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Developing multi-professional learning organisations in primary care: *opportunities and challenges*

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Section 1: Background and context

1.0 Introduction

This is the final report of a development and research project designed to develop multi-professional learning organisations in primary care in the East Anglian region of the United Kingdom.[1] A pilot study undertaken in seven practices between January-April 2009 evidenced enthusiasm for such a project, as an opportunity to develop work-based learning that would support the development of primary care teams in changing contexts.

It also identified the problematic issue of implementing such a project in the context of heavy workloads and external demands. The project aimed to help primary care teams develop a productive culture of work-based learning and reflective practice, has had very different levels of success in participating practices. This report explores why this was the case and identifies changes in primary care as a place in which to work, learn and implement action research and development initiatives. It has implications for how to engage busy professionals in this form of work-based learning.

1.1 The professional and political context

Learning organisations have been part of the discourse within medical education for some time. They form part of a response to policies associated with continuing professional development in primary care.

In 1998, the UK Chief Medical Officer's report: *A Review of Continuing Professional Development in General Practice*, articulated a re-focusing of the role of work-based learning in professional development. (DOH 1998). The report encouraged the development of Professional Practice Development Plans (PPDP), which sought to link individual professional development with the organisational development of the practice/clinic. In the PPDP initiative, the development of individuals and the organisations within which they worked were to be associated with each other. This attempt to purposefully align personal and organisational development in primary care proved both challenging and problematic (McKee and Watts 2003).

On March 31 2004, the ending of an established system that offered credit to individual GPs who attended approved learning events, known as the Postgraduate Educational Allowance (PGEA), affirmed the aim to refresh the processes and cultures of professional development. Underpinning the change agenda lay an intention to focus professional development activities more intensely upon individual and organisational performance. Since then, national frameworks and mechanisms have been established to steer and review primary care organisational systems and those who work within them. Examples of these include

1 Primary Care settings in the United Kingdom, typically refer to general practice clinical settings.

annual individual professional appraisal and organisational performance review through the 'Quality Outcomes Framework' (QOF, 2011). Learning and performance management agendas have been coupled in new kinds of alliances.

More recently, Secretary of State for Health, Andrew Lansley introduced a new policy *Liberating the NHS: Developing the Healthcare Workforce: From Design to Delivery,* 2012. The overall aim of the policy is to ensure that the National Health Service (NHS) has a system that can plan and develop the ***whole*** work force. (DOH, 2012) It is argued that this requires education and training that is more flexible and responsive to changing health demands and new patterns of health care. Central to the proposed changes is a renewed and strengthened focus on continuing professional development.

There is also a renewed focus on patient outcomes and learning outcomes and a link between the two, as the following extract from the forward to the new policy illustrates:

> *'The Education Outcomes Framework will directly link education and learning to improvements in patient outcomes. By providing a clear line of sight and improvement to patient outcomes, it will help address variation in standards and ensure excellence in innovation through high quality education and training.'* (DOH, 2012)

Employers are to have a role in educational commissioning and governance. New organisational structures are to be put in place, reflecting a further strengthening of public accountability.

From an educational perspective, these changes imply:

- an extended stakeholder curriculum (with)
- learning outcomes set nationally
- education and training provided locally to meet both national education outcomes and local needs
- (within) a top-down accountability structure.

In the *Equity and Excellence* section of the policy, the importance of the accountability structures is emphasized.

> *'Making these changes work is all about placing accountabilities in the right place. ..Locally with providers supported by professionals who understand the local needs of their workforce, and nationally with Health Education England to interpret workforce intelligence and planning and then lead in support, guidance and oversight for the commissioning and education of training.'* (DOH, 2012)

Figure 1 depicts the new structure with arrows indicating intended accountability flows.

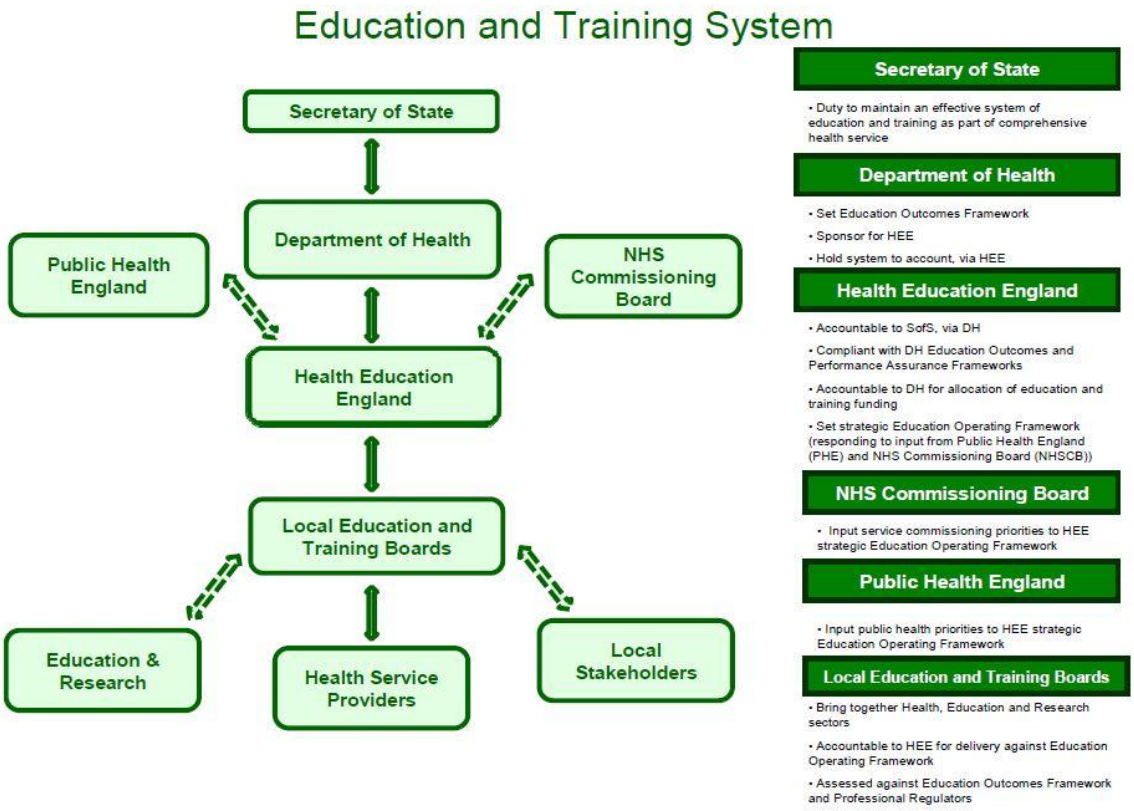


Figure 1: Proposed Education and Training Structure

The national consultation on the Secretary of State's original proposal in 2010 reported that the scale and scope of the changes were a major concern, as was the speed with which they were to be introduced.

Organisational changes created uncertainty and this was to have a significant impact on the East of England Deanery. As part of the Strategic Health Authority, an organisation that was to be abolished, they entered a period of re-organisation and downsizing. There were constant changes to the personnel who administered the project. This included facilitating some access to and communication with primary care practices. Demoralization was evident in remaining Deanery employed personnel. The project team was later to learn that the re-distribution of their work-loads was not always clear and was sometimes resisted.

Uncertainty was not confined to employment or changing workloads. Deaneries play a vital role in the organisation and provision of postgraduate medical and health professional education. There was concern that transition arrangements for their key functions were hurried and unclear. Changes to how education and training is funded fuelled anxiety within and beyond the deanery.

It appeared that a new national education agenda was emerging that:

- was outcomes-driven
- included employers as stakeholders

- involved new organisational structures, and
- new funding and accountability mechanisms.

It was within this changing context that the *'Developing multi-professional organisations in primary care (MPLO)'* project operated - or strived to.

The primary care practices that participated in this project hoped that becoming learning organisations would help them survive in fluid and high-demand contexts shaped, in part, by policy requirements.

1.2 Learning organisations

Learning organisations are prized because of their perceived ability to enable responsive and flexible approaches to work-based learning. They are described as:

> *'…organisations 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 to see the whole together.'* (Senge, 1990)

Peter Senge is generally credited with coining the term 'learning organisation'. His vision of an organisation in which learning reaches the very heart of what it means to be human, an organisation that is able to re-create itself in response to changing conditions relies on mastery of five disciplines:

- systems thinking
- personal mastery
- mental models
- building shared vision
- team learning.

The leader of a learning organisation will be aware that his or her role is to serve the organisation and all the individuals within. This commitment to 'servant leadership' requires creating an environment in which each person is valued as an individual within the larger team and is able to exercise his or her own power, achieve personal mastery and adapt to changing circumstances.

Developing multi-professional learning teams would involve enabling:

- shifts in organisational systems and cultures
- concepts and practices of leadership that are responsive to implementing change
- understanding and skills about how to facilitate the learning process
- a culture of reflective practice.

So, how did these policy directions and empirical research into learning organisations relate to the Eastern Deanery's intention to support the development of learning organisations in the Eastern Region?

1.2.1 Supporting the development of learning organisations in the Eastern Region

As the main providers for training primary care practitioners, the Eastern Deanery needed to build capacity within general practices in order to provide suitable learning environments for a range of learners that include: medical students, medical registrars, pre- and post-registration nurses, allied health professionals, practice managers and other members of the primary care team who hold administrative posts, such as receptionists.

The Eastern Deanery, along with other regional Deaneries, uses Strategic Workforce Investment (SWIFT) funds to support 'ways in which staff can work productively and efficiently whilst providing excellent services in areas relating to (regional) needs' (Eastern Deanery website, 2011)

In their letter inviting expressions of interest from general practices to join a project to develop as multi-professional organisations, the Deanery said;

> *'This (project) is funded for two years to support engaged GP health care teams to develop as multi-professional learning organisations, using current expertise and a commitment to expand practice access to all learners.*
>
> *All health care trainees are required to undertake periods of time within a service in order to support the application of knowledge to a clinical situation as well as further developing their skill base. …There is a need to develop truly multi-professional learning organisations that can deliver a range of practice learning experiences to a broad range of trainees…. The health workforce of the future will need to be flexible, capable of growth and working in a non-blame culture where honesty is respected, and staff are learning from and supporting each other. Learners need to be exposed to these organisations so they can engender similar organisations in the future.'*

The training need and policy direction is evident in this invitation to participate in the project but, apart from funding for development, little attention was given in the invitation to what practices themselves might get from the initiative.

Was the invitation unfortunately framed or does this reflect what we later came to experience: a complex weave of relationships between the Deanery and practices and different needs and priorities?

