Educational Facilitator Project Report

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Introduction and background

In May 1998, the Department of Health published *A Review of Continuing Professional Development in General Practice*. This report was the product of a multidisciplinary group, chaired by Kenneth Calman, Chief Medical Officer, and addressed the Government's agenda for quality set out in the White Paper *The New NHS – Modern and Dependable* (1997). The principle recommendation of the report is to integrate and improve the educational process through the Practice Professional Development Plan (PPDP) developing the concept of the 'whole practice' as a human resource for health care.

The framework recommended for a PPDP would be based on an annual plan for the professional development of the practice and would confirm the professional development needs both for the practice as a whole and for each health professional within it. Learning should be practice based with emphasis on learning together.

General Practice does not currently lend itself to a climate of interprofessional learning. Educational barriers are exacerbated by an organisational structure in which the effects of different funding and different management structures are reinforced by differing professional standards, working to the various criteria and responsibilities of individual institutions (DoH 1998). Existing restrictive funding and accreditation such as the Post Graduate Education Allowance (GP Principals only) encourages uniprofessional educational activity. Terms and conditions of employment for community nurses also hinder an interprofessional approach to education. Although these differences have not been formally reconciled, the issue of funding interprofessional practice-based learning has been overcome locally by an amalgamation of funds from health authorities, training and education consortia along with research and development monies.

Interprofessional learning in General Practice

The agenda for PPDPs is for GPs, practice and community nurses, managers and administrative staff to focus on a specific issue; by sharing current knowledge and reflecting on individual experiences they will agree future action.

The Department of Education and Employment and the NHS Executive commissioned a study into the competencies in primary health care teams (1998).

Project aims

The aims of the project were:

- To analyse the functions of primary health care teams.
- To explore the concept of organisational competence.
- To develop an understanding of the process and potential for organisational learning within this setting.

Key messages

The study concluded three key messages:

- Team members learn both individually and as a team through formally structured courses and events and more informally through the daily course of their work.

- Most practices have positive attitudes towards learning. However, informal learning is under-valued and team members find it difficult to identify examples of organisational learning.

- There is a need to create a learning culture within a practice and to plan strategically for the learning needs of individuals and for the needs of the team as a whole.

Professionally led education has developed a structure in practice of uniprofessional support. A system of GP tutors, practice teachers for health visitors, district nurses, practice nurses,

community psychiatric nurses and social workers are just some of the groups that have their own specialist practice educator. A situation could occur where six or more education-led posts could all arrive to visit members of the primary health care team at the same time! There is obviously a need for specialist educational support but this project also explored the need and issues in providing educational facilitation to the whole team. At a time when we are encouraged to work in teams, there is a need to develop roles that support team learning in relation to patient/client need as well as specialist input. There is a developing need to debate the interface between these general educational facilitator roles with colleagues responsible for uniprofessional development of individual members of primary health care teams.

The role of the facilitator in the process

Shared learning in an interprofessional team is enhanced when the facilitator comes from outside the organisation involved in the learning process. When the facilitator has no vested interest in any external agendas, the focus of attention is entirely on the teams' needs. This is perceived positively by the learners, and raises the level of safety in the group allowing for more disclosure and risk taking.

Facilitating shared learning involves an awareness of group dynamics such as the emergence of non-contributors, status hierarchies or interpersonal competition which, dependent upon the skills of the facilitator, can either enhance or inhibit learning.

The learning experience will be determined largely by what the learners bring to the situation, which requires the facilitator to be flexible in their approach to working with the emerging material, in other words, to go with the flow. To gain most learning from individual contributions, the facilitator needs to skilfully question and delve more deeply into the initial account, paying particular attention to the language used to describe or interpret the situations.

Facilitators should remain totally impartial and at no time should they offer personal interpretations or analysis of the accounted experience (Boud et al. 1985). They must be aware that feelings can be a barrier to learning and both facilitator and learner must understand this. Boud et al. (1985) suggest that facilitators should be aware of the limits of their own skill in such situations and be prepared to put learners in touch with people who could offer more appropriate assistance if necessary.

The role of the facilitator is to create an effective learning environment in which learners feel comfortable and safe. Issues of confidentiality and of contributions being equally valued are essential ground rules at the outset. The skills of the facilitator in encouraging reluctant participants to contribute whilst respecting

the ‘right to silence’ are paramount to the group’s cohesion. The facilitator is required to make a number of assumptions about the group he/she is helping to learn. It is unlikely that there would be any prior knowledge of individual competencies, personalities, levels of motivation or learning styles.

