Research paper

Implementing a strategy to promote lifelong learning in the primary care workforce: an evaluation of leadership roles, change management approaches, interim challenges and achievements

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ABSTRACT

Objectives To identify and explore leadership roles and responsibilities for implementing the workforce development strategy; to identify approaches used to implement and disseminate the strategy; and to identify and explore challenges and achievements in the first 18 months following implementation.

Design A formative evaluation with qualitative methods was used. Documentary analysis, interviews ($n = 29$) and two focus groups ($n = 12$) were conducted with a purposive sample of individuals responsible for strategy implementation. Data were transcribed and analysed thematically using framework analysis.

Setting Regional health area in Kent, Surrey and Sussex: 24 primary care trusts (PCTs) and 900 general practices.

Results Primary care workforce tutors, lifelong learning advisors, GP tutors, patch associate GP deans and chairs of PCT education committees all had vital leadership roles, some existing and others newly developed. Approaches used to implement the strategy encompassed working within and across organisational boundaries, communication and dissemination of information. Challenges encountered by implementers were resistance to change – evident in some negative attitudes to uptake of training and development opportunities – and role diversity and influence. Achievements included successes in embedding appraisal and protected learning time, and changes in educational practices and services.

Conclusions The use of key leadership roles and change-management approaches had brought about early indications of positive transition in lifelong learning cultures.

Keywords: achievements, challenges, change management, evaluation, implementation strategy, leadership, lifelong learning

How this fits in with quality in primary care

What do we know?
For health professionals, continuing professional development is essential to maintain up-to-date evidence-based knowledge and skills. Primary care cultures and role boundaries can present challenges for embedding lifelong learning environments.

What does this paper add?
This paper offers insights into innovative leadership roles and change-management approaches used to implement a local workforce development strategy to embed lifelong learning. It also gives examples of interim challenges and achievements identified by implementers. Future research should further evaluate leadership roles in implementing lifelong learning, and aim for longer-term evaluation of the challenges and achievements in sustaining changes in learning cultures.

Introduction

A need for continuing professional development (CPD) to ensure that all who work in health care possess up-to-date evidence-based knowledge and skills in a culture which promotes lifelong learning, has been viewed as fundamental to quality assurance, clinical governance and effective risk management in the UK NHS.[1,2] CPD has been defined as 'a process of lifelong learning for all individuals and teams, which enables professionals to expand and fulfil their potential and which also meets the needs of patients and delivers the health and healthcare priorities of the NHS'.[1] A policy review of CPD in general practice emphasised 'working and learning together', although it was acknowledged that practice structures, professional philosophies and role boundaries might not initially support a learning environment or organisation.[1,3] It was also recognised that CPD in the NHS should be multidisciplinary and team based, with individual learning plans focused not only on individual needs, but also within the context of the needs of organisational development and patients.[4,5] The impact of national policy on CPD was highlighted in the National Tracker Survey,[6] which found that 93% of primary care groups were using education to improve quality through personal development plans (PDPs). In the context of primary care, CPD is now viewed as intrinsic to the 'learning practice' envisaged as a microcosm of the learning organisation, characterised by non-hierarchical, team-based learning structures that prioritise learning, empower change, involve staff and are open to suggestion and innovation. Benefits of learning practices are envisaged to be improvements in service provision, communication and interprofessional working, while barriers to learning practices are tightly defined roles and individually oriented support systems.[7] There also seems to be a shift in leadership style and culture; although leadership is about leading groups of people as well as organisations,[8] organisational development may mean a shift away from short-term targets to improving services overall,[9] and good leaders should switch between different styles of leadership as and when necessary.

Local strategies to implement CPD and lifelong learning are seldom discussed in the literature, although education as an approach to implement appraisal linked to personal development planning and CPD locally has been utilised.[10] In a broader context, systematic reviews have suggested that multifaceted strategies, for example combining leadership roles and education, are more likely to succeed in changing professional behaviour and practice, as are strategies tailored to overcome local barriers to change.[11–13]