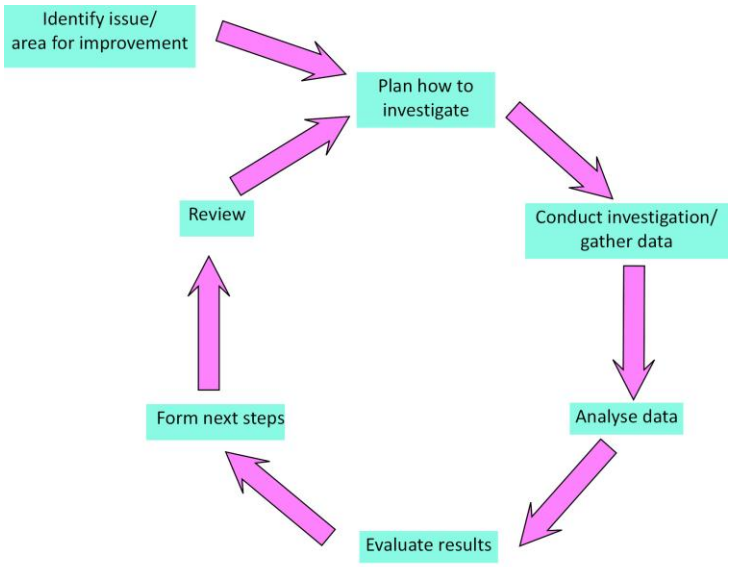
Section 2: How and why?

2.1 Methodology

The aim of this project was to develop learning organisations. Learning organisations require shifts in the values and structures of organisations. They are prized because of their perceived ability to help groups and organisations engage in flexible and responsive work-based learning. Action research supports evidence based and reflective practice that would enable those shifts and processes.

Action research is undertaken with the express intention of informing and improving what people do (Reason and Bradbury, 2001). Development is at its heart. It is often used to address practical problems or pressing issues in a process of inquiry that embeds cyclical development. Typically this involves framing a question or concern, designing and conducting an investigation, identifying and implementing a change, reviewing that change and implementing any necessary further changes. Action research reveals the complexities of a situation and the social practices or social behaviours associated with it. It takes account of contexts.

Figure 2, below, illustrates the action research development cycle.



Action learning/research processes within the MPLO programme

The Deanery identified 19 training practices. The map in Figure 3, below, shows their geographic distribution. Four practices did not choose to participate in the programme (they are in red). Four completed the programme (they are in green). 11 practices left the programme at various stages and for various reasons.

Figure 3: Geographical spread of potential, participating and completing practices

There were two phases to the project:

Phase 1: January-April 2009 (pilot phase)

Phase 2: September 2010-June 2011 (research and development phase)

In Phase 1 of the project (January-April 2009), a pilot test of the feasibility of developing learning organisations was conducted, using a development and research strategy that included:

- exploring with participating practices what multi-professional organisations involve (in a regional workshop and individually within practices)
- identifying where the practice/team is in the process of becoming a learning organisation (individually within practices)
- agreeing a development plan to enhance practice development as a learning organisation (individually within practices) (See Appendix 1: Project development activities, processes and adjustments, for a full list of activities).

The seven primary care practices that participated in the pilot were all recognized and regulated training practices within the Deanery. Training status is a mark of quality in organisational systems, teaching and, by proxy, provision of care. The pilot practices were potentially fertile sites for development.

Access to participating practices was delayed by the slowness of deanery administrators sending contact details to the project team. This delay was compounded by inaccuracies in the contact information and the typical challenges of finding time in the schedule of busy primary care practices to engage in non-service activities. The compound effect of the delay was two months in a four month pilot. (See Appendix 2: Contacting practices - the pilot).

The planned introductory workshop, which would have brought all practices together, had to be abandoned, and activity focused upon the semi-structured interview programme. Six individual interviews and two group interviews in four practices took place, lasting between one and two hours each. The semi-structured interview design allowed interviewees to raise issues, ideas and reflections of their own. Data was collected about practice demographics, role descriptions, perceptions about the quality of care provided by the practice, identification of areas for development and related professional development support.

From an early point in the project, it became apparent that perspectives about the purpose of the project differed among the key stakeholders[2], with consequences for how the success of the project might be assessed or evaluated. Those stakeholders were:

- the **East of England Deanery**, who commissioned the project to develop learning organisations
- **participating general practices**
- the research and development **project team**.

In the rest of the report, these stakeholders will be referred to as: 'the Deanery', 'participating practices' and 'project team'.

As commissioners, the Deanery (the organisation responsible for the training of doctors, nurses, allied health professionals, health care scientists and the pre-professional workforce) had decided to explore developing learning organisations in primary care to increase the capacity for training placements. Their main priority was to address the shortage of placements for all the professional groups for whose training they were responsible.

2.1.1 Phase 1

During the pilot phase (January-April 2009), it became apparent that participating practices had other purposes and priorities. Recruitment of practices was organized by the Deanery. The sample was small. Seven training practices agreed to take part in testing the feasibility of developing learning organisations in primary care. (Two of these regarded themselves to be learning organisations but hoped for support for further development.) Those practices that participated in the pilot expressed enthusiasm for a project that would facilitate their development as a learning organisation. They saw becoming a learning organisation as a means of enabling primary care teams to develop in fluid contexts of change.

'*There is no energy here (in this practice) to be creative*', one General Practitioner (GP) told a member of the project team. Others talked about lapsed away days and concerns that as training practices they should be doing more than surviving heavy workloads and persistent external demands.

[2] A stakeholder is a person, group or organisation who has an interest in or is responsible for an initiative (in this instance) the Developing Multi-Professional Learning Organisation project.

The seven doctors, three nurses and six practice managers who took part in either individual or group interviews were enthusiastic about the potential benefits of engaging in development as a learning organisation. Participants from all participating practices agreed that the project would help them develop the ability to be pro-active in a world which they experienced as one of incessant enforced change and external scrutiny. Their purpose for engaging in the project was about surviving and thriving in practice. The semi-structured interview schedule used in pilot interviews documented some of the work pressures they faced and identified practical, resource and staff development issues that needed to be addressed if practices were to become, or develop further as, learning organisations.

Some practical challenges to becoming a learning organisation included the lack of:

- physical space for accommodating trainees. A private space in which to have learning conversations, particularly sensitive ones, was either non-existent or in much demand within practices.
- physical space for group or team meetings. Places for group or team meetings were also in short supply but high demand.
- time to think, learn, and reflect. Busy, demand-led workloads made engaging in learning and teaching challenging.
- motivation -Doctors raised concerns about 'burn-out', exhaustion' and 'cynicism', their own and others.
- resources for locum cover, presence at external events and staff development inside and outside the practice.

For the project team the primary purpose of the learning organisation initiative was to support participating primary care practices develop a productive culture of work-based learning and reflective practice. That culture would enhance the learning environment of the practice, enriching provision for placements.

These different purposes reflect different needs and priorities. Evidence of success for each purpose or priority varied.

For the Deanery, their evidence of success would be an increase in the number of primary care trainees in placements.

Participating practices would look for successfully addressing internal practice problems or concerns.

The project team would want evidence of practices formulating and engaging in a project to develop their practice or address a concern together with evidence of some of the features of a learning organisation. Building a consensus definition of success would involve sharing an understanding of these different perspectives and negotiating criteria for determining achievement.

Following deliberation on the report from the pilot study, the Deanery decided to fund Phase 2 of the project.

2.1.2 Phase 2

The project was established as a research and development project involving first and second order action research (Elliott, 1991). Participating practices would be supported in identifying their learning needs, formulating a development project and implementing that project. Key to this process was developing reflective and evidence based approaches to practice as they moved through cycles of action, review and reflection.

Methods to support this process included:

- reflective logs
- recorded discussions
- a learning plan
- questionnaires
- a final review or report of learning in portfolio form.

This represents the 'First Order Action Research' element of the study.

The project team leading the study collected data about the learning processes within participating practices. Methods included:

- field-notes of development activities
- semi-structured interviews
- questionnaires
- collection of narratives through the construction of digital stories.

This is the 'Second Order Action Research' element of the study.

The project team supported participating practices to develop as learning organisations in the following ways. They themselves modelled ways of operating as learning organisations, sharing reflective commentaries about their work with each other and on the website with the practices. They welcomed feedback from each other and from practices, and responded to the challenges of the project in ways that supported the core values of a learning organisation. Six of the participating practices constructed learning plans, and identified a 'development project. The project team facilitated this process by means of:

- semi-structured interviews with lead clinicians, practice managers and a sample of others supporting the delivery of primary care, such as receptionists
- focus groups with members of the primary care team

- bespoke workshops delivered within practices. Typically these focused upon identifying and addressing challenges to engaging in collaborative and reflective practice
- individual coaching
- Reflective Digital Storytelling workshops (three were planned)
- a website to support intra- and inter-practice conversations and shared learning.

All empirical work encounters unanticipated problems. This project encountered a large number. The Deanery was engaged in reorganisation and downsizing. There was an impact from part-time working patterns, changes in personnel and their workloads, frustrated communication with the project team and participating practices. It also impacted on the timely release of project funding.

Participating practices found it difficult to attend events that required them to leave their practice premises and to prioritise and protect time to engage in development work. The challenges of developing as learning organisations that practices identified during the pilot phase of the project accounts for most of the drop-outs. The project team would add other challenges including: sickness of sponsoring GPs and practice managers, swine-flu workload implications, external requirements from other parts of the NHS (such as Primary Care Trusts) and competing internal practice priorities.

To facilitate practices' engagement with the project, the project team adjusted their planned activities as Appendix 1 indicates. This included the development of a website to enable intra- and inter-practice learning and sharing, as time to meet as a practice or with other practices was so limited.

The main activity of participating practices was the construction of a learning plan and its implementation. Their learning was to be represented in a portfolio that was to include a self-assessment questionnaire based upon Garvin et al (2008) 'Is your practice a learning organisation?' administered three times during the course of the project.

2.2 Theoretical framework

2.2.1 Learning organisations

Learning organisations are often seen as providing an approach to develop people and systems in change contexts. Senge's definition of a learning organisation is often quoted to claim that such organisations have powerful attributes that will ensure success and quality:

> *'You can gradually evolve a new type of organisation. It will be able to deal with the problems and opportunities of today, and invest in its capacity to embrace tomorrow, because its members are continually focusing on enhancing and expanding their collective awareness and*

abilities. You can create, in other words, an organisation which can learn.'
(Senge, 1994)

What are learning organisations and how do they excel?

Argyris 1977 identified the distinguishing levels of learning that characterized learning organisations. He argues that double loop learning involves a shift from the application of routinized or established practice to the ability to think critically and modify practice in response to the uncertain, unpredictable and particular challenges that practitioners encounter. At this level, practitioners/learners can question assumptions and process both their formal and informal learning to develop a new responses or practice.

This ability to exercise professional judgment has been extensively researched and reported across the literatures of professional education, reflective practice and informal learning.

Within the educational literature of primary care, how are learning organisations described and understood?