Limitations to facilitated shared learning

In addition to the different learning styles, there is the danger that traditional, stereotypical views of the different professions and how they relate to each other may hinder the process of shared learning in PPDPs (Reeves & Pryce 1998). Developing organisational learning involves questioning organisational norms and values, so that problems can be recognised and appropriate solutions can be formulated. According to Argyris (1992), this process of questioning is often uncomfortable and threatening and many individuals and organisations are defensive about examining what they do and contemplating different ways of working. In his discussion about the value of interprofessional shared learning, Funnell (1995) identifies situations in which shared learning is likely to be more valuable:

- Where learners are united by a common or a commonly perceived task with clear goals.

It can be argued that once the task is complete and the goal achieved the group reverts to their custom and practice mode of unidisciplinary learning (Revens 1983 p12). This gives rise to the question: is facilitated, interprofessional shared learning sustainable? The desire is for practices to be self directing in developing a culture of shared learning and not for them to rely on external sources to stimulate their need to learn.

- Where learners perceive themselves as equals.

In the medically dominated arena of General Practice where GPs are business owners and employers as well as being regarded as professionally superior, the issue of professional/learner equality may be compromised.

- Where experiential teaching methods, with emphasis on the learner's experience, independence and openness, are applied.

Funnell, himself, recognises that this learning environment may be potentially intimidating for all members of the group.

- Where there is balanced group membership in terms of professional status, clarification of previous experience, significant representation, clarity of expected outcomes, prior information and appropriate teaching styles.

The practices participating in the local university project have to meet these criteria as part of the project design and facilitation support. Practices endeavouring to develop PPDPs without external support may not be aware of such requirements.

- Where deliverers of shared learning themselves have experience of learning, and preferably working, in this way.

Funnell is acknowledging the need for skilled facilitation of the shared learning experience. Not all practices have a trained facilitator in their team, but even if they do, facilitating and participating in your own team's shared learning is difficult and may not be successful. To perform the role of facilitator and participant is to 'break the rules' of facilitation, i.e. facilitators should remain totally impartial (Boud et al. 1985).

In an interprofessional context such as General Practice 'external' facilitation is best suited to organisational development and strategic planning issues where impartiality is necessary in ensuring equal opportunity for all participants to make a contribution.

Practice professional development planning

In 1997, the Institute of Health and Community Studies at Bournemouth University designed a process for practice professional development planning using a model of continuous quality improvement. Langley et al. (1996) offers a framework to assist in the complex change process within an interprofessional organisation. It is based on the concepts of stating an aim, establishing a baseline, e.g. current knowledge, and increasing knowledge to bring about change, learning and improvement. IHCS designed a project entitled Interprofessional Learning in Practices in which GP tutors and members of the lecturing staff facilitated the process for six primary health care teams across the South West Region.

Practice professional development planning does not necessarily require the traditional skills of the GP tutor or University lecturer, although these roles remain vital to the instigation of the educational processes underpinning learning needs identified as a result of the planning process. The process of planning requires facilitation from an individual who can not only enable a primary health care team to identify the key elements of their PPDP, but can also assist them in developing as a learning organisation. As a result of this project, it was identified that there was a need for a new role; that of an educational facilitator, who could provide facilitation skills and enable teams to learn together.

Towards the end of 1998, one of the Dorset GP tutors retired and the Associate Directors of GP Education proposed replacement with a non-clinical educational facilitator in an attempt to move away from the traditional style of GP education towards a more interprofessional team approach. The Wessex Deanery and the Nursing Faculty at IHCS supported the proposal and joint funding was made available for an 18-month project to run from September 2000 to March 2002. The Associate Directors wrote the job description and person specification and the post was advertised across the county.

Appointment to the role of educational facilitator

The educational facilitator post was advertised as full-time, preferably shared between two individuals each working 2.5 days per week. The successful applicants, both females, came from different backgrounds but neither had a medical/clinical professional qualification. One was a practice manager and a facilitator on the original Interprofessional Learning in Practices project who also had experience as a Health Authority training co-ordinator for practice staff and had recently completed a Masters Degree in Interprofessional Health and Community Care. The other was a widely experienced change agent/facilitator and GP educator with the Wessex Deanery. The two had met and worked together previously.

