant S et al. 2008;Guthrie B et al. 2006;Huby G et al. 2008;Marshall M and Harrison S 2005;McDonald R et al. 2007;McDonald R, Campbell S, & Lester H 2009;McGovern MP et al. 2008;Sutton M and McLean G 2006;Wang YY et al. 2006). Although there were divisions in learning, the 2004 GMS Contract did result in benefits for patient care, in particular with regards to chronic disease management (McCarlie J et al. 2007;McGovern MP, Boroujerdi MA, Taylor MW, Williams DJ, Hannaford PC, Lefevre KE, & Simpson CR 2008).

Edwards and Langley interviewed a number of practice managers from one locality in Wales in order to understand the changes experienced by primary health care teams after the introduction of the 2004 GMS Contract (Rhydderch M

et al. 2006). They identified that the structural differences that existed between the general practice and the community nursing team caused a strain within the primary health care team. As with my findings constructed from the perceptions and experiences of the community nursing team, district nurses in Edwards and Langley's study considered the extra work for the QOF component of the 2004 GMS Contract resulted in benefits for the GPs but more work and no benefits, for the district nurses.

In some respects, the conflict between GPs and community nurses at the inception of the NHS in 1948 was replicated by the introduction of the QOF component of the 2004 GMS Contract (Hadfield SJ 1953;Hockey L 1966). Much of the theoretical work that examined team-working and team-learning suggested that being involved in shared tasks usually resulted in closer working relationships (Field R & West M 1995;Katzenbach JR & Smith DK 1993;Øvretveit J 1995;West M & Field R 1995). Although community nurses and GPs may have looked after shared patients, the format of their work dissimilar and had different endpoints. The endpoints resulted in disparate rewards for the separate staff groups of the primary health care team, resulting in a sense of division rather than collaboration.

The relative position of individual nurses in the community nursing team had an influence on how they perceived the work relating to chronic disease management within the 2004 GMS Contract. Some nursing managers saw the improvements to patient care that this contract aimed to achieve for patients, and saw their nurses' efforts in this endeavour as being a legitimate use of their time. This was in marked contrast to community nurses' perceptions related to the workload of the contract. Price and colleagues from Australia reported that nursing managers and nurses may have contrasting perspectives with relation to the quality of care, and that their perceptions were founded on their structural position within their organization (Price M et al. 2007).

Physical structures

Co-location

Although co-location helped some primary health care teams to reduce isolation and increase the amount of team-working and collaboration, teams being co-located in health centres or similar premises in themselves did not guarantee that team work would just happen. Beales identified that the design process and planned use of health centres needed to involve the whole team. Failure to do so resulted in separate staff groups within the team using distinctly isolated sections of the shared building (Beales JG 1978;Cookson I & Millard FW 1970). Beales identified that, for various reasons, GPs were the 'stumbling block' to the introduction of health centres in the 1970s (Beales JG 1978). In some cases GPs refused to be involved or included in the construction and development of health centres, they were fearful that they would lose their autonomy and control over their building and working processes.

Legitimate shared spaces

My research has shown that health centres (or shared premises) need legitimate shared spaces, in other words, physical areas where all team members can feel comfortable, and that allow team-members to mingle, interact and to get to know each other. This finding had comparisons with Sargeant, Loney and Murphy's study which considered that co-location and the opportunities for proximity were important for teams (Sargeant J, Loney E, & Murphy G 2008). They argued that these factors alone were not enough to produce effective teamwork, and that as others have suggested, shared work with common objectives and goals is also required.

Legitimate shared spaces may include formal spaces, such as meeting rooms and conference rooms, but also informal spaces such as coffee rooms, kitchens and canteens. Although co-location was not a recommendation identified by Stinson for group learning, it is clear that shared premises and co-location can be a useful, initial foundation for teams in order for them to get to know each other, and to develop deeper and useful working relationships (Stinson L, Pearson D, & Lucas B 2006). Informal areas such as kitchens and dining rooms may act as areas which encourage informal friendships and alliances between staff groups,

and their absence may have unforeseen consequences (Imison C, Naylor C, & Maybin J 2008).

9.3. Relationships in primary health care

Community nursing team and GPs

The relationships between the community nursing team and GPs have been shown by this research to be variable in the NHS area studied. These relationships seemed to be determined by a number of factors and it was clear that it was patchy and heterogeneous across NHS Ayrshire and Arran. Personalities of senior GPs, practice managers and senior nurses influenced relationships and there was a lack of planning and co-ordination in relation to team-building. As Walker and McClure identified in 1969, the matching of general practices with community nursing teams was undertaken with little thought or preparation, and once teams were considered to have formed in a structural sense, it was assumed that they would function in the sense of a team (Walker JH & McClure LM 1969). My research findings have shown this to be a dangerous assumption.

A number of community nurses felt that their work was unnoticed by the general practice and in particular by the GPs. They felt they were working in a sense of isolation rather than collaboration with the general practice. When team-members gained knowledge of the person and not just the job role, they were then comfortable in sharing and learning from each other. Bond noted in 1987 that "chance meetings" between health professionals, where team-members met in an unplanned and informal manner, encouraged collaborative working (Bond J, Cartlidge A, Gregson B, Barton A, Philips P, Armitage P, Brown A, & Reedy B 1987). These unscheduled meetings clearly cannot readily occur when different staff groups of the primary health care team are not located together, unless they meet in patients' houses during domiciliary visits.

Closer working relationships

Lanham and colleagues emphasized the need for team-members to get to know more about each other than just their job role and functions (Lanham HJ,

McDaniel RR, Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009). From my research findings there seemed to be contrasting experiences of how much was known about individuals within the primary health care team. Some participants recalled positive in-hours and out-of-hours social events at which team members had enjoyed themselves, and which had enabled them to get to know each other better. Some A & C staff had stated that this involved their own families, and the families of their colleagues in their team. At times, there were blurred divisions between professional and occupational lives, and between private lives.

There were references from focus group participants as to how the primary health care team itself was "like a family" and that community nurses felt included. This was especially strong if the efforts to involve the team in this way, originated from the GPs or practice managers. Leadership was important to the development and maintenance of familiarity amongst team members. If GPs and practice managers gave their approval to this concept, or encouraged it by setting precedents and examples, then it seemed to be adopted by the A & C staff, and became a shared culture in the team.

It was noted from the focus groups, as mentioned in the findings chapters, that such teams tended to call each other by their first names. This was not purely for PLT but seemed to occur during normal working activities. This finding was not just symbolic of proximity or familiarity but was also a marker of democracy whereby participants were equal in their state of address to each other. No one had their formal title of 'doctor' or 'sister' used to infer status or hierarchy.

Isolation of health visitors

Many community nurses felt isolated from GPs and these feelings of isolation were particularly apparent in health visiting teams. From their accounts in the focus groups, health visitors spent a lot of time in patient's homes and were thus not visible to the general practice. The focus of their work had changed from health promotion to that of child protection, following much highlighted public concerns about a number of child protection cases (House of Commons Health Committee 2003). Thus, an increasingly focused and specialized service meant that their work contrasted with the generalist nature of the general practice.