In a series of three papers based upon theoretical concepts and empirical research into learning organisations in health care settings, Rushmer, Kelly, Wilkinson and Davies (2004), examine the characteristics of, and conditions for, becoming a learning organisation in primary care. Key themes from the papers are summarized below.

Characteristics of a learning organisation:

- flatter team based structures
- values - learning is prioritized
- values - empowerment for change is also a priority.

Becoming a learning practice:

- individual and organisational learning begins a process of moving towards a learning culture.
- routines need to be established that help to create a supportive systematic approach to learning which-
- creates conditions that make learning an integral part of what a practice does.
- Core conditions for learning organisations:
- strong and visionary leadership: leaders who support and develop others, ask challenging questions, are willing to learn themselves, see possibilities, make things happen, facilitate learning environments.
- involvement and empowerment of staff where changes grow from the willing participation of all concerned.

- setting aside of times and places for reflection (Rushmer, Kelly, Wilkinson and Davis, 2004).

Figure 4 illustrates the interconnectedness of the key components of organisational learning in terms of Senge's five disciplines.

Figure 4: Senge's five disciplines as components of organisational learning

The Royal College of General Practitioners (RCGP) has a module within their *Quality Practice Award* on learning organisations. The module seeks to involve practices in established good practice, such as, ensuring appropriate qualifications to undertake roles, annual appraisals for non-clinical staff, significant event reviews, patient involvement and a commitment to working effectively together. (RCGP Quality Practice Award, 2012)

The action research-based approach of the '*Developing Multi-Professional Learning Organisations in Primary Care'* project was different but complementary to that of the RCGP. Our emphasis was on benchmarking the starting point of practices in relation to their learning needs and concerns and facilitating participating practices to address those within an action research inquiry process. Collaborative working and co-creating 'action' addressing problems and issues characterize action research methodology.

2.2.2 Thinking organisations

> *'The quality of everything human beings do depends on the thinking we do first. Creating a Thinking Environment, therefore, is the first responsibility of leadership. Every subsequent act gains quality from there.'* (Time to think website, 2012)

Conditions for learning

In order for learning to take place, certain conditions need to be in place. Foremost among these are the conditions that make thinking possible.

Nancy Kline has developed her idea of the thinking environment over many years. In her book, *Time to Think* (Kline, 1999), she sets out ten components that are the foundation of the thinking environment.

The components are:

- **Attention** – respectful listening and thoughtful attention have a powerful effect on others.
- **Equality** – valuing everyone equally, ensuring equal time and attention, respecting boundaries and agreements enable thinking to be articulated.
- **Appreciation** – focusing on the positive provides a balanced view that is not only seeking to identify problems but also recognises the good in every situation.
- **Ease** – people need to feel relaxed and comfortable if they are to think clearly. Freedom from pressure and a sense of urgency will contribute to a creative, thoughtful environment.
- **Encouragement** – thoughts and their thinkers should be encouraged on their own merits in order to reduce the sense of competition which can stifle creativity and given courage to explore the frontiers of thought.
- **Feelings** – creativity is sparked by feeling, whether the feeling is sadness or joy, elation or despair. Allowing – even encouraging – the expression of emotions can help to promote thinking.
- **Information** – a reliable supply of accurate, timely information is just as vital as the recognition of the truth, however difficult this might be.
- **Diversity** – just as diversity is essential to the survival of the biological world, difference is essential to creative thinking. Diversity should be encouraged and people must feel safe enough to express divergent and differing views.
- **Incisive questions** – unexamined assumptions inhibit new thoughts and good ideas. It is important to become aware of assumptions that limit our ability to do things differently and discover those that free us to think creatively.
- **Place** – the physical environment provided for thinking lets people know how much they matter. Care should be taken to provide a pleasant, safe, secure place in which body and mind are well cared for.

2.2.3 Narrative and the role of digital storytelling

> *'… The ability to tell, hear and share stories of experience and aspiration is a pre-requisite for the development of a learning organisation of reflective individuals.'* (Sumner, 2009)

Stories help people make sense of experiences – their own and those of others. They are a beneficial way for people to process difficult, confusing or painful experiences, as well as to share achievements and accomplishments. Above all, stories convey values and tacit knowledge: those things we need to know, but don't necessarily know we need to know – the stories of a family, a group, an organisation, a society.

Storytelling approaches bring with them the problem of how to capture the story in a way that may provide opportunities for reflection beyond the span of the story:

> *'Stories are products of reflection, but we do not usually hold onto them long enough to make them objects of reflection in their own right.'* (Schön, 1987)

Through the processes and technologies employed in digital storytelling, we can hold onto – and share – those previously ephemeral stories.

Digital stories are short, multi-media presentations, lasting only two or three minutes, consisting of still images, music, a voiceover and some simple titling. The stories are told by real people about real experiences in their own words; the process of scripting and creating the stories results in a *distillation* that reveals the heart or 'essence' of the story.

The digital story format offers viewers an unusual opportunity to step into the shoes of the storyteller and thus to develop empathy and cultivate greater compassion and understanding. It also offers a powerful means of raising awareness, challenging assumptions, examining and reflecting on practice – one's own as well as that of others – and to explore possibilities for change.

Digital storytelling incorporates skills drawn from creative writing, community theatre, group work and art therapy, while engaging people with the skills of storytelling using new technology and new media. Offering 'ordinary' people a voice, allowing their stories to be heard in lecture theatres, board rooms and conference centres anywhere in the world, the sharing of authentic stories can help to generate trust within and between both disparate and similar groups of people.

Digital stories can be used as valuable, focused, flexible and impactful teaching and learning resources that can be disseminated widely and effectively for use in a wide variety of contexts. Digital storytelling is, above all, a highly democratic, emancipatory and humane means of promoting understanding, respect and social justice.

Chochinov (2007) acknowledges the use of stories as one of the best ways to cultivate compassion, an essential ingredient of what he calls 'the ABCD of dignity-conserving care'. Our experience with the Patient Voices digital stories shows that the stories are a highly effective way of engaging the hearts – as well as the minds – of viewers, whether they are clinicians, managers, commissioners, educators or students of healthcare. Indeed, the stories illustrate the 'revolt of our hearts against our heartlessness' (Tilby, 2007), reminding

us of our common humanity and of the need to treat our patients, carers and colleagues with dignity and respect.

Stories are increasingly acknowledged as playing a crucial role in the redesign of health and social care services, not least in Robert Francis' report on the investigation into failures of care in Mid Staffs:

> *'If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented.'* (Francis, 2010)

The Patient Voices Programme, founded in 2003, aims to carry out the important task of gathering and disseminating the stories of patients, carers, service users and those involved in delivering health and social care in a creative and accessible way so that important lessons might be more easily learned and shared. Initially intended to remind those who make decisions about, and those who deliver healthcare and other public sector services, of our shared humanity, the stories are now used in a wide variety of contexts from induction and recruitment, through patient safety, service improvement, audit and evaluation, to team-building and organisational development (Moss, 2012).

It is our view that, for the reflective learner, true learning is about transformation at a personal level as well as professional and, ultimately, organisational and societal level. We use a storytelling approach because 'storytelling is the mode of description best suited to transformation in new situations of action.' (Schön, 1987).

Section 3: What happened?

3.1 Project process and activity

The context in which the Deanery operated placed constraints on the progress of the project which we identified under the communication issues resulting from their reorganisation, part-time working and downsizing. Participating practices also worked within a context that constrained both how they prioritized and engaged with the project which we now examine.

The seven primary care practices which took part in the pilot study between January-April 2009 were all training practices within the East of England Multi Professional Deanery. They were potentially fertile sites for development and had expressed enthusiasm for taking part in the project.

During the pilot phase the project team encountered some obstacles in getting access to and communicating with practices. This produced a two-month delay in a four month pilot (see Appendix 2: Contacting practices - the pilot).

During February and March, the usual constraints in communicating with practices were added to by the demands of practices submitting data for the Quality Outcomes Framework (QOF) by the end of March. This was also the end of the financial year for many practices, which involved another critical deadline that had priority over participation with the Developing Multi-Professional Organisations in Primary Care (MPLO) project.

Key people within some practices were on annual leave during this time. Two GPs were on holiday and Practice Managers were unwilling to agree any interviews in their absence. In the end it proved impossible to organize visits and interview to these practices in the time frame available.

Communication challenges with practices endured in the second phase of the project. 18 practices expressed an interest in the project following the pilot study. Of these, six established an initial commitment to the project beyond the first six months. Four practices stayed to the end of the project, submitting a portfolio of their learning, which focused mainly on the development project, they had undertaken. These practices had participated in the pilot.

Practice managers were the main and usually only point of contact with practices. They could be slow to respond to telephone or email requests, sometimes for weeks or months. Arranged meetings could be cancelled at the last minute and rescheduled for months later. On some occasions agreed lunchtime visits would be shared with other external visitors, reducing the time available for developmental support.

It became apparent that while some GPs had expressed enthusiasm for this project, that was not always shared or shared with equal enthusiasm by their partners.

To facilitate practice engagement, the project team found they needed to constantly adjust schedules and activities in response to constraints generated by the regulatory, financial and clinical priorities of practices and the challenging circumstances in which the Deanery exercised an extended commissioning role.

In Appendix 1: Project development activities, processes and adjustments, we outline planned learning support activities and how they had to be adjusted. The table helps to illustrate how our assumptions about how to engage with practices had to be re-thought regularly. For example: a project website was developed to enable intra- and cross-practice communication and shared learning, but activity in it was very low, indeed, negligible. NHS firewalls, access to practice-based computers for non-clinical activity, slowness of some practice managers to circulate the website URL and competition from the development within practices of their own intranets, all acted as obstacles to engagement.

Workshops for cross-practice sharing, though identified during the Pilot Phase as a motivation for participation, failed to recruit. Indeed any activity that required leaving the practice attracted little, if any, support.

There were other unanticipated dis-incentives to engagement with the project. Some Primary Care Trusts (health authorities) funded time for staff development which included closing the practice. Others did not. Project funds to support closure for staff development were not effectively communicated and were difficult to access for those who tried. In these circumstances, some practices felt engagement with the project was not adequately resourced. Deanery expectations about what activity could reasonably be associated with participation in the project and claimed for and practice expectations could differ. These obstacles to access, communication and engagement are discussed in *Section 4: What did we learn?*.

Once the project team could meet with staff it became apparent that what people within practices recognized and valued as work and learning could vary significantly. This became apparent during both whole practice and small group meetings. Not all clinical staff shared enthusiasm for a project that focused on organisational development and the process driven approach supporting that. It seemed that in the business of some practices the urgency for action had created a caution about interruptions from going the job. Yet this pressure and its perceived detrimental effects on the quality of care had been described as an incentive to join the project during the pilot phase.