Results presented in this paper form part of a wider study, conducted with the principal aim of evaluating the implementation of a regional primary care workforce development strategy.[14] The strategy, implemented early in 2003 in south east England, following the success of a local pilot, encompassed the NHS lifelong learning framework applicable to all health professionals. It sought to address the challenge of ensuring that the future workforce was fit for purpose in terms of professional knowledge, lifelong learning skills, recruitment and deployment. At the heart of this lay dedicated support for continuing professional education and career development planning linked to appraisal. Primary care workforce tutors and lifelong learning advisors were specifically recruited to work with others to support implementation of the strategy. This paper reports the approaches used to implement the strategy from the perspectives of those involved in development and implementation, i.e. the 'implementation group'. Views of recipients (general practitioners (GPs), practice nurses and practice managers) have been reported elsewhere.[15,16] Specific objectives are to identify and explore the leadership roles and responsibilities within the implementation group; to identify approaches used by the implementation group to implement and disseminate the strategy; and to identify and explore challenges and achievements in the first 18 months following implementation.

Methods

Study design

A descriptive, formative evaluation with a qualitative methodology (documentary analysis, focus groups, and semi-structured interviews) was used. Demographic features relevant to the study design were that the regional health area encompassed 24 primary care trusts (PCTs) and 900 general practices of varying size, covering urban, rural and coastal catchment localities. Twenty-two PCTs agreed to participate following multi-site research ethics committee (MREC) and local research governance approval. A purposive sampling framework stratified by professional group and strategic role was used to select potential participants from those who implemented the strategy. The implementation group was drawn from a population comprising lifelong learning advisors ($n = 3$), primary care workforce tutors ($n = 22$), patch associate GP deans ($n = 13$), GP tutors ($n = 25$) and chairs of PCT education committees ($n = 22$).

Sources

Documentary analysis of key information within the public domain was used to identify processes and methods used to develop and implement the strategy together with its key objectives and targets. Sources include local strategy documents, job descriptions of key informants, working framework documents forming a digest of the original strategy to aid local working in PCTs, and selected information relating to training events, e.g. conferences for GP tutors and primary care workforce tutors (PCWTs).

Participants

Semi-structured interviews were offered to potential participants to explore issues in depth. The choice of having a telephone or face-to-face interview was given, in order to facilitate participation at times convenient to participants. They were also invited to participate in focus groups to provide the opportunity of exploration of some issues in more depth and in a group setting; and to cross-validate findings of interviews. Topic guides were developed from pilot work, based on key areas related to the study aims (see Box 1 for key topics explored). The topic guides were used flexibly, being informed by the participant responses and allowing for slight changes in the questions and content of the interview/focus group.

Interviews with 29 implementers were completed. They were conducted at a location/time convenient to participants and lasted between 30 and 60 minutes. Two focus groups ($n = 12$) of 60–180 minutes'

Box 1 An evaluation of a local workforce development strategy interview and focus group topics

- Background, existing roles and culture
- Inception of roles
- Mechanisms and strategies/approaches used to develop, implement and disseminate the strategy
- Experiences/job satisfaction (autonomy, flexibility, support)
- Working relationships/communication and own needs
- Progress and impact of individual roles
- Barriers and facilitators
- Impact on appraisal and equality
- Exemplars of good and bad practice
- Recommendations

duration were conducted at a convenient, accessible local venue. Interviews and focus groups were tape recorded, transcribed verbatim and checked for accuracy. Transcripts were returned to half the participants for validation, and comments on accuracy and confidentiality; few transcripts were returned with clarifications.

Analysis and validity

The interview and focus group data were analysed using thematic framework analysis, which provides a systematic and staged process for interpreting data. The first stage involves data familiarisation, achieved by intensive reading, followed by the identification of themes. The themes identified are indexed and data rearranged or 'charted' according to appropriate thematic reference. The final stage is mapping and interpretation where there is a search for explanation and meaning by examining the thematic framework for patterns and connections.[17,18] Transcripts from both interviews and focus groups were read repeatedly by the main authors (SM, LW and MB) to identify key themes, codes and categories, which were then developed into a coding framework by MB. The framework was used, amended or modified accordingly. Multiple coding of data tested the acceptability and reliability of the designated categories. The final framework – derived from both interviews and focus groups – formed the basis for data interpretation and was discussed and agreed by the three researchers.

A workshop was planned at the last stages of the evaluation, where participants would have had the opportunity to discuss and validate the findings, but due to practical and participation difficulties, it did not go ahead. Summaries of the findings were instead sent to all participants for their information and

further comments; no comments were received on the summaries.