West and Field commented that health visitors often perceived themselves to be isolated from primary health care teams (West M & Field R 1995). West and Poulton also highlighted the problems that community nurses faced when working in primary health care teams, and identified the lack of shared work and work objectives, and the dual management system as being contributors to poor team-working (West MA and Poulton BC 1997) . This is paradoxical given the recommendations of child protection inquiries that primary health care teams should work closely together and communicate freely and readily in order to safeguard children.

Legitimate use of PLT

My findings showed the value of developing teams by the use of team-building events which foster relationships, and encourage closer working. Some key individuals in the NHS board area in question considered such events during PLT as an illegitimate use of time. Most of these judgments came from individuals with power, but who were relatively detached from the day-to-day workings of teams. Practice managers described how CHP managers and members of the PLT steering committees did not regard some of the team-building events as being relevant or appropriate PLT topics. There are comparisons with earlier research that showed that the opinions and actions of influential individuals, within the primary care organization, were important to the likelihood of team-building being successful. Walker and McClure state that, in the 1970s, the attitudes of nursing and medical superintendents were important to the formation of primary health care teams (Walker JH & McClure LM 1969).

Use of humour by the primary health care team

Humour was often seen as an indicator of proximity or intimacy within primary health care teams. Individuals who laughed together with others in the team usually enjoyed working together, and there was a perception that humour could help reduce the effects of employment hierarchies within teams. Humour required permission from those with power and if teasing and jokes between staff groups were taken with good grace and considered acceptable by GPs then it led to a sense of proximity. Some fun and enjoyable events during practice-based PLT were perceived to reduce hierarchy. Examples such as self-defence

and self-protection from violent or aggressive patients allowed teams to enjoy each other's company. This was more likely to happen when there was no perceived hierarchy: no one individual or staff group in the team had prior knowledge or experience of a topic or learning activity.

Health care teams in other settings use humour in everyday work. Cooper commented that the use of humour can improve relationships between individuals in teams and lead to improved teamwork (Cooper C 2008). Moran and Massam stated that humour is often used in hospital emergency departments to reduce stress amongst health care professionals and other staff groups (Moran C and Massam M 1997). Other hospital departments such as operating theatres use humour as a method of coping with workload, stress and uncertainty (Chinery W 2007).

Poor working relationships

Some members of primary health care teams described very poor relationships, and this usually involved the GPs, the practice manager or both of these staff groups. In such teams there was little identification of individuals and other staff groups were usually described by their professional role, rather than as a person. A number of participants seemed to know very little about other staff groups in their team, in both a professional and personal sense.

Brooks and colleagues have also alluded to the lack of shared working by primary health care teams, contrasting their deficiencies with the relative success of hospital based teams (Brooks D, Hendy A, & Parsonage A 1981). The research presented in Chapter Three showed that in comparison to other teams studied, primary health care teams often performed less well with regards to effectiveness. The dominance of GPs in the primary health care organization was seen to be one of the main causes of this problem (Molyneux J 2001).

9.4. Learning processes in PLT

Practice managers

Practice managers were seen by many of the research participants as being the natural leaders and organisers of PLT for the primary health care team and in particular for practice-based PLT. All of the staff groups who were interviewed, including the practice managers, envisaged that practice managers were ideally placed in the general practice to undertake this work, and that it was a natural extension to their usual duties. The questionnaire given to NHS Ayrshire and Arran practice managers confirmed that they saw this as a duty for the general practice, but that for many, this expression of duty did not extend to community nurses (Cunningham D, Stoddart C, & Kelly D 2006c).

The variable skills of practice managers in the planning and preparation of learning processes during PLT was an important factor in many of the responses from A & C staff. Baker showed that the practice manager was a crucial performer in the targets set out in the 1990 GP Contract (Baker R 1992). A diverse range of practice managers was found by Newton in 1996, and in the area of PLT education, it could be said that practice managers had variable skills within the area studied (Newton J, Hunt J, & Stirling J 1996).

Practice managers' skills and knowledge

Nursing managers felt it was inappropriate for them to interfere in practice-based PLT. Few practice managers commented in their research focus groups on whether they themselves or their colleagues had the appropriate skills, knowledge and attitudes to use PLT to its maximum potential for the benefit of their teams. Some researchers suggested that a significant number of practice managers were promoted from the ranks of A & C staff, and may not have had a wide range of managerial skills that were needed for their post (Laughlin R, Broadbent J, & Willig-Atherton H 1994). Other research showed that some practice managers were operating in the area of operational tasks rather than strategic tasks (Checkland K 2004;Fitzsimmons P & White T 1997). It is possible that their lack of skills relating to learning processes may have resulted in their use of the pharmaceutical companies in providing for this deficiency.

A & C staff

Habitus

The habitus of the A & C staff had an impact on what they considered was relevant learning for their staff group. Opinions varied about this and some A & C staff participants saw learning about clinical topics during practice-based PLT as being irrelevant for them and outwith their normal range of duties. This finding was in keeping with research which examined education for the primary health care team on the clinical topic of backache (Harvey E, Farrin A, Underwood M, & Morton V 2004;Underwood M, O'Meara S, Harvey E, & The UK BEAM Trial Team 2002).

Clinical work for A & C staff

Some participants in the A & C staff focus groups talked very positively about the expansion of their duties and described how they were becoming resources for patients, escaping from the previous boundaries of their work. One staff member described to her focus group how she had become a resource for patients with chronic illness and disabilities, and helped them to identify local support agencies such as charities and social care organizations. This caused division in her focus group in that some saw her work as being fascinating and breaking barriers, while others saw her role as being invalid. They believed it was not appropriate for her as a clerical worker to become involved with patients and their care in such an intimate way. It was clear that these contrasting opinions suggested that not all A & C staff would welcome an increasing involvement in direct patient care.

This research finding had similarities with other research that showed that the actions and behaviours of A & C staff were very important and relevant to patients, and in particular they were influential to how patients accessed GPs for appointments or house calls (Arber S & Sawyer L 1981;Arber S & Sawyer L 1985;Drury M & Kuenssberg E 1970). A & C staff historically have had little formal training for their work, and although studies have shown that untrained staff are able to perform a wide range of duties competently, their habitus or view of themselves may mean that not all members of that staff group will welcome learning about clinical topics (Eisner M & Britten N 1999;Silverstone R,

Southgate L, & Salkind MR 1983;Thornley C 2000). Eisner and Britten considered that some A & C staff felt that their teams were so hierarchical in structure that this prevented the A & C staff from perceiving that they were working as a team with GPs (Eisner M & Britten N 1999).

It is perhaps paradoxical, but not surprising, that the staff group with the fewest opportunities for learning before PLT started was the group that seemed to have gained the least from PLT (Copeman JP & van Zwanenberg TD 1988;Silverstone R, Southgate L, & Salkind MR 1983). Protected time for learning opportunities for A & C staff had been seen as a desire expressed by practice managers in the past (McLaren S, Woods L, Boudioni M, Lemma F, Rees S, & Broadbent J 2007). The A & C staff focus groups pointed to their limited opportunities to learn from other teams, and felt that the small business model of general practice limited their abilities to learn from other teams. The A & C staff were not empowered to leave their own buildings to venture into the physical structures where other primary health care teams were based. This was in contrast to the relative freedom of GPs, community nurses and practice managers.