Within practices, experiences of learning differed among professional groups and secretarial and administrative staff. Clinicians were more practised at talking about their practice and reflecting upon it. Their postgraduate training provided some models for work-based learning that they could continue to use, at least as individuals. Secretarial and administrative staff were either engaging in learning from work for the first time, or were less practised in reflection and sharing. In some practices, these different starting points impacted upon how contributions from these different groups were valued. Nevertheless,

there was a tendency for project activities to focus mainly on secretarial and administrative developments. Each of the completing practices had supportive lead clinicians and practice managers.

3.2 Practices that dropped out of the project

Those practices that dropped out of the project cited a range of reasons including: illness of GPs or practice managers, the demands of building work, or lack of time. These reflect some of the obstacles to engagement that practices identified during the pilot study. Taking on commitments beyond the everyday demands of primary care appeared to be difficult for many.

Supporting development of learning organisations became an activity involving mostly facilitation and coaching within practices. Activities, which involved people leaving their work and attending outside events, even though there was financial support to do so, failed to recruit. Practices felt and behaved as if they were 'pinned down'.

Within participating practices support focused on:

- Addressing issues of respect and trust which were essential for the improvement of communication horizontally within clinical and non-clinical groups and vertically, moving up and down hierarchy. This was also important for developing a sense of safety in which to contribute and deal with sensitive or otherwise challenging issues.
- Re-visiting what work-based learning might be and helping those within practices to engage in reflective conversations about everyday working events and value learning from that.
- Related to re-thinking what work-based learning is and might involve, the project team arranged visits to practices to explain how narratives and the role of individual narratives through the creation of digital stories, could support learning and reflective practice.
- Finding ways of recording learning that was not onerous. These included: the use of dictaphones, postings on practice intranets, use of meeting minutes, the customization of a survey that each practice used three times during the life the project to identify their progress as a learning organisation.
- Coaching individual practice team members. This included: receptionists, practice managers and nurses.

Once the project team could meet with staff it became apparent that what people within practices recognized and valued as work and learning varied significantly.

How effective was engagement with practices and what did we learn?

3.3 Practice projects

The proposed schedule of activities to support the development of practices as learning organisations had assumed that the process would involve moving from an understanding of learning organisations to identifying a practice work-based learning need. This would be formulated into a development project that would then be undertaken and reported. Two of the completing practices found this to be a useful process. They were the two practices that already regarded themselves to be learning organisations. The remaining two practices did not find this a useful process. Though they did identify a learning need (area they wished to develop) they became active in what they decided was the most appropriate action they could take. Creating a proposal or fully worked out learning plan was not something they found useful.

Practice 1 and Practice 2 submitted a proposal. Though both regarded themselves to be learning organisations, Practice 2 talked about the remaining challenges they felt they faced.

3.3.1 Examples of project activities

Practice 1 proposed finding out what teaching and training skills existed within the practice and would use this to help staff recognize those skills in themselves and build upon them.

Practice 2 wanted to change further the culture within their practice and set themselves a series of objectives.

Practice 3 developed a new intranet to improve practice communication and share learning.

Practice 4 started a blog to improve communication and extend the use of the practice internet to share documents and support informal learning. They also developed training activities for receptionists.

3.3.2 Practice 2: a vignette

The following vignette of a practice portfolio provides a snapshot of practice participation and reporting. The project team provided the headings.

Profile and rationale for joining the project

'We have a history and interest in building a learning organisation. Staff development, quality of service, patient safety and patient care are the four fundamental principles of our daily engagement in Primary Health Care.

We became a Vocational Training Practice for clinical learners as well as being one of the first Practice Nurse (1990) and Manager (2005) training practices in the country.

We have also made sustained investment in staff training and development, e.g. non-GP Associate Trainer, CPD and lifelong learning and to improve capacity and to be ready to respond to and, even compete in, the changing social and economic environment.

.. we were inspired to join the Multi-Professional Learning Organisation Project.. to support the development of the culture of whole team learning and, hopefully, improve the quality of care offered to patient.

In the MPLO project we aim to:

- *create a culture in the practice which celebrates and encourages success and innovation, a culture which recognizes and has scope for acknowledging and learning from past mistakes*
- *protect time and space for multi-disciplinary learning - in teams and as a whole practice*
- *improve effective communication for the Team and for Patients at a time of NHS reforms*
- *provide a safer, quality environment for our patients and for team members,*
- *be sustainable for the future*
- *learn from others and share experiences through networking with other organisations.*

Summary of activities

- *extending 'Team Talk' – weekly facilitated protected learning for reception, administration and secretarial staff*
- *team building and team working-building trust, respect and value across professional teams, across the whole practice team and with our patients via the Patient Participation Group*
- *organizing our first extended whole practice-learning event*
- *undertaking a series of three Learning Organisation Evaluation questionnaires.*

Practice 2 serves 18,000 patients in an area of high unemployment, poverty, social deprivation, childhood obesity, teenage pregnancy, safeguarding issues, single parent families, an ageing population, chronic illness and elderly carers. (All this contributes to) higher than average consultation rates and other demands on services offered by the Team'.
(Extracts from Practice 2 Portfolio)

The portfolio documents the implementation and refinement of communication activates, some planned at the outset of the practice development plan and others that emerged. Two

electronic forms of communication were added to the practice intranet. A daily bulletin was produced for all staff with reminders of cover arrangements for holidays, other changes to working patterns, visits to the practice from external people or agencies and progress on actions agreed at practice meetings. The Tree of Knowledge was an interactive communication bulletin board where all staff could post social and work related information. This stimulated cross-practice communication and provided a means for continuing conversations about progress of the development plan and other work issues that were arising.

'Team Talk' became an established weekly communication and development meeting for non-clinical staff. However, following feedback from this group a Partner (GP) representative attended each meeting to ensure the 'visibility' of two-way communication. Secretaries' lunch-breaks were adjusted to ensure that their attendance at these meetings was paid for.

The practice did hold two whole practice-learning events. One was a 'Significant Event Audit' workshop with external speaker, Professor Mike Pringle. Active in primary care development at a senior level, Professor Pringle is a past Chairman of the RCGP (1998- 2001). He complimented the practice on their open and inclusive cross-professional group conversations.

The practice was accepted onto the testing of a curriculum that formed part of the national 'Productive General Practice Programme' and their self-assessment questionnaire was taken and used as a basis for development work within that initiative. A practice manager of Practice 2 said that they had been accepted on the basis of work undertaken with the 'Developing multi-professional learning organisations' project. However the demands of the national project proved onerous as a practice manager reflected upon in their Practice portfolio:

> *'We hoped the (Productive General Practice Programme) could continue the (kind of) support we (were having) to develop as a learning organisation. Our experience is that (initiative) is hugely demanding on us (practice managers) and on other staff. There is little or no awareness of the realities of our daily working lives and the demands this makes on our time in the context of excellence in patient care.'*

The portfolio concludes with an observation from a practice manager of a whole practice development meeting.

> *'When I was aware of laughter around the room, I looked and I could see virtually everyone was involved, smiling, nodding, laughing-and I thought - It's happening - we are getting there.'*

Each completing practice submitted a portfolio of their development project. They include items such as: materials from development activities, accounts of away days, reflections of

learning (some of which are very brief bullet points and others are more detailed) and self-assessments of progress in the form of questionnaires.

Portfolios show that three out of the four practices focused upon developing communication and this involved addressing issues around respect for individuals, the need for safe spaces to learn, developing approaches to learn from everyday practice and the importance of senior management support for this kind of practice based development. The fourth practice focused upon identifying teaching skills within the practice and, recognizing, valuing and developing teaching skills in all practice team members. Here the emphasis was upon developing a teaching organisation. This practice was one of the two practices that had been developing as a learning organisation for a number of years.

3.4 Development as a learning organisation: practice self-assessment tool development, application and results

In Chapter 3 Getting the basics right of Learning for a change in healthcare, Professor Fryer notes that:

> *'Implementation of the vision will entail healthcare employers benchmarking their widening participation in learning practices against the best, by collecting systematic data on staff learning and development and critically reviewing progress. Success will be marked by healthcare organisations becoming genuine 'learning organisations' and being increasingly regarded as 'best in class', in the effective deployment of new ways of learning for staff at all levels, especially with regard to widening participation in learning, including innovative work-based and e-learning.* (Fryer, 2006)

The approach to learning organisations and the recommendations in Fryer's report are underpinned by the work of Peter Senge, widely credited with the concept of the learning organisation, who defined learning organisations as:

> *'Learning Organisations are organisations where people continually expand their capacity to create the results they truly desire; where new and expansive patterns of thinking are nurtured; where collective aspirations are set free and where people are continually learning how to learn together.'* Senge, 1990

One response from potential and participating practices was that, as they had completed the Royal College of General Practitioners (RCGP) Modular Quality Practice Award (mQPA), they were already learning organisations.

The mQPA does contain a module on learning organisations, but as can be seen below, the approach to assessing whether or not a practice is a learning organisation differs markedly from that advocated by Fryer, or defined by Senge. The module contains a set of criteria that

define a learning organisation, together with the evidence requirements for each criterion and, in most cases, guidance on suitable evidence.

The criteria, and the RCGP descriptions, are shown in Appendix 3: RCGP Learning organisation criteria. As can be seen, these criteria are largely checks for the existence of particular processes or procedures within the practice. They do not preclude reflection but rather emphasise organisational structures.

Whilst some practices had engaged with the RCGP mQPA approach to self-assessment of the status and practices as learning organisations, the mQPA procedural audit approach did not fit with the philosophy of the MPLO project, which was to develop practices and to provide them with reflective, self-contextualised tools that carried a sense of ownership.

3.4. 1 Supporting participating practices in developing and owning their own self-assessment tools

In order to provide a tool for practice self-assessment that was more closely aligned with the philosophy of the MPLO project, participating practices were provided with adaptable self-assessment questionnaire templates.

The first possible model tool was adapted from *Leadership and Teambuilding in Primary Care* (Mullins and Constable, 2007).

A second possible model tool was provided, adapted from *Is Yours a Learning Organisation?* Garvin, D., Edmondson, A., Gino, F., Harvard Business Review, March 2008. Both model tools can be seen in Appendix 4: Model self-assessment questionnaires that could be adapted by participating practices.

3.4.2 Adaptations of the learning tool by participating practices

After discussion with the Principle Investigator, participating practices decided to review and adapt the model tools in the light of their own context and goals, so that the self-assessment tool and measure of development was internally-acceptable and organisationally-owned. This permitted practices to develop adaptations that were deemed by them to be appropriate to their own learning goals.

Three practices chose to develop and administer their own learning organisation self-assessment tool. Practices adapted the content and questions within the model tool, and the method of data-gathering and categorisation, to better match their own perceived needs. All of the modified questionnaires can be seen in Appendix 5: Modified self-assessment questionnaires.