Reflecting on the process, transcripts, various analysis steps and findings was an integral part of the project, which allowed for flexibility in the processes, openness and agreement on the interpretations.

Results

The analysis of data drawn from documentary sources (strategies, job descriptions) and informed by interviews resulted in the identification of subgroups within the implementation group who had *leadership roles* and responsibilities for implementing the strategy.

Analysis of data drawn from interviews and focus groups identified three themes and six subthemes; findings relating to these are summarised under the thematic headings:

- change-management approaches to implement the strategy
  - working within and across organisational boundaries
  - communication and dissemination of information
- challenges encountered by implementers
  - resistance to change
  - role diversity and influence
- achievements
  - embedding appraisal and protected learning time
  - changes in educational practices and services.

Given the small sample size, individual roles have not been identified in the use of quotations derived from interviews and focus groups for ethical reasons.

Leadership roles

The subgroups responsible for implementing the strategy and their specific roles and responsibilities are summarised below.

Primary care workforce tutors (PCWTs)

The PCWT role was a new role developed to implement the strategy. It emphasised leadership and development of processes to implement appraisal, PDPs, CPD and learning environments. Roles varied in terms of interpretation and operation, reflecting and combining to variable extents the PCT needs, priorities and regional deanery job description. Many PCWTs offered 'one stop shop' support for CPD across the PCT (all or most staff groups) and GP practices; some focusing solely on GP staff, others working mostly with PCT staff. Work in partnership with GP tutors was developing strongly with regard to

the objectives of the workforce development strategy, together with close liaison with PCT clinical governance and education leads.

GP tutors

These existing roles were in transition, with many focusing on both facilitation and leadership in relation to education issues. More specifically, they ran appraisal learning sets to maintain standards of GP appraisers; some were involved in GP appraisal. In addition, they provided feedback on PDPs and developed and managed local education programmes/events linked to audits of training needs taken from PDPs.

Lifelong learning advisors (LLAs)

These new roles had overarching responsibilities for partnerships, strategy, policy and project management of the workforce development strategy for primary care at county level. Selected, pivotal elements of their role included partnership, working on multidisciplinary educational issues, building a network of PCWTs, development of working frameworks for practitioners and management of change.

Patch associate GP deans

These existing roles varied in strategic and operational core responsibilities regarding the workforce development strategy, with more general aspects of their roles relating to 'patch' responsibilities for GP training. Changing the culture towards education, team learning and CPD were considered to be a requirement of the role.

PCT chairs of professional education committees

These existing roles had overall leadership and responsibility for the delivery and provision of education, learning, development and training in the PCTs, working with key partners in achieving educational, learning and development outcomes, i.e. tutors, education committees, providers, etc. In addition they had responsibilities for the development of the overall PCT learning and development plan (LDP), ensuring that this matched the PCT's corporate objectives.

Change-management approaches to implementing the strategy

Working within and across organisational boundaries

Some of the approaches used to implement the strategy are illustrated below. These included quality assurance processes within one organisation; partnership working using diverse committees and networks with a remit for education and training; and organisation of interprofessional learning for PCWTs and GP tutors

through shared conference events. Inherent in these approaches are key change agent skills of encouraging participation by stakeholders, facilitation and local ownership.

'... getting recruitment right, getting our processes right and the quality assurance right and the HR [human resources] and equal opportunities right has been a very, very, important part of that process.' (Interview 21, p3)

'We're working a lot with the PCT, training alliance, Workforce Development Confederation, and then there's the clinical governance lead and assistant director of the primary care team. We have a meeting which is about appraisal management and education, where we discuss how the appraisal process is going.'
(Interview 1, p2)

Developing a working framework document, which provided user-friendly, accessible guidance to tutors, local practitioners and managers about implementing the workforce development strategy, was found to be helpful. This framework identified specific objectives to be achieved, clarified accountabilities and provided information on role redesign, quality issues, team development, information technology, recruitment and retention. In terms of change management, this illustrates the importance of reducing complexity and facilitating local ownership and engagement with the strategy.