Evidence has existed for many years of the benefits of A & C staff learning with and from their GP colleagues, but this study has shown that some teams found this problematic as a consequence of hierarchy and of the power dynamic in primary health care (Middleton JF 1989).

A & C staff as adult learners

Knowles and colleagues summarised their thinking, and that of others, with regards to adult learners (Knowles MS, Holton EF, & Swanson RA 2005). Their adult learning theory consists of a number of elements that have been summarised by me as follows:

- Adults are motivated to learn as they experience needs and interests that learning will satisfy

- Adults' orientation to learning is life-centred, therefore the appropriate units for organising adult learning are life situations, not topics

- Experience is the richest resource for adult learning

- Adults have a deep need to be self-directing

- Individual differences among people increase with age.

A number of A & C staff participants described their situation in the practice and how their experiences of PLT showed that they were not treated as adult learners. Some recalled how practice managers decided for them when options were given by steering committees when organising large central PLT meetings. Others described how their suggestions for practice-based PLT events would be vetoed by either their practice manager or a GP. Participants from the practice managers' focus groups confirmed this. A number of practice managers admitted that they nominated A & C staff to attend events that they themselves as managers, chose. Others did not pass on important booking arrangements to A & C staff preventing them from attending large central events. Key personnel from the steering committees did not always regard education for A & C staff as being vital for the organization (Cunningham D & Kelly D 2007).

Team size

Practice managers alluded to the difficulties of planning and preparing practice-based PLT for smaller practice teams. There were some suggestions that small teams gained by making connections with nearby larger teams but it may be that earlier research helps us to understand the dilemmas of smaller teams with regards to learning processes as well as organizational structures. Some researchers argued that smaller primary health care teams have a narrower range of skills and knowledge compared to larger teams (Law R 1971). Larger teams, because of their economic strength and resources may be able to employ more diverse staff, especially with respect to the practice's management team (Westland M, Grimshaw J, Maitland J, Campbell M, Ledingham E, & Mcleod E 1996). It may be that there is a critical minimum of primary health care team size that is needed to enable practice-based PLT to be of a useful quality. West and colleagues considered that larger teams with a range of diverse staff groups were more innovative and they were able to harness the diversity of their team in order to make improvements to practice (West MA et al. 2003). However, researchers on the theoretical aspects of team-based learning have argued that there were upper limits of size of effective team functioning, and that many

primary health care teams exceeded that maximum (Anderson NR & West MA 1998;Grumbach K & Bodenheimer T 2004).

PLT – the potential unrealised

The call for PLT

A number of academics and educationalists had called for primary health care teams to have PLT in order to work together more effectively and to become learning practices (Berwick D 1996;Clark PR 2009;Dean P, Farooqi A, & McKinley RK 2004;Pitts J, Curtis A, While R, & Holloway I 1999;Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004a;Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004b;Rushmer R, Kelly D, Lough M, Wilkinson JE, & Davies HTO 2004c).   Others published studies showing that time could be used effectively when primary health care teams were given such opportunities (Campion-Smith C & Riddoch A 2002;Carlisle S, Elwyn G, & Smail S 2000;Cross M & White P 2004a;Cross M & White P 2004b;McMillan R & Kelly D 2005;Rutherford J & McArthur M 2004;Wilcock PM, Campion-Smith C, & Head M 2002). I argue that there were contrasts between my findings and the findings of the specific projects listed above. Exploration of their research shows that the studies were based on teams who had volunteered to take part in new and shared educational endeavours. It is possible that such teams were more likely to react positively to such opportunities and may have had the organizational and personal attributes that would welcome PLT. My findings were based on the perceptions and experiences of individuals from a wide range of primary health care teams (potentially from 57 teams within NHS Ayrshire and Arran). What was apparent from these was that a number of teams were not ready for PLT for their primary health care team. It is of significance that the academic call and empirical research of earlier work was not based on the diverse range of teams that participated in my study.

9.5. Comparisons with the literature regarding team-based learning

Teams or organizations?

Borrill and colleagues suggested that larger primary health care teams were functioning in the sense of an organization rather than a team (Borrill CS, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D, & West M 2000). Their study showed that in comparison to other types of teams under scrutiny, primary health care teams were often much larger. As mentioned earlier in this chapter, some practice managers struggled to provide relevant learning for everyone in the team who potentially could attend practice-based PLT. As Borill and colleagues suggested, many teams were the size of small organisations, yet few practice managers had training in working in this way.

In the study, community nurses described how some junior nurses felt detached and unwelcome at practice-based PLT resulting in declining rates of their attendance. It may be that this was related to poor working relationships between staff groups, but it could also be aggravated by a lack of knowledge of other team members simply because teams were large, and relationships could therefore be distant. Some community nurses acknowledged that their own team was large, and that it was unrealistic for practice managers to be aware of the learning needs of diverse individual roles, within the community nursing team.

Inter-personal relationships

A number of the studies in Chapter Three stressed the importance of strong and effective inter-personal relationships between individuals in teams. In my findings, teams who know each other well and had effective working relationships with each other often showed a number of the attributes identified by earlier research (Guzzo RA & Shea GP 1990;Lanham HJ, McDaniel RR, Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009;Mickan SM & Rodger SA 2000b;Øvretveit J 1996).

Mutual respect

The concept of mutual respect and of a sense of team cohesion gained from this respect, was mirrored in my own research findings. Some of the research participants who were health visitors illustrated that relationships in a small number of practices were poor, and that they had been poor for many years before the research took place. It was as if GPs did not value certain staff groups rather than specific team members, and that this attitude persisted amongst the GPs over long periods of time. Molyneux stressed how effective the team she belonged to was in working together, and suggested that the lack of a GP in her team favoured this effectiveness (Molyneux J 2001). In my study, a number of health visitors perceived that GPs held a number of negative attributes that led to poor team-working. GPs were perceived to be dominant, not prepared to listen to others, and to place little value on the work of others. They were also perceived to adopt a leadership role within the team that was based on their position and social capital, rather than whether they had the relevant attitudes, skills and knowledge pertaining to quality leadership. This finding has comparisons with Reid's work which showed that, in another health board area, GPs were least likely to be ready to learn from other professionals (Reid R, Bruce D, Allstaff K, & McLernon D 2006).

Management and leadership

Mickan and Rodger, Guzzo and Shea, and Øvretveit stressed the importance of effective management and leadership of teams in order to influence and contribute to team performance and effectiveness (Guzzo RA & Shea GP 1990;Mickan SM & Rodger SA 2000a;Øvretveit J 1996). Their studies did not allude to teams that shared dual management when considering the special situation of community nurses. Nor did they concern the special context of practice managers who must manage GPs, but are directly employed by them.