All chose to base their own custom tool on the provided adaptation of Edmondson and Gino. All made some changes from the model suggested. Two practices followed the model

closely. One of those chose to use a subset of the questions, omitting the section on 'Experimentation' which contained the following questions:

- Your team frequently experiments with new ways of working together.
- Your team recognises the importance of informal learning through spontaneous conversations.
- Your team has a formal procedure for discussing, planning and evaluating new ideas.
- Your team frequently uses simulations or developmental meetings to try out new ideas.

The third practice changed the tool more significantly.

3.4.3 Administration of the self-assessment tool

The self-assessment tools were used twice by each practice, approximately six to seven months apart. Each practice used the results internally for their own reflection and self-assessment. The data was also returned to the project team, who entered it into Excel spreadsheets in order to analyse the data returned for each adapted questionnaire.

3.4.4 Analysis of results from the self-assessment tool

The data from each of the six sets of returns was entered into specially-constructed Excel spreadsheets that calculated arithmetic average responses overall, average by Part, average by Section and average by Question.

Charts of key response changes are shown in the figures below.

Practice 1

Changes in questionnaire response over the six months between administration of the self-assessment by Practice 1 are show in Figure 5. Changes are shown on a per-section basis.

Most notable is the increased score for the section of questions on experimentation, which perhaps reflects a response to the engagement of the practice in the programme. Most other sections show a decline. This may be due to a change in the practice environment, or due to an increased awareness among respondents of the nature of a learning organisation.

Practice 2

Changes in questionnaire response over the six months between administration of the self-assessment by Practice 2 are show in Figure 6 below. Changes are shown on a per-section basis. Note that this practice chose not to use the 'Experimentation' section of questions, which was the section with a notably high response in the responses from Practice 1 above.

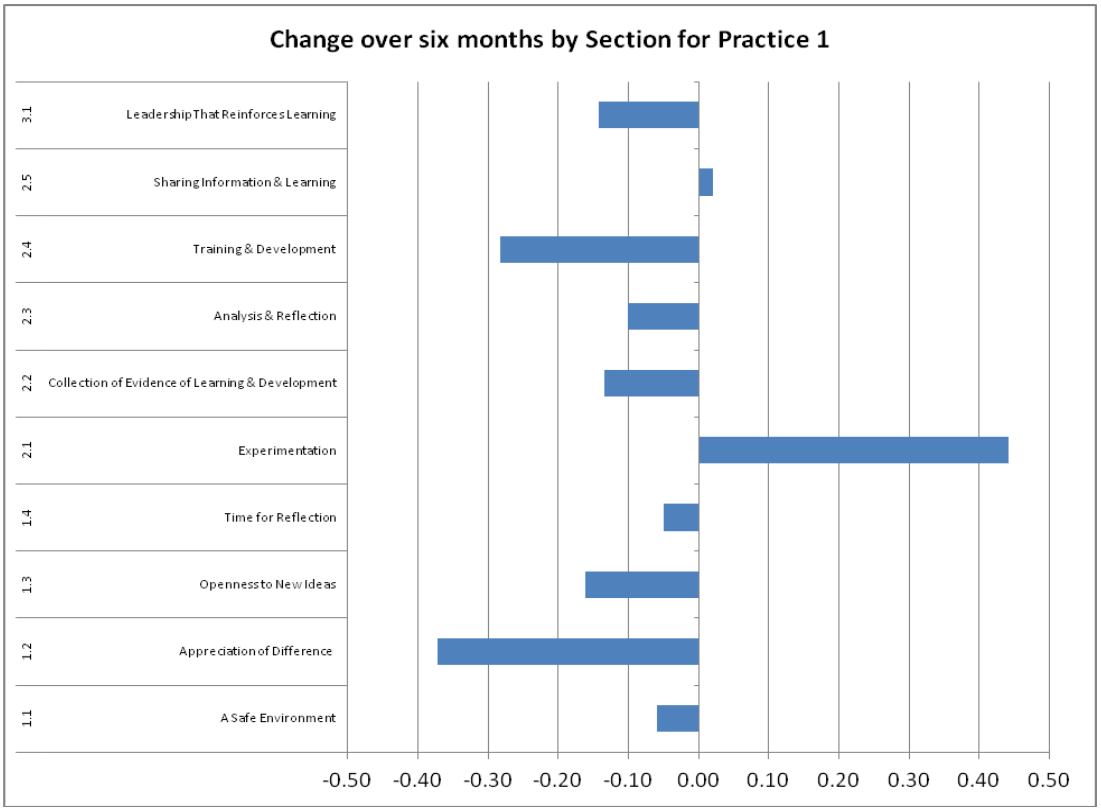


Figure 5: Change in questionnaire response by section for Practice 1

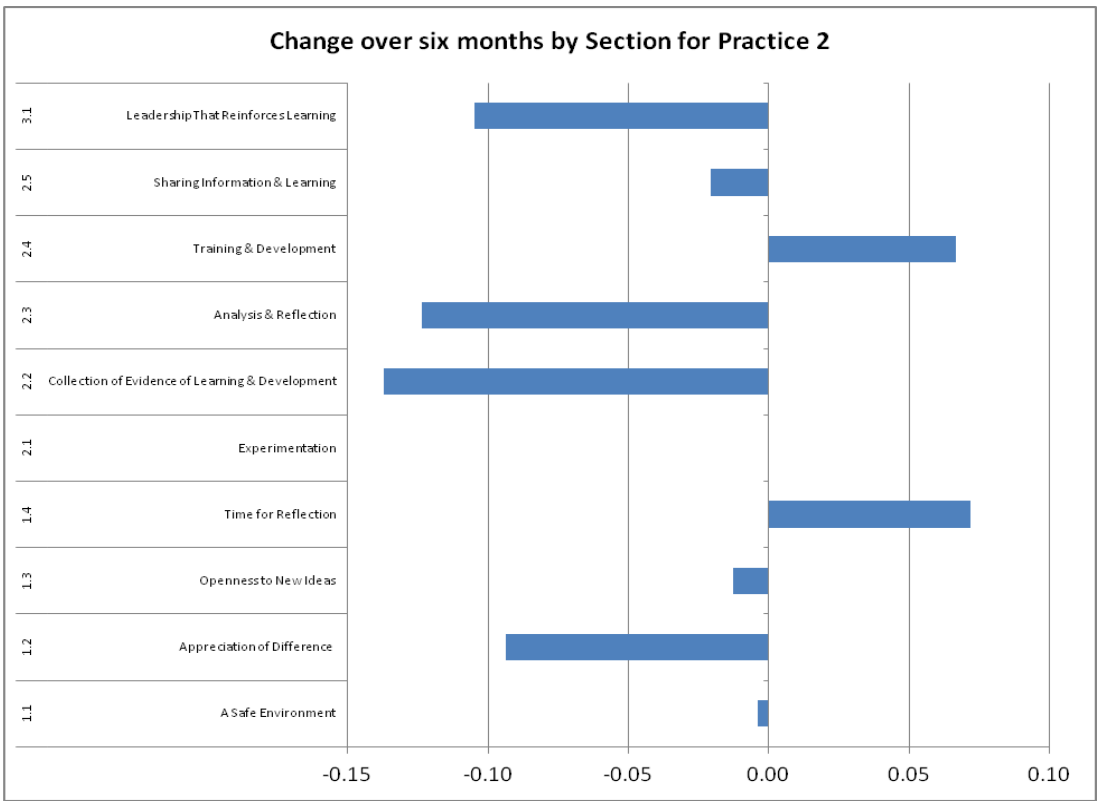


Figure 6: Change in questionnaire response by section for Practice 2

Most notable here is the increase in scores for the sections on 'Training and development' and 'Time for reflection'. These would seem an appropriate response to the intervention by the project.

Most other sections show a decline. This may be to a change in the environment in the practice, or due to an increased awareness among respondents of the nature of a learning organisation.

Practice 3

This practice chose to administer their tool in a different manner, and adapted the questions more heavily. The results shown (in Figure 7) are the whole-practice changes in average response by question over the six month period between the two uses of the tool.

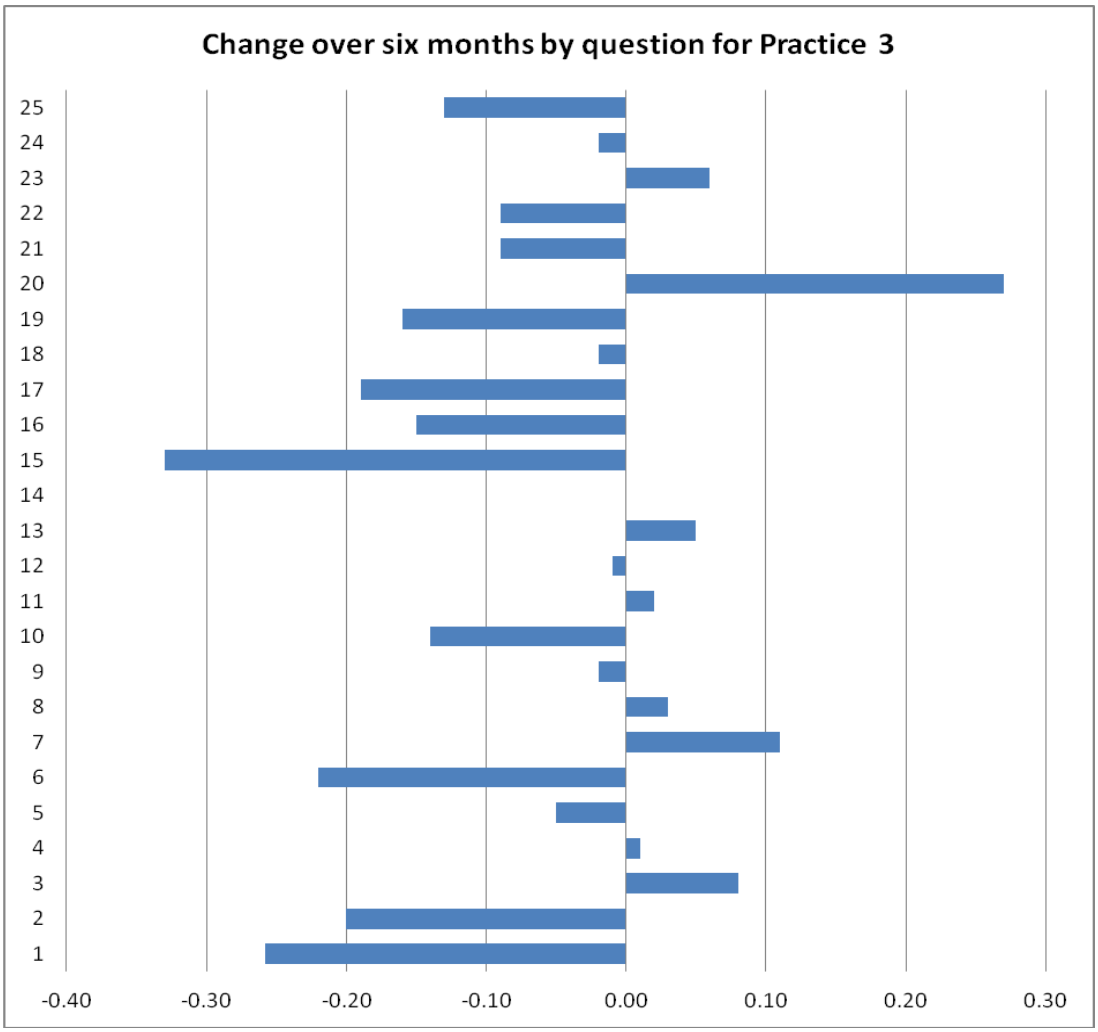


Figure 7: Change in questionnaire response by section for Practice 3

The single best improvement in response is to Question 20, which was 'The quality of care delivered by this Practice is supported by reliable and effective in-house administrative systems.'