Job share

To get the most out of any job share, the individuals concerned need to be aware of and acknowledge each other's strengths and weaknesses. The appointees were aware of their differing backgrounds, skills and styles of facilitation, with one favouring a pragmatic approach, the other focussing more on process. These differences enhanced the role enormously, as they were able to draw on each other's skills as and when appropriate. The first task was to agree some ground rules around 'job sharing', to establish a mutual understanding of the requirements of the role, and to agree some aims and objectives.

Strategy group

A strategy group comprising GP tutors and nurse educators planned to meet bi-monthly to provide support and advice to the educational facilitators. A smaller sub-group comprising a GP tutor and a nurse educator was formed to provide close support and supervision. This group was also responsible for the publication of three articles; the first outlining how the role came about, the second describing the work carried out and highlighting the benefits of facilitation, and the third the evaluation of the project.

Vision, aims and objectives for the role of educational facilitator

1. To work towards the role being successful, repeatable and sustainable.

    - Define successful outcome measures.
    - Define the knowledge, skills and attitude required for the role to be successful.
    - Identify the pitfalls and difficulties.
    - Collect appropriate data.
    - Evaluate and report/publish results.
    - Define what reports are required, by whom, and at what intervals as the work progresses.

2. To match the education needs of the environment by offering advice, options, flexible designs, processes, frameworks and resources to meet those needs.

    - Explore and identify needs with key stakeholders/clients.
    - Prioritise those needs and time plan within the scope of the role.
    - Explore individual client's outcomes: what is it they want to achieve via education?
    - Offer the educational options to meet the need.

If direct facilitation is required:

- Design processes, frameworks to support the clients requested outcome.
- Identify with the client the resources required to support the work (people, venue, funding etc.).
- Contract with clients via a written proposal that includes the client's needs.
- The way the needs will be met, the process, design etc. How will it be evaluated? What resources are

required? Who will do the administration?

- Costing of facilitation time and a time plan.

3. To support and help practices to develop a learning culture that involves and includes all those who work within the practice. To look at ways of learning and working together to improve the delivery of care for their patients

    - By working with Primary Care Trusts, GP tutors, nurse lecturers and community practice teachers to identify practices that may need facilitation to support the learning and development needs of all those working within it – using the Bournemouth University PPDP framework as a model.
    - Consult as above with the practice as the client.

4. To support the development of education provision within the University

    - By sharing the learning needs identified by the primary care environment with those who provide education within the University.
    - By offering help and support to the education providers to deliver education in new ways that will support the changing service delivery within primary care.

Evaluation

Research design

The educational facilitators met with a member of the research team from IHCS to design an evaluation process for the project. The discussion centred on different approaches i.e. quantitative and qualitative:

- Democratic, inclusive of stakeholders, focus on processes, case studies, semi-structured interviews, observation, and narrative evaluation aimed at providing depth.
- Focus on outcomes and evaluation against aims and objectives, effectiveness of arrangements and quantitative evaluation aimed at providing breadth.

Research limitations

The first approach is research intensive, but may be useful given the innovative nature of the role and lack of previous research. The second approach could be difficult if outcomes and measurements are unknown. It would, therefore, be doubtful that the evaluation would be meaningful in terms of developing the role. The strategy group were therefore required to answer the following questions:

- Is evaluation formative to assist development, or summative to provide hard evidence in terms of viability and value for money?
- What are the various stakeholders' expectations? Wessex Deanery, IHCS, community care teams, practice staff?
- What are the operational and strategic elements of the role?
- Is there equity of service to all 107 practices?
- What are the management and supervisory arrangements?
- What support is available to the post holders?
- What are the prevailing cultures and dynamics among the community care teams?

Establishing relationships

The first two months of the project period were spent setting up internal organisational arrangements and contacting:

- The Chief Executive or General Manager, Clinical Governance Lead and Education Lead of each Primary Care Trust or Primary Care Group in Dorset.
- The Director of Public Health and the Performance Management Director at the Health Authority.
- The researchers and nurse educators at IHCS.
- Postgraduate medical centre personnel in Poole, Bournemouth and Dorchester.
- GP tutors, trainers, and course organisations.