Purpose and processes of the team

Mickan and Rodger considered that clear purposes and goals were important for teams and enabled them to be clear about individual and team functions (Mickan SM & Rodger SA 2000a). Tallia, Lanham and colleagues emphasized the importance of 'mindfulness' and of 'inter-relatedness'(Lanham HJ, McDaniel RR,

Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009). Both groups of authors stressed the importance of team members seeing what others in the team did, and how work was inter-connected and involved other individuals and other staff groups. This was under strain in some of the teams involved in my research. A number were unaware of each other's work and purpose and isolation caused by structural barriers (both physical and organizational) resulted in narrow visions of the team's purpose. Participants saw their actions in the view of an individual rather than collectively – as part of a team.

Communication

A number of the papers relating to the research of team-working saw communication as being a key component to the effectiveness of team-working (Grumbach K & Bodenheimer T 2004;Lanham HJ, McDaniel RR, Crabtree BF, Miller WL, Stange KC, Tallia AE, & Nutting PA 2009;Mickan SM & Rodger SA 2005;Molyneux J 2001;Sargeant J, Loney E, & Murphy G 2008). Recommendations included an 'open' communication style where formal and informal communications would be valued and welcomed by team members. Different modes of communication were also deemed to be important to teams. Thus face-to-face meetings were seen as being complementary to printed and electronic communication methods. This had resonance with community nurses in my study. This staff group welcomed open communication with GPs and with practice managers and they valued the opportunity to discuss problems and patients with relevant people in the team without appointments or set times to do so.

A & C staff also considered informal communication to be important for their effective working. There were contrasting reports about the ability of A & C staff to speak to GPs directly. This was often aided by teams who used first names when talking with each other, rather than surnames or job titles.

9.6. The grounded theory element of power and comparisons to the literature

Introduction

In this section I want to consider my theoretical element of power in the context of some of the literature concerning power. The element of power was evident in the participants' perceptions of what happened at PLT, and also seen in the learning processes used during PLT events. Participants considered how some individuals in their teams were able to influence or control what happened at PLT meetings, and additionally, influenced who attended and what was learned at such events. Some participants discussed how some in their primary health care team could be enabling or empowering within the context of working and learning. There were contrasting perceptions that others could be controlling and disabling. In general, A & C staff reflected on the behaviour of their practice manager in this regard, whereas the community nursing team reflected on the behaviour and attitudes of both GPs and practice managers.

Lukes' view of power

Clegg provided an overview of a number of philosophies concerning power from the 17th century to the end of the 20th century (Clegg SR 1989). Clegg considered that Lukes' published works on power have considerable relevance on current thinking on power today. Lukes has published several texts that present his views on power (Lukes S 1974;Lukes S 2005). He has reviewed and explored the work of a number of sociologists and academics who had an interest in power, and Lukes is considered to be a major contributor to the theoretical understanding of power (Bernhagen P 2003;Hay C 1997). Lukes conceptualised power and presented these conceptions in three views or dimensions. The one dimensional and two dimensional view conceptualised the earlier thinking of Dahl, and of Bachrach and Baratz respectively.

One dimensional view

Lukes drew on earlier conceptions by Dahl, which in turn were developed from the work of Weber (Dahl RA 1957;Dahl RA 1961). The one dimensional view of

power is often termed: "the pluralist view." (Lukes S 1974) Dahl expressed this view of power as:

> "A has power over B to the extent that he can get B to do something that B would not otherwise do." (Dahl RA 1957)

In addition, the pluralist, or one dimensional view of power seeks to observe or examine the behaviour of individuals who have power in the decision-making process, or in the ability to determine policy. As Lukes stated:

> "Thus I conclude that this first, one-dimensional, view of power involves a focus on *behaviour* in the making of *decisions* on *issues* over which there is an observable *conflict* of (subjective) *interests*, seen as express policy preferences, revealed by political participation."
> (Lukes S 1974) (Original emphasis)

Two dimensional view

Lukes presented his concept of the two dimensional view of power which was initially posited by Bachrach and Baratz, as an alternative view to the one dimensional view of Dahl and other pluralists (Bachrach P and Baratz MS 1962;Lukes S 2005). Bachrach and Baratz emphasized the need to explore the concept of power, and stressed that power existed in a variety of formats. Lukes interpreted the importance of Bachrach and Baratz's two dimensional view of power as:

> "Their central point is this: to the extent that a group or person – consciously or unconsciously – creates or reinforces barriers to the public airing of policy conflicts, that person or group has power."
> (Lukes S 2005)

Bachrach and Baratz described a typology of power, stressing that power exists in a variety of forms. They suggested that power could be seen as "coercion", where power is enforced by the "threat of deprivation." (Bachrach P & Baratz MS 1962) They also described "influence" whereby a party can cause others to change their course of action, but without the need of a threat to do so. In addition, Bachrach and Baratz described "authority" as a form of power were one party recognises that the command or instruction of another party is a reasonable or legitimate one to follow or obey. Pfeffer agreed with this view, seeing authority as a legitimate form of power (Pfeffer J 1981). Lukes

considered these different expressions of power in the context of whether there was a conflict of interest, or not.

Lukes emphasized that Bachrach and Baratz's considered that power can operate in two different ways. One way is by the direct application of power, used in the one dimensional view described by Dahl to achieve the aims of the party with power. The second way was of the development of a context, or working conditions, where those individuals without power may not be able to recognise that they could or should have the ability to determine their own actions. Bachrach and Baratz concluded that:

> "A set of predominant values, beliefs, rituals and institutional procedures (rules of the game) that operate systematically and consistently to the benefit of certain persons and groups at the expenses of others. Those who benefit are placed in a preferred position to defend and promote their vested interests. More often than not, the 'status quo defenders' are a minority or elite group within the population in question." (Bachrach P & Baratz MS 1962)

Thus, Bachrach and Baratz stressed that those individuals or groups with power can control others through the manipulation of working conditions, cultures, traditions and environments. Thus, individuals with power can control because they are in charge of decisions, and because they are in charge of the context and environment. Lukes described these two elements as "decision-making and non-decision making." (Lukes S 1974)

Bachrach and Baratz stressed that non-decision making was:

> "…a means by which demands for change in the existing allocation of benefits and privileges in the community can be suffocated before they are even voiced; or kept covered; or killed before they gain access to the relevant decision-making arena; or, failing all these things, maimed or destroyed in the decision-implementing stage of the policy process." (Bachrach P & Baratz MS 1962)

In this way, conflict between groups is avoided and individuals are not aware of their potential to determine their own lives and decisions. In some respects, this has a degree of overlap with Bourdieu's thinking on habitus. Bourdieu suggested that power in an educational context was legitimised by the habitus of existing groups of people, and that certain groups did not think it was appropriate for

them to challenge existing structures and prejudices. Their own self-view, or habitus prevented them from development.