There are areas for concern in the responses to questions 1 and 2, and questions 15, 16 and 17, which may indicate internal cultural or structural problems or, as with the other practices, be due to an increased awareness among respondents of the nature of a learning organisation.

In summary, the customised administration of the self-assessment tool among practices and the small numbers mean that no statistical evidence can be drawn. However, there are patterns across practice self-assessments. Overall, scores relating to time for and engagement with reflection increase. Scores relating to the presence and characteristics of a learning organisation appear to decrease. This could be the effect of engagement with the project as practices begin to focus on development needs and improvement activities.

3.4.5 Summary of self-assessment activities

The customised administration of the self-assessment tool among practices, and the small numbers, mean that no statistical evidence can be drawn. However, there are patters across practice self-assessments.

Overall, scores relating to time for, and engagement with, reflection increase.

Scores relating to the presence of characteristics of a learning organisation appear to decrease.

This could be the effect of engagement with the project as practices begin to focus on development needs and improvement activities.

3.5 Digital storytelling

> *Digital storytelling empowers patients, carers and clinicians to convey their felt experiences of healthcare via technology so that their voices can be heard in any lecture theatre, Board room or conference venue anywhere in the world*. (Hardy 2007)

3.5.1 Our aims

Our initial aim was to encourage the telling and sharing of stories within and between practices through established means of storytelling such as those described by Hardy and Sumner 2008; Lambert 2002; and Baldwin 2005. Creating an opportunity for the voices of all those within primary care practices was central to our methodology and embedded in the multi-professional orientation of the MPLO project. We envisaged that the primary care practice teams would share and document their challenges, hopes, progress, learning and future plans through story circles. The stories that emerged, along with their reflections on their practice, was intended to form part of the 'practitioner inquiry' element of the research.

A selection of team members was to be invited to participate in an initial digital storytelling workshop to create digital stories. These stories would be used as an initial benchmark of where people and practices perceived themselves as they embarked on the development of their primary care practice as a learning organisation. . A second digital storytelling workshop was intended to reveal progress, celebrate achievement and highlight challenges along the way. With permission from storytellers, stories would be shared among participating practices as a means of generating reflection and discussion and would also be preserved in the Patient Voices Programme so that others might share the learning.

3.5.2 What actually happened?

Difficulties in making contact with potential storytellers in practices, added to time pressures and a reluctance to leave practices resulted in several delays and cancelled workshop dates. Eventually, a digital storytelling workshop was held in May 2010. There were three participants: one from the project team and two from practices.

3.5.3 Concerns and issues before the workshop

Despite our attempts to organize briefing sessions in practices and recruit a wide range of storytellers, lack of time was given as a reason for the low numbers of participants. Lack of time was also cited as a reason for some participants who had not engaged with the pre-workshop material we provided. The expectations and levels of preparedness of storytellers were varied. One had not received the briefing notes that had been sent to the practice manager and another had been explicitly briefed as to the story she was expected to tell. She commented:

> *'I wish my practice manager had come to the briefing session – it might have given her a bit of insight into what it was really about.'*

3.5.4 During the workshop

Participants were concerned about issues of ***safety*** and ***disclosure***, and there was some tension between the expectation to tell a particular kind of (professional) story for or about the practice, and the desire to tell a more personal (and personally meaningful) story.

While this is a tension that often causes confusion, it is the process of telling a personal story that gives digital storytelling its distinctive ability to engage people of all ages, classes, religions, levels of educational attainment, nationalities, gender orientation, etc., and to touch the hearts as well as the heads of those who watch the story. Sharing personal stories, i.e. stories that reveal something important about values, we are reminded of our common humanity and the universal experience of being human.

It is, after all, people who make up organisations. Unless transformation begins at an individual level, it is unlikely that the organisation will transform.

After considerable discussion, each of the participants made the decision to tell a more personal story than they had first anticipated telling. There was a recognition that this was risky and that their stories might not be able to be used, but the desire to find some meaning in difficult experiences was strong. The need for ***safety*** and ***confidentiality*** was particularly great and it seems that the need was met, if the resulting stories are any guideline. The courage of the storytellers was something of a surprise, particularly as it was in marked contrast with what they had been briefed by practices to do. The stories that were ultimately created revealed remarkable resilience and courage in the face of highly emotional and challenging situations that had an impact on the personal and professional lives of storytellers. Storytellers grappled with the details of painful events in their personal lives and attempted to make some sense of them in the context of their professional lives.

Issues around disclosure, secrecy, privacy, information sharing are often of some concern at Patient Voices digital storytelling workshops. Patients and service users may fear reprisals in the shape of poor treatment, carers may share similar concerns for their cared-for people. Clinicians and other staff may fear negative responses to a story that highlights safety issues. However, these concerns ***were more prominent*** at this workshop. There were particular concerns here in relation to *reporting back, hierarchy, disclosure, power, trust* and *respect.* Participants didn't feel that they were working in an environment of mutual trust and respect within their practices and so were reluctant to share, let alone release, the stories that they ultimately told. This is unfortunate as there were important lessons that could be drawn from each of the stories about trust, respect, value, the danger of making assumptions, the ways in which hidden sorrows impact upon professional lives.

Section 4: What did we learn?

The findings from this project fall into three categories:

1 Contemporary challenges of organisational work-based learning in primary care

2 Pre-requisite conditions for developing learning organisations in primary care

3 Learning from digital storytelling activities.

4.1 Contemporary challenges of organisational work-based learning in primary care

The working and learning environment of primary care practices presents some contemporary challenges to engaging in work-based learning. While some of these challenges are not new, they are re-shaped with significant implications for developing learning organisations.

4.1.1 Access to participating practices

Access to practices was challenging, and this has continued throughout the project. Arrangements were vulnerable to a range of changes including: the re-scheduling of date and time as well as availability of staff. Meetings with staff other than the practice manager were usually allocated to lunchtime slots shared with other external 'visitors' such as pharmaceutical representatives. In contrast to previous experience within the project team of working with primary care practices, getting into practices and getting heard was not just an initial challenge and negotiation followed by a more informal and relaxed set-up of contact, but a visit by visit negotiation with a gatekeeper, typically the practice manager.

4.1.2 Gatekeeper blocks

Practice managers functioned as gatekeepers in many ways. Some would act as the only point of direct contact with the project. They could be slow and unresponsive channels for communication. Information the project team would send about events or access information for our website was not always passed on to staff, (in one case for 7 months). Preparatory materials and exercises for the Digital Story workshop were not given to staff who were interested in attending and even to staff who had booked to attend. Some workshop participants had not received information sent to practice managers about travel, accommodation and what to bring to the workshop. Practice managers could act as shields to the outside world.

They too were busy and additional requests for their time and attention had to compete with the relentlessness of service demand. In interview one explained that the Strategic Health Authority, the Primary Care Trust (both health authority organisations) and other consultancy or training agencies could demand to come into the practice for meetings or to

deliver training at quite short notice. This made it difficult to maintain visiting agreements with those who did not have 'visiting rights' or even to get access to the GPs whose calendars were often fully booked weeks in advance. Similar issues arose with access to space.

4.1.3 Safe spaces to learn and share

Spaces within participating practices

When working with individuals in private spaces, the conditions to explore difficult issues could be created. Physical privacy, a consulting room or an office, helped facilitate candid discussion. However, such private spaces were few and they were frequently in use. Small group work might have to take place in a staff room amid the babble of lunchtime conversations. On a few occasions, reception and administrative staff could not hear conversation during the externally facilitated development session because of the loud comments of practice clinicians who had come to check the Visitors' Book or patient notes which were stored at the back of the area.

The physical constraints of spaces in which to learn presented challenges when addressing sensitive issues around respect for individuals, responding to error, managing angry or distressed patients or senior staff. There were other kinds of space constraints, these related to the culture of the working environment. Professional hierarchies, cultural values relating to people and ways of knowing and expectations played a significant role in shaping engagement with the project.

For example, a receptionist giving a presentation for the first time to the whole practice was reduced to tears. A clinician challenged her during her presentation on inaccurate spelling and superficial thinking. The humiliation was witnessed by other clinicians, nurses, receptionists and the practice manager. Later, the practice manager asked the GP to apologise. He refused to do so at first because *what* he said was not wrong.

This incident was an illuminative event of what kinds of knowledge and contributions were valued and valued most within the primary care practice.

In terms of Kline's 10 components for a thinking environment this incident suggests that there were some omissions, notably, attention (attentive listening), equality, appreciation, ease and encouragement.

Spaces outside participating practices

The project had anticipated creating different kinds of learning spaces external to the practice environment. These included the web-site and Reflective Digital Story Workshops.

Reflective Digital Storytelling workshops provide safe spaces for people to identify and explore their own 'issues' or narratives, the stories that have meaning in their lives. One participant was happy to share his story within the workshop and with other practices but

not his own practice. The story remained private but the emotional resistance to sharing with his practice raised questions about the nature of safety. Was his response to an individual or a group? Would others in the practice be surprised if they knew of his refusal to share within the practice, or not? Did the reaction relate to a problematic episode or did the response relate to an issue embedded in the values, organisational culture and working practices of this primary care practice?

4.1.4 Re-thinking work-based learning

Initially some of the participating practices thought the project would be delivering formal inputs about how to become a learning organisation, with clear tasks and targets (as in the RCGP Module 5: Learning Organisations, for the Quality Practice Award). Instead the project engaged them in thinking about what a learning organisation was or might be, what their own learning needs were, and how they might start to address those.

This process formed part of a facilitation to help practices identify their own 'development projects' and to reflect upon assumptions, values, interactions and protocols as they began to change the culture of their working community.

The project team assumed that facilitation would involve a neat and helpful process of:

- moving from an understanding of learning organisations,
- to creating a baseline of learning needs,
- submitting a proposal for a development project related to learning needs,
- implementing and reviewing that project within an action research cycle.

Problems of access meant that the unfamiliarity of this process was addressed slowly. Only two practices found the submission of a development proposal useful – or two submitted a proposal. For others, this was a laborious requirement. Indeed, much of the initial development support was to help practices identify what kind of project they wanted to do and ensuring that the project enabled them to address their learning needs or development aims.