Contact was made either by letter, telephone or personal visit to inform others of the educational facilitator role and to explain the resource on offer.

Work undertaken

The first enquiry came in late November 2000 from a Primary Care Trust (PCT) of 22 practices. It requested input to discussions regarding setting up the process for enabling practices to produce a Practice Professional Development Plan. This was to become a major piece of work and, in addition to the facilitation of PPDPs, the educational facilitator was invited to join the PCT Education and Development Sub-Committee.

In December, a neighbouring PCT of 25 practices requested input to their Education and Development Sub-Committee and some time later requested facilitation of the PPDP process. It was interesting how the two PCTs approached the PPDP exercise. The first provided a detailed proposal offering practices facilitation, funding for protected time to produce a PPDP and a clear indication of the expected outcome. The second had very little funding available, only via the GP tutor. There was no explanatory correspondence to practices and it was reliant on the tutor to offer the services of the educational facilitator.

The remaining PCTs and PCGs did not respond as organisations. Instead, individual practices became aware that this facility was available and contacted IHCS directly. The educational facilitators provided external facilitation to around 50 Dorset practices between January 2001 and January 2002.

Educational facilitator role

As a direct result of the PPDP process, practices requested assistance with a number of issues and the educational facilitators acted as:

- Change agents where practices were experiencing difficulties with organisational change, and interprofessional and partnership relationships. External facilitation enabled teams and individuals to acknowledge and to deal with their reluctance to change. It also helped them to address issues of professional boundaries and encouraged a sharing of each other's professional values and beliefs.

- Support for health professionals in coping with stress. The educational facilitators supported a number of individuals on a one-to-one basis to help them recognise stress inducers and to offer options for dealing with their stress.

- Advisors in the management of conflict. External facilitation proved valuable in assisting partnerships to air their differences and plan a way forward in a positive and constructive manner.

- Support for GPs whose performance gave cause for concern. Educational facilitators were utilised as a neutral resource by advising GPs on personal learning plans in response to the learning needs identified by the Health Authority.

During the course of the project, the educational facilitators provided formal teaching sessions for nurses on a variety of topics. All sessions were conducted in a facilitative style with maximum group participation.

- Nurse practitioners – continuous quality improvement.
- Community practice teachers – personal development and facilitation skills.
- BSc (Hons) in Primary Health Care – personal learning plans.
- Senior nurses in advisory roles – leadership skills.

They also supported GP tutors in delivering professional development workshops for GPs and GP trainers.

Conferences and presentations

The project has been presented at:

- The UKCRA Conference (United Kingdom Conference for Regional Advisors) in Scotland – June 2001.

Conclusion

The role of the educational facilitator is not just about PPDPs, although to date most of the work carried out during this project has been in facilitating practices through this process. PCTs took a variety of approaches ranging from full support in terms of external facilitation and funding, to no involvement at all. Where PCTs did engage, and despite the lack of strategy, protocol or funding, most practices wanted to go ahead. Other successes are recorded in practices where relationships and management issues were getting in the way of progress and the role has been effective as a catalyst for change. The role has also influenced and contributed significantly to Educational Strategy Groups and Clinical Governance Groups in some PCTs.

The limitations of the project lie in the under-developed strategy group responsible for supervision and support of the post holders. Apart from the data collected by the educational facilitators, there has been no formal evaluation of the project and the publications are still outstanding.

However, satisfied clients have expressed the value of the role on numerous occasions, both verbally and in writing. There is still work to do in building the confidence of GP tutors in the utilisation of the role, particularly in relation to unidisciplinary education of GPs. On the other hand, nurse educators embraced the opportunity to draw on the skills of the role throughout the project and beyond. In the opinion of the post holders, the model has been successful and should be continued. It is understood that this will be dependent upon securing continuing funding.

Proposed future model

At the close of the project period, one of the post holders was offered a similar post with another organisation. The remaining post holder proposes the secondment of two, possibly three, primary care professionals ideally from different backgrounds, such as medical, nursing, managerial, each working one day per week in the role of educational facilitator. Recruitment of a non-principal GP may be more financially viable. Costing would also need to include a researcher. An accurate costing would be prepared once future funding has been decided. The existing post holder would project manage the work of the secondees including training, as well as working in the field. Peer supervision and a defined strategy group should support these developmental roles.

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