A schematic diagram of Lukes' interpretation of Bachrach and Baratz's typology of power is reproduced below:
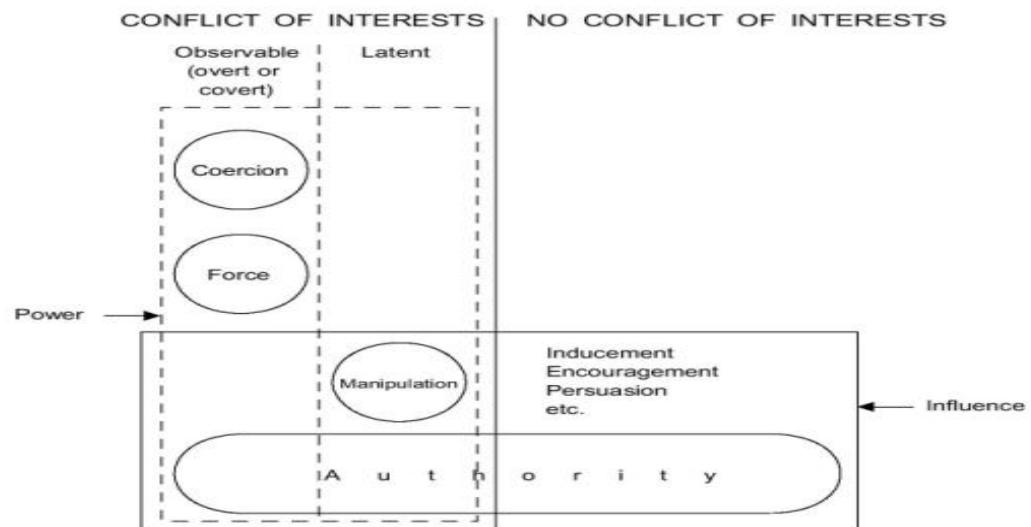
Figure 2: Different forms of power and their relationships. (Reproduced from Lukes: Power – A Radical View 1974)

Interpretation of Lukes' Diagram on power

The diagram captures the different forms of power and illustrates how the forms are located within two different arenas: whether there is conflict of interest between parties or not. The importance of observing behaviour is noted. As Clegg emphasized, the observation of behaviour is only one method of interpreting which party has power (Clegg SR 1989).

Three dimensional view

Lukes three dimensional view builds on the earlier one and two dimensional views of power. Lukes argued that his third dimensional view of power: "allows one to give a deeper and more satisfactory analysis of power relations than either of the other two." (Lukes S 1974) In addition, Lukes argued that the two dimensional view of power was too restrictive, as some manifestations of power did not involve conflict between parties. For example, those with power may use strategies such as manipulation or of authority, where conflict is not obvious.

Lukes argued that the manipulation of context was important in controlling what others do without resorting to coercion, force or manipulation. Lukes stated:

> "Decisions are choices consciously and intentionally made by individuals between alternatives, whereas the bias of the system can be mobilised, recreated and reinforced in ways that are neither consciously chosen nor the intended result of particular individuals' choices." (Lukes S 1974)

> "Moreover, the bias of the system is not sustained simply by a series of individually chosen acts, but also, most importantly, by the socially structured and culturally patterned behaviour of groups and practices of institutions, which may indeed be manifested by individuals' inactions." (Lukes S 1974)

Thus Lukes argued that the use of power was not simply concerned with decision making, or conflict, but with the construction and maintenance of systems and cultures that resulted in individuals not having power, and also not being able to envisage the advantages of having power. As Lukes maintained:

> "Indeed, is it not the supreme exercise of power to get another or others to have the desires you want them to have – that is, to secure their compliance by controlling their thoughts and desires?" (Lukes S 1974)

Hay analysed Lukes three dimensional view of power further. Hay concluded that with regard to the first and second dimensional view of power:

> "…power is a behavioural phenomenon which is immediate, directly observable, and empirically-verifiable, in the second, power refers to the capacity to redefine structured contexts and is indirect, latent and often an unintended consequence." (Hay C 1997)

Hay developed Lukes work further by suggesting that power has two modes of action (Hay C 1997). Hay argued that person A's power can directly affect the conduct or behaviour of person B, but that power can also be used indirectly to shape the context in which B is involved. Thus, power is conduct-shaping and also context-shaping.

Relevance to the element of power in the context of PLT

A number of primary health care teams demonstrated, by their use of PLT, who held power in the team, and how this power was used to decide what was

offered at PLT. Power was also important in the decision making of who from the team was able to attend the PLT events. If we consider the typology of power as presented by Bachrach and Baratz, much of the power was exerted as influence or authority, rather than by the use of force or of coercion. In addition, some participants were not able to envisage that they were entitled to have an opinion about what happened during PLT, nor did they see that they could benefit personally as a consequence of learning. Those with power had, consciously or unconsciously, developed a culture that disabled some in the team from valuing learning. As Hays argued, those with power were able to control the behaviours or conduct of others in the team, but in addition, were able to shape the context of how the primary health care team operated. For example, a number of A & C staff preferred to work during PLT rather than learn, and did not perceive the benefits of further training and learning. A number of managers shared this view and reinforced it, rather than challenged it. As a consequence the practice manager focused his or her activities on the clinicians in the team.

Power was noticeable in the learning environment or atmosphere at practice-based PLT. For some teams, the cold reception that some of the community nursing team faced when they attended, was an example of how the GPs manipulated PLT for their own benefit. Authority was also used by practice managers as they sought to legitimize the practice's learning when topics relevant for the new contract were chosen. The dominance of medical practitioners in primary health care teams was identified by other researchers (Calnan M and Gabe J 1991;Molyneux J 2001;Øvretveit J 1985;Porter S 1992;Svensson R 1996). This research has shown that the phenomenon of power also affects primary health care, and to a degree involves practice managers. The employment structure evident in primary health care teams is an example of how such structures can demonstrate who has, and who maintains power. Not all GPs and practice managers used their authority in a negative sense at PLT. A number of practice managers had delegated the planning and preparation of PLT to assistant practice managers, and senior receptionists and this was seen by participants as being enabling and empowering.

Lukes' concept of power in relation to my theoretical element

Studying the above literature on power has encouraged my reflection on this theoretical element of my grounded theory. Perhaps power is too general and simplistic a term, and that the definitions of different forms of power are useful in considering how PLT is shaped by primary health care teams. The ways in which power is used to both influence conduct, but also shape context in the setting of PLT increases the understanding of it.

Chapter Ten – Conclusions

"Insanity. Doing the same thing over and over, and expecting different results." (Albert Einstein 1879 – 1955)

10.1. Introduction

Aim of the thesis

The aim of this thesis was to explore and understand the perceptions and experiences of practice managers, A & C staff, and the community nursing team on PLT. A further aim was to construct a grounded theory from the perceptions and experiences that would help to improve the understanding of what was happening during PLT. Data generated was rich and participants talked freely and honestly about their experiences. It was possible to construct a theory grounded in the data that led to a deeper understanding of the phenomenon of PLT.

Strengths of the thesis

There were various strengths of the thesis. A significant number of participants were involved with the research, and their focus group interviews were grounded in some years of experience of PLT. Participants were from a large number of primary health care teams in three CHP areas within one Scottish health board. Participants were from different sizes of primary health care team, and a range of staff groups participated. Within each staff group were individuals with distinctly different duties and responsibilities. The long timeframe of the study allowed for iterative changes which helped with theory development. Theory was developed from an integrated analysis of all four staff groups undertaken in a holistic sense, rather than the representation of each staff group in isolation from the others.