A few practices submitted a proposal retrospectively to secure some funding. They had got on with the development task to be done. The Deanery took the view that some but not all of their request for funding should be granted. This was on the basis that the practice would have engaged in some of the proposed activity as an expected part of their everyday work. Deanery and practice definitions of work based learning in the context of this project did not align. This is issue requires further investigation. .

Our strategy to make involvement in this project feasible and embedded in reflective practice and learning organisational values was to emphasise that participating practices would determine the focus of their development plans. This could address the practice-

based issues that they were currently concerned with. The context of their working was a legitimate priority in a world of external demands.

Within practices there were other issues around defining what work based learning was and should involve. Part of the support the project offered was to help those working within the practices to recognise and value the learning that occurs every day. This involved engaging in and valuing new methods of learning and ways of knowing. For example: conversational learning that takes place at the coffee machine, finding quick and easy ways to record critical incidents, crisis or triumph, formed foci of facilitation and recognition that this kind of learning was of value. There were other development needs that addressed not just valuing different ways of knowing but understanding the importance of the cultural climate of learning, the values underpinning the learning process. This involved valuing and respecting people. For example: Staff with lower status explored strategies to develop confidence to address bullying or inappropriate behaviours from some senior staff. One receptionist described how she was capable of with angry and aggressive patients but anxious when she had approach a certain GP ask them to check the morning Visits. She knew that she would be shouted at. Frequently, following such incidents, she had to go to the toilet to cry before returning to the reception area. She learned how to handle the situation differently. Other staff helped all involved in such incidents to interact differently.

4.1.5 The role of the Deanery

During the course of the project the Deanery was re-structured with the loss of a number of staff. This had an impact on the working climate for those who remained in terms of workload and also morale. It became a climate characterised by demoralisation. We noted previously the impact of part-time working in terms of responsiveness in providing information to the project team and also on the timely dispensing of funding for project activities.

For those participating practices that continued with the project, only funding part of their requests for funding, delays in providing a response to their proposals, and then delays in reimbursement of expenses, fuelled their discontent with the Deanery.

The project team has also been affected by the failure of the Deanery to pay promptly. A process of invoicing and raising purchase orders that had been fraught with delays and errors. This has resulted in one member of the team been subjected to severe financial difficulty and this caused distress.

In this project, the Deanery extended its role as commissioner by seeking to identify participating practices and, with the project director, to agree practice development projects and requested funding. This extended role came at a time when the resources of the Deanery to undertake it were very stretched.

Caught between the Deanery and practice managers, progressing the schedule of project activity proved very challenging and was much delayed.

4.2 Pre-requisite conditions for developing learning organisations in primary care

The challenges of engaging primary care teams in action research reflect not only high demand, high volume workloads but also hierarchies of professional power within practices and externally with the Deanery. These challenges are not new in primary care where professional cultures have influenced how doctors, nurses, practice managers and receptionists work with and value each other for some time.

Primary care practices participating in this project and the experienced members of project team, believe that engaging in practice based development and research has become more difficult in primary care. Is this the case? If so, what has changed? What are the implications for engaging busy professionals in action research development?

There appear to be four significant changes.

1 The practice manager has become a new gatekeeper for primary care practices. The busy-ness of this role can result in very slow response times and fragile access that will change as external agencies with visiting rights can requisition time. As gatekeepers, practice managers have the power to determine priorities not only in access but also in information flow, from external agencies into and around the practice. Every visit is negotiated. Access is not for the life of the project. Consequent delays in the progress of the project are significant.

2 In most practices respect for individuals and safety to explore difficult issues influenced and inhibited the learning environment. Creating safe and respectful environments for learning needed attention, even within practices that would espouse values of trust and inclusive practices. The extent to which respect for individuals was or was not present varied across practices.

3 What does multi-professional work based learning involve? The assumptions and expectations that work based learning had to follow the format of GP or nurse training in placements needed to be reconsidered. Valuing the range of every-day learning at work and how this affected the working of the practice took time in most practices. Did the practices who dropped out value this work based learning or, as they said, amid the pressures of working life was this approach to learning an additional task too much?

4 The Deanery itself was experiencing the pressures of re-structuring. Loss of posts and high dependency on part-time employees created difficulties in exercising financial administration and engaging with the project and practices. The role of the deanery changed from commissioner to active administrator of the project but against a backdrop of a diminishing resource to take on this role. At an organisational level the project became vulnerable to pressures within the Deanery.

Both the project team and practices experienced isolation and fragmentation. For the project team getting and sustaining engagement with practices was a challenging and time consuming activity. For practices engaging with this projects' events that required them to go out of their practice, such as, Digital Story workshops and meeting other practices, proved very challenging.

The project team have found ways of supporting the development of learning organisations in primary. Constraints in terms of access to practices and engaging with the Deanery, particularly in the timely payment of project invoicing, threatens the feasibility of this kind of work.

4.3 Learning from digital storytelling activities

Participants found the workshop inspiring, valuable and a useful personal development opportunity. There was much to learn in terms of crafting and editing a story, choosing and working with images, getting to grips with both image- and video-editing software, working with others (effectively strangers) to develop quite personal stories.

> *'I didn't want the weekend to stop – I'd just like to learn more!'*
> (Workshop participant)

Figure 8 A word cloud representation of the most common 20 words in digital story 1

Storytellers enjoyed learning to use the technology and all commented on the therapeutic benefits of being able to tell a story in this way.

> *'I really struggled to see how the digital stories would help us become a learning organisation, especially for non-clinical staff. I was worried that I'd come and I wouldn't have a good time, I wouldn't have anything to report back, but it's been just the opposite. I feel like I've had a weight*

> *lifted from my shoulders. It's been really therapeutic and it's been really good to get everything down on paper and put it behind me and get some closure.'* (Workshop participant)

4.3.1 The value of personal stories

There was a real recognition of the value of personal stories, as opposed, or in addition to, training videos.

> *'You can tell the most personal story and learn from it, and other people can learn from it as well. I didn't understand that telling a story that was nothing to do with my working life could provide lessons – I wasn't expecting that.'*

Participants realized that they could learn from other people's personal experiences as well as from reflecting on their own experiences, especially where these had been difficult. Although many people come to a digital storytelling workshop with the intention of telling a 'professional' or 'safe' story, participants often gravitate towards telling a very personal story. This may be the result of a recognition, at some level, that there is a block to learning that cannot be unblocked until the personal story is acknowledged and told.

One storyteller (not in this project) suggested that:

> *'Creating the personal story offers a different kind of understanding and frees the storyteller from the block.'*

This storyteller went on to explain:

> *'I felt that there was a lot to learn from my story: working with someone with addictive disorder and the erratic behaviour that may ensue; the nature of institutional power games; institutional failure to deal with difficult situations… Meanwhile, other people in my institution were telling their own stories in a way that denied my experience and sanitized the institutional reality.*
>
> *Digital storytelling brought me into a dimension of experience where I wasn't fully aware of the depth of the emotional impact. It brought me into an unsafe place but the process helped me to acknowledge that lack of safety and hurt and offered an emotional release.*
>
> *I was able to cry during the making of my story whereas, in the professional context, I hadn't been able to do this.*
>
> *When I found and recognized that unsafe space, I realized that I could deal with it.'*

Figure 9 A word cloud representation of the most common 20 words in digital story 2

The two- or three-day workshop process facilitates a journey from the initial emotional reaction (to a particular experience) to making sense of that experience through narrative.

As storytellers articulate their immersion into emotion, through a process of refinement and distillation conducted in an inclusive and collaborative way, they begin to make sense of the experience. The emancipatory nature of the workshop methodology encourages storytellers to assume control over their own story. Learning skills that enable use of new technologies is one more characteristic of digital storytelling workshops that facilitates storytellers being able to embrace the emotional and psychological dimensions of learning which, even if they are acknowledged, are often ignored in practice.

4.3.1 Being judged

While participants in the workshop were very happy to share their stories with one another, there was a reluctance to share their stories more widely, for fear of being judged; there were particular concerns about sharing their stories within their own practices.

The issue of judgment was an important one. Participants felt anxious that they might be 'judged' if their stories were to be made public; equally they felt that the experience of creating their own stories reinforced the understanding that it is inappropriate to judge others without knowing the full story.

4.3.2 Growing in confidence

Participants also commented on a new-found sense of confidence. This was partly due to having the time and space to work through a process and reflect on past experiences. Participants said that writing the story down and discovering where the blocks were was

helpful in learning more from their own story, but they also commented on discovering common themes and sharing some common experiences.

4.3.3 Getting to the heart of the story

There was a recognition that the ability to get to the 'core' or 'heart' of the story would resonate with most, if not all viewers, because of our shared human experience.

Figure 10 A word cloud representation of the most common 20 words in a digital story

Some participants felt that the experience had given them the opportunity to 'be brave' and step outside their comfort zone. One storyteller described moving through a process from the initial emotional reaction to an experience, to making sense of that experience through narrative.

4.3.4 Additional learning

Other learning included:

- appreciating how important a conversation can be
- self-reflection, leading to self-understanding and recognition of inter- and intra-personal blocks
- seeing how learning organisations could operate, with respect and trust and transparency (Patient Voices 2011)

  'All the time there's reflection going on.'
- the digital stories are a really good example of communication to yourself and others – which is what's lacking in many GP practices
- You can say a lot in a short amount of time!

- learning to be non-judgemental
- this is a good method for Learning Organisations
- the value of small-group experience
- the importance of conversation:

> *'I hadn't really appreciated how important a conversation can be, how much you can learn from them. So you can have deeper conversations and learn things from them, sometimes something quite subtle that you can take away with you, and learn from that.'*
>
> *'The essence is that we are all human, not just male or female'.*

The general feeling was that opportunities for sharing stories could be extremely valuable in helping to create a culture of trust and respect, which is essential for a learning organisation.

This observation has been noted in a project with very small numbers. However, the Patient Voices Programme has now been sharing stories of health and social care since 2003. Some 600 stories have been created under the Programme's auspices. It is our observation that story circles and the process of creating a digital story do have the potential to stimulate greater trust and a more open culture in which sharing can more easily take place. In such a culture, there is the potential for honest exchange of ideas and a desire to share learning that will enhance the work and the working environment.

It seems that digital storytelling workshops offer the potential for threshold learning to take place. In other words, the process of creating their digital story, thinking about an experience visually as well as verbally, making sense of it and linking it with work take many people to the threshold of new understanding, enabling them to see things differently.

Due to the issues mentioned above in relation to trust, secrecy and disclosure, the stories have not been released. So, although there was significant learning among the workshop participants, the learning from their stories will not be realized because the conditions for sharing where not present.

Two years after the workshop, the principal investigator has decided to release her story so that some of the lessons she learned might be shared.