'Because the [tutors] are all doing slightly different jobs, one of the things ... which helps motivate them is [to] give them indicators in the early stages and then ... this framework to give them something which was longer distance.' (Focus group 1, p4)

Communication and dissemination of information

Approaches used at early and late stages to communicate and disseminate information about the strategy to recipients working in general practice settings (GPs, practice nurses, managers) were identified. Communication is a key change-agent skill, and a number of very creative ways of conveying information and receiving feedback from recipients are identified in the extracts below. Negotiation and facilitation of access to GP practices by implementers, and facilitation of recipients' access to CPD can be discerned in communication approaches.

Early phase communication had two functions: communicating key points of the strategy and also enabling tutors to access general practices. Methods used to achieve this were information leaflets, participating in meetings and organising road shows.

'I've handed out the original document ... I have mainly disseminated it [the strategy] by meetings with people ...

talking them through the process of the strategy ...' (Interview 9, p3)

'When I came into post I designed a leaflet for the practices and circulated it to all the practices saying who I was, what my role entailed, how I could help them and how they could contact me. I addressed some of the GP evening meetings, talked about the role, the opportunities to work with them ...' (Interview 15, p2)

'We [PCWT/GP tutor] set up a series of road shows where we visited ... practices. I did a session on PDP and [PCWT] did a session on practice professional development. There were several aims to that strategy; to communicate the importance of PDP to GPs and to give [PCWT] access to general practice settings ...' (Interview 4, p1)

Later phase communication with PCTs and GP practices was achieved using career counselling, training needs analyses and encouraging learning using reflective logs. Employing practice nurse advisors with a remit to support practice-based learning was also identified as helpful. Communication through email, telephone, post and face-to-face meetings supported all stages of information transfer.

'I'd develop materials for them or I'd work with individuals, I do a bit of career counselling. I had a background in NVQ [National Vocational Qualification], so if they were looking at vocational qualifications if there was the opportunity to provide an assessment or a bit of coaching and support then I'd be involved in that way ... I tried to ensure that they were able to access local-based training that met their needs. I ran a couple of training needs analysis questionnaires.' (Interview 15, p3)

'I think it's been yet another very powerful indicator to the PCTs of the way in which they need to engage with the wider world, and the information that these processes are available to help their thinking in developments.' (Interview 21, pp10–11)

'Just simple things like getting them to use a reflective log.' (Interview 15, p3)

'We've employed and just increased [the] practice nurse advisor role in the PCT, and were able to get some extra funds identified so that we had specific support for practice nurses.' (Interview 16, p3)

Challenges encountered by implementers

Resistance to change

Challenges that arose during implementation of the strategy included resistance to change in culture and existing educational practices.

'I think not all the players that I have to appraise, for example, are that convinced that it's important. I've had discussions with GP tutors, for example, who have said, if we put on joint learning things none of the GPs want to

come so I'm not going to. We've done that on half days and it doesn't work, I'd rather let the nurse tutors deal with the nurses, I'm supposed to be here for GPs.' (Interview 12, p3)

Resistant attitudes to interprofessional learning and negative attitudes to uptake of training and personal development for themselves and others were also encountered.

'... maybe some GPs still don't see that their practice nurses need to have development, or maybe they're okay with the practice nurses but maybe their admin staff don't need developing and maybe it's also the admin staff don't feel they need to be developed, I just come to work, I only do six hours a week, I do my job and I go home, I don't want to be developed thank you ...' (Interview 25, p5)

Resistance to facilitating access to CPD through local implementation of protected learning time was also an important challenge.

'What we can't influence is practice managers' and GPs' rights to say that they don't want to be attending protected learning time [PLT], and therefore not all staff have access to PLT, and I think it's probably fair to say that the GP lead and the manager doesn't want to implement a mandatory policy, protected learning time, and therefore we will never be able to make it accessible to all because it will be up to them to decide.' (Interview 16, p9)

Role diversity and influence

Other challenges encountered were the diversity of the PCWT roles, which could lead to inconsistency in working to implement the strategy.

'Well, I think the fact that all of the primary care tutors were doing different jobs, all in different directorates, managed by different people. Establishing some consistency, helping people to see that they were part of a strategy, they're related to each other, that has been very difficult because they're all doing very different jobs.' (Interview 10, p5)

A perceived lack of authority in influencing the activities of independent GP practices in promoting the uptake of appraisal linked to CPD was problematic for one implementer, while another identified finding ways to exert a strategic influence within PCTs as problematic.