The thesis focused on those members of the primary healthcare team who did not value PLT, or did not attend events regularly. The views of staff not normally involved in research added to the literature concerning such staff groups. A&C staff are under-represented in research, yet are an important group to consider, given their function in primary care, and the very size of this

staff group. A&C staff have an important role in the delivery of care to patients and this is often not visible to others and to researchers.

The study followed the grounded theory methods recommended by Charmaz, and her methods were used to conceptualise the entire thesis (Charmaz K 2006). Although some modifications were made, for example to the coding strategy, the key methods of her developed grounded theory were employed. The thesis did construct a grounded theory, grounded in the perceptions and experiences of the staff groups who participated, and this theory was compared to the theories of two others: Pierre Bourdieu and Etienne Wenger. This was done by employing the constant comparative method – a key component of the grounded theory method. Kennedy and Lingard have commented that a number of grounded theory studies do not follow grounded theory methods, and as a consequence, no theory is produced (Kennedy TJT & Lingard LA 2006).

The thesis was able to challenge the assumptions about the functioning of primary health care teams. Since the late 1970s, there has been an assumption that primary health care teams will be able to deliver complex care to patients using a multi-disciplinary approach (Waine C 1992). This thesis challenged these assumptions, and illuminated that the delivery of primary health care is not straightforward, and exposed the difficulties and problems of staff groups faced by working within some teams.

Weaknesses of the thesis

There were weaknesses also. Practice nurses and GPs were not interviewed, nor were others in the primary health care team who may have participated in PLT but were not included in the recruitment to focus groups. These staff groups might have held differing perceptions and experiences and contrasting opinions when compared to those who participated in the research.

The process of recruitment to the focus groups had weaknesses. It proved difficult to find A & C staff without using practice managers as a contact. A & C staff are directly employed by GPs, and they do not feature on a centralised record within the health board or CHP. This reflects the nature of employment structures in general practice. Although the method of recruitment used was

pragmatic, it might have allowed practice managers to select A & C staff who had benevolent opinions of their own practice-based PLT, or who valued the efforts of their own practice manager's role in PLT. Two general practices in North Ayrshire CHP did not take part in PLT. One had not participated since the time of the scheme's inception, and a second practice left the scheme after three years. It might have been fruitful to interview key informants from these practices to see what their perceptions and experiences of PLT were, and to explore their thoughts on non-participation.

10.2. Key findings and contribution to knowledge

Deeper understanding of PLT

This thesis constructed a deeper understanding of what was happening during PLT, and what the underlying reasons for this were. An understanding of the social processes of teams was gained: during PLT and also outside of PLT. How primary health care teams made decisions was illuminated by the research and how power was used by certain staff groups. This thesis adds to the small number of published studies which have described and evaluated PLT.

The research illuminated the needs of teams to improve team-working and team learning. There was an assumption when PLT started in 2001 that teams would be well placed, and well prepared, to make effective use of PLT. The research has identified that a number of primary health care teams need to focus learning efforts on the processes of team-working, and need help to learn how to become a team. It was clear from the perceptions and experiences of a number of participants that their team struggled with the concept and practicalities of teamwork, and that some teams were a team in a structural sense rather than a functional one. Over the years of the NHS, a number of researchers emphasized the importance of effective teamwork but also of the importance of planning for teamwork and of maintaining it (Brooks D 1983;Pringle M 1992;Walker JH & McClure LM 1969).

Cultural values

The thesis challenged how primary health care teams worked and interacted with each other. Established cultures and hierarchies were exposed by the research, and it seemed difficult for some NHS managers, operating at health board level, to challenge the long-term thinking of some general practices. Nursing managers found these cultures difficult and were resigned to the problems that stemmed from them. Primary health care teams could have markedly contrasting cultures yet be separated by only a few miles from each other in a geographical sense.

Practice managers

An assumption before PLT started in NHS Ayrshire and Arran was that practice managers would be able to deliver a number of practice-based PLT events, and that they would be able to plan and prepare for these events. It was likely that a number of practice managers struggled with these processes and needed help with the adoption of effective learning processes. There was no training needs assessment undertaken by the PLT steering committee prior to the pilot phase, or when the scheme was extended to the two other CHPs. All staff groups felt that the PLT learning needs assessment at some point was ineffective, and this resulted in irrelevant learning being offered to a number of individuals. With time, these individuals stopped attending and participating in PLT and worked instead, often preferring this.

The power of general practitioners

Although a number of staff groups made up the primary health care team, the GPs, and to some degree practice managers, held the power within the team, and made key decisions. Indeed the GPs were often the staff group that determined whether the entire team took part in PLT, determined whether learning topics were undertaken or not, ultimately decided who participated in PLT. It was clear from the research findings that such power brought disruption to teams and that this power could be disabling. The employment structure of general practices may cause this, but GPs are not the only profession in primary health care that have this business model. Professions such as pharmacists, optometrist and dentists have similar arrangements in primary health care.

Size of teams

Large teams with separate premises, and separate working areas often behaved as an organisation, rather than as a team. In these practices, Individual staff groups were more accurately working in the sense of a team. Although larger teams often had more practice managers possibly with a wider range of educational skills, these could be hampered by communication problems and lack of leadership of PLT. As a consequence, some primary health care teams were not ready to make effective use of PLT.

Legitimate learning

A number of individuals from different staff groups raised the issue of legitimate learning. They described events that had brought the team closer together, and resulted in deeper working relationships and increased proximity. Others, who were distant from the team but who were influential and powerful, were critical of these events and perceived that they did not appear to be learning events, at least in their eyes. They had a narrow view of learning and needed to expand their thinking on this.

Contribution to knowledge

This thesis contributed to the knowledge of collective learning within primary health care, by constructing a deeper understanding of how primary health care teams learn and function, both within PLT, but outside of it also.

10.3.Implications and recommendations

This thesis has identified a number of weaknesses, both about PLT and also about primary health care teams. The research findings and grounded theory have implications and recommendations for a number of individuals, staff groups and organizations within the NHS.

Implications and recommendations for practice managers

The attitude of practice managers towards the primary health care team and its learning opportunities was a key finding in this thesis. Just as Baker identified their employment as being key to the success of general practices after the

introduction of the 1990 GP Contract, I would argue that they are the single most important individual for PLT (Baker R 1992). Practice managers come from a range of backgrounds and it was clear that some practice managers struggled with the learning processes of PLT. Yet their attitude, skills and knowledge of learning and development were crucial to the team, and many participants benefited from their enthusiasm. In contrast, a number of participants found that their practice manager could prevent their attendance at large PLT meetings, and disable their learning experience at practice-based PLT.

Some practice managers were susceptible to criticism from others in primary health care: CHP managers were one such group and their criticisms disabled risk-taking. Practice managers should be encouraged to take risks with regards to learning, and to encourage honest feedback in evaluation processes which might lead to improved educational activities.

Implications and recommendations for A&C staff

Many in the A&C staff teams were keen to learn from each other and from others in their primary health care team. PLT enabled this and allowed this staff group to widen their experiences of their community and of NHS services. At times, their own habitus restricted this, and this needs to be challenged. A&C staff require the development of their own fora, to allow the sharing of learning and of ideas. In addition, A&C staff need to represent themselves on PLT steering committees to increase their voice. Clinical learning is allowed to dominate the PLT agenda, but it was clear from the research findings that a wider learning curriculum was needed.

Implications and recommendations for educational authorities

Practice managers may need additional resources to enable them to maximise the potential for PLT. The identification of learning needs was vital for the effectiveness of PLT, as was the employment of learning methods that participants enjoyed and found beneficial. The development of a learning needs assessment tool for all of the primary health care team may prove valuable, as would additional training for practice managers in selecting and using effective learning methods. If practice managers are not helped with these endeavours, then it was clear from the experience of participants, that pharmaceutical

representatives were willing and able to provide for this gap. The costs of this involvement may not be readily apparent to the NHS.

Implications for Health Boards and The Government

The call for shared premises that may facilitate shared working was first made more than 90 years ago, in 1920 (Ministry of Health - Consultative Council on Medical and Allied Services 1920). Surveys and studies of primary health care teams and their premises during the 1960s and 1970s showed that co-location had increased but was still not common place. It is unlikely that all primary health care teams will be co-located in the near future, but if shared premises are to be constructed, it is important that they have shared legitimate spaces to encourage mingling and informal interactions between different staff groups.

CHPs need to engage more with primary health care teams and with practice managers in particular, in order to make effective use of large centrally organised PLT events. They need to ask more questions from participants, provide learning focused on learning needs when they are given to CHPs, and work more collaboratively with teams.

Different employment structures may result in PLT having different outcomes than that experienced in NHS Ayrshire and Arran. Changes in NHS England have resulted in different employment structures in comparison to Scotland. Some entrepreneurial GPs have become leaders and employers of a number of primary health care teams, and some teams are now directly employed by Health Authorities. As a result general practitioners are not the employers of other staff groups, and their power may be different compared to the traditional structure in Scotland. Such structural changes in the traditional NHS contracts with GPs in NHS England might have an effect on teamwork and on team learning (Department of Health 2004;McDonald R 2009;Pollock A et al. 2007).

The introduction of GP fund-holding with the 1990 GP Contract resulted in some general practices directing the work of their attached community nurses (Department of Health 1990;Wood N, Farrow S, & Elliott B 1994). It would be of interest to progress further studies of these functional and employment arrangements to see what the consequences would be for patient care.

The literature review and research findings of this thesis illustrated that the GP charter and contracts from 1965, 1990 and 2004 had significant consequences for all in the primary health care team, and especially for A&C staff, practice managers and practice nurses. These contracts were negotiated by the Department of Health and negotiators from GP professional bodies, and the opinions of other staff groups were generally not included. GP contracts were negotiated uni-professionally, but their consequences were multi-professional. Borrill and colleagues emphasised that separate reward systems developed by the Government and the NHS do not support team working:

> "…NHS management directly undermines teamwork in primary health care when they provide bonus systems to GPs as independent contractors, despite the whole team contributing to the final outcome." (Borrill CS, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D, & West M 2000)

It may be preferable for contracts to be negotiated across different professions and staff groups. Borill and colleagues also maintained that the relatively small size of primary health care teams and their isolative and competitive working styles prevented easy and rapid spread of developments throughout primary health care.

Implications for community nursing

Community nurses were keen to have shared learning with the rest of the primary health care team. Many expressed how they valued working with the general practice and were keen to work with general practitioners as equal partners. They perceived that the learning offered to them at PLT was not relevant to them, as it did not meet their learning needs. Nursing managers may need to work with practice managers in sharing the managerial role especially in the area of teamwork and shared learning. The managerial conflict is not helpful to community nurses and this problematic area requires a degree of managerial collaboration rather than conflict. The sharing of community nurses' appraisals with practice managers may be one solution if considered appropriate for those involved. District nurses found that their service cover during PLT was inadequate and nursing managers need to develop alternative models and solutions that provide adequate cover for safe patient care.

The debate concerning the structures of the community nursing team continues in NHS Scotland and leadership is needed to determine what model would impact on teamwork positively (Scottish Executive 2006). The debate concerning the attachment to specific general practices and the move to locality nursing has continued over many years, and community nurses need to know to which team they belong (Anderson JAD, Draper PA, Kincaid IT, & Ambler MC 1970;Department of Health 1986;Jarman B & Cumberlege J 1987).

Implications and recommendations for GPs

Those participants who identified effective PLT events often described close working relationships with GPs. A number of participants were keen to reduce the hierarchy in primary health care. GPs need to engage with these calls, and to value team-building events. They may need to consider how their primary health care team may gain from a learning event, rather than just their personal gain. They need to develop enabling strategies for their staff, and they need to restrict their usual predisposition to control PLT and the primary health care team.

10.4.Further research

The completion of research in one area often leads to the development of further research questions, or the adoption of different research approaches.

Other staff groups

In this thesis, the research questions were posed to three of the main staff groups who regularly took part in PLT, and to nursing managers. The perceptions and experiences of these four staff groups were presented. The questionnaire surveys of PLT to the North and East Ayrshire CHPs also included GPs and practice nurses. The survey responses from these two staff groups suggested that they valued PLT, wanted it to continue and that they regarded it positively. It is possible that this might have changed since 2004 and gaining the perspective of these staff groups would be worthwhile. Thus, future research should include them, and could also include other staff groups who have an interest in PLT. Staff groups such as pharmacists and allied health professionals

may have different perceptions and experiences of learning with the primary health care team, and it would be interesting if these could be collated and analysed.

Different research methodologies

Other research methodologies and methods could be used to answer different research questions. Ethnographic research methods could enable the construction of different perceptions about PLT and give in-depth information about what happens during PLT, and in particular practice-based PLT. It would be valuable to identify primary health care teams who judge that their practice-based PLT is effective, but also to identify teams who have contrary opinions about PLT, or who have withdrawn from the PLT scheme altogether. It would be useful to conduct in-depth interviews with key informants from such teams to further understanding about how primary health care teams learn with, and from, each other.

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List of appendices

Appendix 1 – Information sheet for A & C staff and practice managers' focus group participants

Appendix 2 – Consent form for research phase one

Appendix 3 – Information sheet for community nurses and nursing manager focus group participants.

Appendix 4 – Consent form for research phase two (community nurses and nursing managers)

Appendix 5 – Mind Map – Non-medical members of the Primary Health Care Team: Their Perceptions and Experiences of Protected Learning Time

Appendix 6 – Mind Map – A&C Staff. Relationships in Primary Health Care (Example of coding and theme construction)

Information Sheet

What do non-clinical members of primary health care teams think about protected learning time in Ayrshire?

You are being invited to take part in a research study. Before you decide to take part, it is important for you to understand why the research is being done, and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Consumers for Ethics in Research (CERES) publish a leaflet entitled "Medical Research and You". This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy will be made available to you.

Thank you for reading this.

What is the purpose of the study?
The LHCCs in Ayrshire are keen to know the thoughts and opinions of non-clinical members of primary care teams concerning the current protected learning time (PLT) in Ayrshire. As you know this has been running for a few years and the organisers are very interested in your experiences of this and as to how it could be improved. They value your opinion and hope to learn from it and to make PLT better.