'They [general practices] don't have to formally report on their activity to anybody, I've got no way of knowing for certain how many of these practices are actually doing it or not ... I think the main difficulty is the ... lack of authority.' (Interview 15, p5–6)

'I think probably one of the main difficulties early on was finding a way within the organisation to influence strategically ... I think most of the workforce tutors in the original pilot were sort of dropped in at the same sort of level and each had their own sort of different managers that they were responding to ...' (Interview 16, p4)

Achievements

Embedding appraisal and protected learning time

Achievements embedding appraisal and protected learning time are illustrated below. The appraisal system and processes were reinforced.

'I've worked with the practice managers, encouraging them to have their own appraisals, because you know that's something that wasn't really happening.' (Interview 32, p6–7)

Despite the resistance to change noted above, in some cases protected learning time was successfully embedded in practices and included non-clinical as well as clinical staff.

'... in terms of access to opportunity I think we've done our best to embrace all staff having access to protected learning time, we've done focus groups, we've done research to ensure that their needs and their access was available, obviously we have out-of-hours cover for the GP staff, so that they can shut their practices.' (Interview 16, p9)

'And I think we've done very well getting the protected learning time for the non-clinical staff, although we'd like to see it all happen together in reality, to get up to 40 we had at one time from receptionist and data entry clerks, etc, etc in one place with being able to come out of practice to have some educational input ... and I think that's been quite a success.' (Interview 34, p5)

Changes in educational practices and services

Achievements in these areas emphasised the importance of co-operative working between general practices and PCTs.

'Inclusion of general practice in the whole education of the PCT. Yes, and I think we've got general practice learning, general practice nurses for example learning alongside PCT nurses. At the end of the day we're all here for the same health economy ... but now they're working together, learning together and I think that's the important thing.' (Interview 13, p17)

Shared, multiprofessional learning in GP services and use of personal learning portfolios in both GPs and PCTs were also highlighted.

'Another example, I've been involved in setting up a whole new way of delivering diabetes care, taking out of hospital diabetes care and practice, and we've set up a whole raft of educational events for GPs but nurses at the same event, doing the same work, same agenda, learning one off the other, and that's working extremely well ... So, that's a good example of multiprofessional working and learning coming together.' (Interview 11, p7)

'I have developed a personal learning portfolio which is implemented across the trust, that means all trust staff, GP

practice staff, including GPs. They receive a personal learning portfolio from the trust which we encourage them to maintain as part of their PDPs.' (Interview 24, p4)

New roles for practice nurses, managers and GPs were also identified in terms of leadership and working across professional boundaries.

'In many practices it's the nurses that are leading the management assistant with the GP just being clinical back up ... Now it's the other way around but collectively across the town you use slightly different models, but all coming together and working well.' (Interview 11, p8)

'One example is something like we're doing in-house integrated care pathways and the practice manager was actually running this session, explaining what care pathways were with the whole team.' (Interview 1, p11)

'I've given examples of where it's working, like where there is an integrated approach to diabetes and you've got healthcare assistants doing one bit and how that takes the load off the nurses so they can do the education bit and the doctors are then left.' (Interview 12, p4)

Some of the responses are suggestive of the development of a 'learning practice' culture, marked by more team-based learning structures and wider staff involvement.

'I've developed some in-house development programmes to take people through the grades which has been implemented and I've seen a huge increase in educational activity as a result of this and it's enabled people to get promotion within their existing places of work, that's generally within community nursing, health visiting and working with the NVQ co-ordinator, looking at the treatment room assistants.' (Interview 34, p5)

Other responses show utilisation of management approaches in using CPD in role design to facilitate service improvements.

'... I think the best thing we've done is the role redesign intermediate care unit that we're going to be opening up ... the unit is being set up so instead of having say nurses come in and look after patients, or therapists come in and look after patients, the person that we're going to employ is going to have a little bit of therapy training, a little bit of physio training, OT [occupational therapy], speech and language ... I put nursing in; dietitian has got an input as well ...' (Focus group 1, p32)

The implementation of a reward scheme, a vital management approach, to acknowledge professional achievements in CPD, was used in one PCT to encourage the need to think of learning as a lifelong process.

'I also have devised a scheme whereby we acknowledge people's work, innovative work, and that is through a [named scheme] ... we have implemented an annual award for staff who have achieved qualifications other than higher education qualifications within the trust to acknowledge their success, I think that has a major influence in encouraging people to think of learning as a continuous process.' (Interview 24, p4)

Discussion

Findings of this qualitative study offer insights into the approaches used by individuals working to implement a strategy intended to develop lifelong learning in the primary care workforce, through appraisal, personal development planning and CPD.[1,2] Findings also identify some of the frustrating challenges they experienced in managing change, together with the short-term achievements over a period of 18 months. It is hoped that these findings will be helpful to other groups working in primary care settings to implement policies related to lifelong learning. Key findings have provided insights into the roles of the implementers. Notable were their range of professional backgrounds, together with the scope and diversity of their respective implementation roles, in all of which can be discerned both leadership and management elements. Leadership was evident in documented accountabilities for delivering specific aspects of the strategy and in the use of change agent skills (negotiation, facilitation, communication, participation),[19] and approaches to change management (fostering local ownership and partnership working),[20] which emerged from interviews and focus groups. Management approaches were evident in the diversity of creative communication approaches used, reduction of the complexity of tasks, redesigning roles and service improvements using CPD and in rewarding achievement. Face-to-face contact with practitioners, aligning individuals and groups with the power to influence change, are all factors intrinsic to success.[14,19,21]

Role diversity, scope and authority were important for the implementation group, who were charged with delivering a strategy for CPD to a multiprofessional group of recipients working in general practices and PCTs. Although not a finding in this study, professional credibility in leadership has been acknowledged to be a factor in achieving successful change management.[13,19,21] The PCWTs were recruited with a specific remit to implement aspects of the workforce development strategy and were employed and based in PCTs, an approach with the potential to strengthen local ownership of the strategy and overcome local barriers, all of which are important in managing change effectively.[13] Set against these advantages were the diversity of some PCWT roles, particularly those that were very complex and that involved working across the entire spectrum of PCT and GP practices. This created the potential disadvantage of inconsistency in approaches to implement the strategy, a factor which needs to be considered in developing job descriptions, lines of accountability and the resources needed to support such roles. Possessing the authority to influence the strategic direction of a PCT was also problematic for some PCWTs; this could have been

overcome by ensuring the role was recognised and represented on appropriate committees and networks. It is suggested that PCT executives consider how to support such roles in their organisations, so that strategic directions can be informed and plans monitored.

Challenges encountered by some implementers were lack of authority, posed by the independent nature of GP practices, placing a great emphasis on the need to negotiate access. Negative attitudes to CPD, interprofessional learning and protected learning time were sometimes apparent, noted in previous studies.[10] Recipients in this study identified time, funding constraints, lack of management support and boundaries between PCTs and general practices as barriers to CPD uptake.[14,16,22] Recent implementation of the new general medical services (nGMS) contract,[23] and the NHS Knowledge and Skills Framework,[24] may do much to redress such problems. Set against the challenges were achievements in educational practices and service, designed to foster interprofessional CPD. An interesting finding was the emergence of educator leadership roles in general practices, where practice managers and nurses were taking the initiative in organising in-house training sessions. Transitions around the boundaries of role development through appropriate training were also identified. These are consistent with the aspirations of policies for learning and working together through multidisciplinary, team-based learning characteristics of the 'learning practice'.[1,3–5] Despite the challenges encountered in implementing appraisal and protected learning time, some exemplars of success were described, in which appraisal had been successfully implemented and wider access to protected time had been achieved. Other studies have identified protected time as intrinsic to uptake of CPD.[25]

Overall, the early examples of achievement suggest some selective success in making the transition to learning practices marked by team learning, and flatter, less hierarchical team structures.[9] This formative evaluation was conducted only 18 months after strategy implementation, so the findings on achievements can be regarded as early indicators of successful transition in embedding lifelong learning in primary care. The key message to emerge from this study is that an implementation group which includes dedicated leadership roles (LLA, PCWT, GP tutors), utilising a range of change-management approaches, can be helpful in the implementation of a strategy to promote lifelong learning. Further research is needed to evaluate markers of longer-term cultural change and the sustained impact of such roles.

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ETHICS COMMITTEE

The studies were approved by the multisite research ethics committee (MREC) and local research governance processes.

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CONFLICTS OF INTEREST

None.

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