We have asked various people; managers, receptionists, clerical and administrative workers to take part, and have arranged them into groups to allow them to discuss their opinions. We hope to have 9 groups and will run the study over approximately 6 months, from June 2005 to December 2005.

Why have I been chosen?
We have selected primary care team members who have been to at least 3 PLT meetings in any of the three LHCCs in Ayrshire. We will likely have approximately 8 people invited to each focus group, and will hold 9 focus group sessions.

Do I have to take part?
Taking part in this research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
The focus group meeting will last about 60 to 90 minutes, with about 15 minutes of discussion with the researcher at the end. You will only attend one meeting with similar colleagues. The researcher will introduce topics for you to talk

about in the group, and with your agreement, will tape record the discussion. This will be transcribed anonymously, that is no-one will be able to identify what you say in the discussion. We guarantee that no single person will be able to be identified from what they have said in a group. Once this material is typed up, you will be given a copy to see if it is accurate and to gain your agreement. We hope to hold these groups in time allocated for PLT, and will be providing a private room with lunch and light refreshments.

What are the risks of taking part?
The research team can't think of any serious risks of taking part. We will take every step possible to prevent comments from group members from being identified as coming from any one individual.

What are the possible benefits of taking part?
The LHCCs hope to improve the quality of PLT for non-clinical members of primary health care teams, and learning what your opinion and thoughts are of this scheme will greatly help in this.

Will my taking part in this study be kept confidential?
All information which is collected during the course of the research will be kept strictly confidential. Any information about you which leaves the focus group room will have your name removed so that you cannot be recognised from it.

What will happen to the results of the research study?
The research team will analyse all the comments and thoughts produced by the focus groups and look for trends and themes. They will produce a report for the LHCCs and the Community Health Division explaining what these are.   The research team hope to publish this in a journal to allow other areas in the UK to learn from your experiences. All quotes and experiences will be anonymised so that anyone reading the report will not be able to identify you.

Who is organising and funding the research?
The research is being funded by the 3 LHCCs in Ayrshire and also supported by the Research Department of Ayrshire and Arran Community Health Division.

Who has reviewed the study?
The design of this study has been reviewed by Research and Development Department of Ayrshire and Arran Community Health Division and also by NHS Education for Scotland.
The study has been approved by the Ayrshire and Arran Research Ethics Committee.

Contact for further information.
Dr David Cunningham
The Surgery
9 Frew Terrace
Irvine
KA12 9DY

Thank you for taking part in this study!
        10.02.05 Version 1

CONSENT FORM
Focus group participants
A & C staff/practice managers

Title of Project: A qualitative research study into PLT education

Name of Researcher: David Cunningham

Please initial box

1. I confirm that I have read and understand the information sheet dated 01.05.2005 (version 1) for the above study and have had the opportunity to ask questions.

<!-- box -->

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

<!-- box -->

3. I agree to take part in the above study.

<!-- box -->

4   I agree to the group discussion/interview being audio-taped and transcribed

<!-- box -->

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Person taking consent   Date   Signature
(if different from researcher)

___DAVID CUNNINGHAM_____   _____
                                                          _____
Researcher   Date
                                          Signature

1 for participant; 1 for researcher;

Appendix 3 – Information sheet for community nurses and nursing manager focus group participants.

Information Sheet

What are the perceptions and experiences of the community nursing team with regards to protected learning time?

You are being invited to take part in a research study. Before you decide to take part, it is important for you to understand why the research is being done, and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Consumers for Ethics in Research (CERES) publish a leaflet entitled "Medical Research and You". This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy will be made available to you.

Thank you for reading this.

<u>What is the purpose of the study?</u>
The LHCCs in Ayrshire are keen to know the thoughts and opinions of the community nurses and of nursing managers with regards to the current protected learning time (PLT) in Ayrshire. As you know this has been running for a few years and the organisers are very interested in your experiences of this and as to how it could be improved. They value your opinion and hope to learn from it and to make PLT better.
We have asked various people to take part and have arranged them into groups to allow them to discuss their opinions. We hope to have approximately 3 groups and will run the study over approximately 9 months, from January 2007 to October 2007.

<u>Why have I been chosen?</u>
We have selected community nursing team members who have been to at least 3 PLT meetings in any of the three LHCCs in Ayrshire. We will likely have approximately 8 people invited to each focus group.

<u>Do I have to take part?</u>
Taking part in this research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

<u>What will happen to me if I take part?</u>
The focus group meeting will last about 60 to 90 minutes, with about 15 minutes of discussion with the researcher at the end. You will only attend one meeting with similar colleagues. The researcher will introduce topics for you to talk about in the group, and with your agreement, will tape record the discussion. This will be transcribed anonymously, that is no-one will be able to identify what

you say in the discussion. We guarantee that no single person will be able to be identified from what they have said in a group. Once this material is typed up, you will be given a copy to see if it is accurate and to gain your agreement. We hope to hold these groups in time allocated for PLT, and will be providing a private room with lunch and light refreshments.

What are the risks of taking part?
The research team can't think of any serious risks of taking part. We will take every step possible to prevent comments from group members from being identified as coming from any one individual.

What are the possible benefits of taking part?
The LHCCs hope to improve the quality of PLT for non-clinical members of primary health care teams, and learning what your opinion and thoughts are of this scheme will greatly help in this.

Will my taking part in this study be kept confidential?
All information which is collected during the course of the research will be kept strictly confidential. Any information about you which leaves the focus group room will have your name removed so that you cannot be recognised from it.

What will happen to the results of the research study?
The research team will analyse all the comments and thoughts produced by the focus groups and look for trends and themes. They will produce a report for the LHCCs and the Community Health Division explaining what these are.   The research team hope to publish this in a journal to allow other areas in the UK to learn from your experiences. All quotes and experiences will be anonymised so that anyone reading the report will not be able to identify you.

Who is organising and funding the research?
The research is being funded by NHS Education for Scotland

Who has reviewed the study?
The design of this study has been reviewed by Research and Development Department of Ayrshire and Arran Community Health Division and also by NHS Education for Scotland.
The study has been approved by the Ayrshire and Arran Research Ethics Committee.

Contact for further information.
Dr David Cunningham
The Surgery
9 Frew Terrace
Irvine KA12 9DY   *thank you for taking part in this study!*

Appendix 4 – Consent form for research phase 2 (community nurses and nursing managers)

CONSENT FORM
Focus group participants
Community nursing staff/nursing managers

Title of Project: **A qualitative research study into PLT education**

Name of Researcher: David Cunningham

Please initial box

1. I confirm that I have read and understand the information sheet dated 01.03.2007
    (version 1) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that
    I am free to withdraw at any time, without giving any reason,
    without my medical care or legal rights being affected.

3. I agree to take part in the above study.

4   I agree to the group discussion/interview being audio-taped and transcribed

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Name of Person taking consent   Date   Signature
(if different from researcher)

___DAVID CUNNINGHAM_____   _____

Researcher   Date
                        _____
                        Signature

1 for participant; 1 for researcher;