Figure 11 A word cloud representation of the most common 20 words in the digital story 'Parting a curtain of silence'

The digital story, entitled *Parting a curtain of silence*, reflects the relationships with the Strategic Health Authority (SHA), with people with key roles in the project and mirrors the experience of practices. The story can be seen at: www.patientvoices.org.uk/flv/0475pv384.htm

Workshop participants felt compelled to delve into the deeply personal and emotional dimensions of their experiences. However, there was a tension between this and their trepidation of sharing their learning more publicly. Their apprehensions reflect findings from the MPLO project that safe spaces for learning appear to be restricted. Our challenge is to secure this much-needed space. Our strategy is to do this within curriculum design and provision.

Section 5: Illuminations and implications

In this section we address two questions:

1 What would the project team do differently to enable practices to better participate in a project to develop learning organisations?

2 What are the policy implications for this kind of work based development in the policy context of *Liberating the NHS*?

5.1 Improving participation in the project

5.1.1 Next step A

It is important to couple the enthusiasm of primary care practices to participate in developing as a learning organisation with help to prioritise and protect time and resources for their engagement. This requires agreeing a 'learning contract' specifying*:*

- minimum time implications to take part in the project,
- minimum funding for the learning contract,
- required external meetings or events.

We outline these below.

Being accepted onto the project would involve agreeing and signing a learning contract between participating practices, the project team and the Deanery. This agreement would include:

For practices

- practice representatives to attend key regional/out-of-practice events,
- commitment to minimum engagement in terms of time identified as weekly time requirements,
- identification of practice lead person to co-ordinate the practice development plan,
- project team access to be negotiated at the start of the project and a mutually agreeable approach to access established thereafter,
- a sum of money for each practice agreed at the beginning of the project as part of the learning contract. Additional funding relating to approved development activities may also be available. Approval to be prospective not retrospective.

Other agreements important to ensure enabling conditions include (for the project team):

- agreement of response times to email communication between Deanery, Practices and the project team
- the project team should administer practice self-assessments in the first year to enhance the confidentiality of the process and build capacity within practices to conduct self-assessments
- if practices find that they need to withdraw from the project the Deanery/educational commissioner will decide if any repayment of funding is needed and explore whether the practice might re-engage at a later stage.

Pre-requisite conditions for developing as a learning organisation

Experiences of participating practices, those who completed the project and those who dropped out, indicate the central importance of effective communication to becoming and being a learning organisation.

This involved a commitment to and demonstration of respect for individuals, trust and safe spaces in which to learn. Without these conditions there was a tendency for professional hierarchies and unresolved issues and resentments within the practice to foster fragmentation and a climate of caution or avoidance when encountering difficult or sensitive issues. Without trust and respect it was difficult to operate as a learning organisation.

In Figure 12 below we show how the skills and competencies associated with learning organisation identified in the work of Senge (1994) and Rushmere et al (2004) overlap.

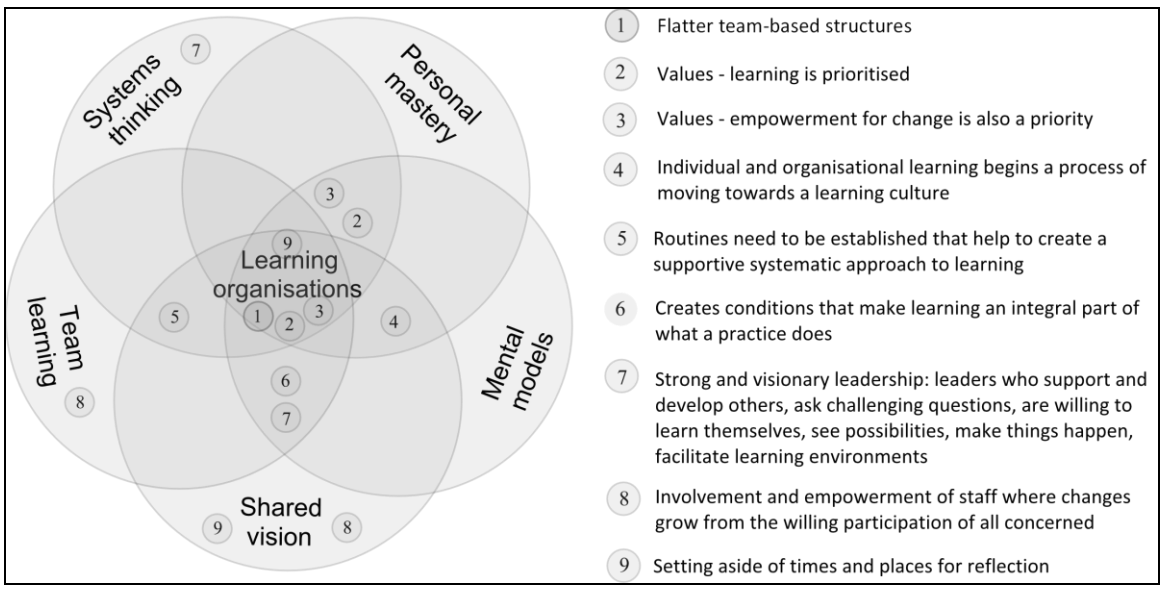


Figure 12: The overlap between the ideas of Senge and Rushmore et al.

At the centre of these Venn diagrams lie conditions 1,2,3 and 9. Two and three reflect underpinning values, learning is prioritised and empowering practice members to contribute

to change is also prioritised. One and nine support these values with practical and structural conditions. Flatter structures soften hierarchies and imply more inclusive and democratic approaches to discussion and perhaps decision making. Setting aside time and space for reflection supports thinking in practical ways and also recognises that being yoked to action is not enough. The quality of what we do reflects the quality of our thinking. (Kline, 1999)

5.1.2 Next steps B

We have indicated in 'The contemporary challenges of organisational work based learning in primary care' (page 31) , how we would clarify the commitment of participating practices to help practices prioritize and engage with this form of work-based learning.

The central importance of communication, respect for individuals and trust to enable purposeful development activity suggests that in the early stages of joining a project to develop as a learning organisation, these pre-conditions should be examined.

One method of doing this would be to conduct a self-assessment to determine the extent to which conditions for open, honest and safe communication exist. This should be administered by an agency external to the practice to strengthen validity and offer confidentiality. The results of this self-assessment should inform whether the practice will need to consider developing these areas. ***It would not mean*** that practices could not choose their own focus for development. ***It would mean*** that if the self-assessment showed that development in trust, respect for individuals and communication appeared low, those practices would be strongly recommended to develop in these areas as part of their development plan. It would have implications for how the external facilitators focused the support they offered.

5.2 Policy implications of *Liberating the NHS* for work-based development

With the policy emphasis of *Liberating the NHS* focusing upon the importance of continuing professional development and the introduction of national learning outcomes, it is timely to anticipate the assessment implications of this kind of professional development initiative.

Examining the project through an assessment lens there are three critical considerations.

1 The impact of policy on practice, learning, assessment and accountability.

2 The practicalities and complexities of administering comparable assessments of work-based learning when stakeholders and primary care professionals interpret project purposes and outcomes differently.

3 Challenges when developing practitioner conducted assessments of learning arising from everyday practice where heavy workloads couple with high external demands.

5.2.1 Discussion

Policy helped shape the climate in which the MPLO project and the main stakeholders operated. Successive policies have sought to align learning and performance management agendas. The scope and scale of the *Liberating the NHS* policy helped generate uncertainty about the future of the Deanery and changes to a national education and training agenda. Those changes included an emphasis upon strengthening the alignment of education and training with patient outcomes and a revitalized role for continuing professional development.

As learning and performance management agendas converge, assessment becomes a high stake. Performance management can have financial and professional credibility impacts which participating practices were very aware of. In initiatives like MPLO, this can act as a disincentive to engagement because of concerns that practice vulnerabilities could be exposed with potentially harmful effects in a climate of scrutiny.

Some participating practices were concerned about possible 'hidden agendas' within the 'Developing multi-professional learning organisations in primary care' project. They were wary about the relationship between the Deanery and the project team. Was the MPLO project an agent of the Deanery scrutinizing practices?

That was not the case in either project design or conduct. However, the extended commissioning role the Deanery adopted made it challenging to establish the real impartiality of the project team. It took time to build trust with practices, particularly given the problems of access described in this report. Despite assurances of confidentiality and the negotiation of data, sharing learning within and across practices met resistance, even though practices had claimed at the outset of the project that they hoped for cross-practice sharing.

The exception was one participating practice that regarded itself to be a learning organisation. This practice was happy to share good practice and was disappointed that other practices did not want to share good practice with them. Sharing success is easier than sharing vulnerability. Many practices appeared wary of sharing possible vulnerabilities within their organisation and beyond it.

While a motivation to join the MPLO project had been to help primary care practices who felt hard-pressed to respond to heavy workloads, acknowledging and examining their need for improvements could make them feel exposed.

Apart from establishing the impartiality of the project team, there was also a need to clarify and reassure practices that they were engaging in formative assessments/judgments that were part of the action research cycle. Practice portfolios are their accounts and judgments of their progress.

The principal project team facilitator encouraged and supported development. A planned end-of-project meeting with the four completing practices was designed as a sharing of

learning in discussion with the project team. Practices needed reassurance that the Deanery would not have a presence at this meeting. This meeting was intended to provide formative feedback to inform on-going practice development. Due to other work pressures, participating practices had to withdraw and the meeting was cancelled. There were lessons here for the project team in how to help practices legitimize prioritizing engagement with the project and about addressing the hesitancy in the public sharing of self- assessments in this current climate of intensifying scrutiny.

The issue of practicalities and complexities of assessment is a significant one. Swine-flu, annual reporting for the national 'Quality and Outcomes Framework', financial year end reports, visits by local health authorities (Primary Care Trusts) who had right of access to practices, building-work, staff changes, staff illness and snow; were all cited as reasons for either re-scheduling project team visits or withdrawing from the project. In a meeting with the Deanery the project team reported '*There is no evidence that this project had any kind of priority over other demands (on practices)*'.

It would have been helpful for a learning contract to have been an essential requirement for participation in the project, as noted in 'What would the project team do differently to enable practices to better participate in a project to develop learning organisations?'.

A learning contract would have tested commitment, provided a rationale for engagement when other demands flooded in, and included an agreement for access arrangements to practices (pages 3 and 7).

GPs or practice managers tended to act as practice lead for the project. Sickness among this group, coupled with heavy workloads, reduced the time they could commit to that role. Practice managers tended to be the *de facto* practice project lead. They organized the learning projects and wrote much of the practice portfolio. Participating practice learning projects were designed to be inward-serving. Self-assessment questionnaires were shaped to 'fit' practice understandings. The practice intended to use the feedback for its own development. (Though as described, an external agency did use Practice 2 self-assessments.) Portfolios seem to be written with an internal audience in mind. At points more information or explanation would have been helpful to clarify what was being reported. In their current form portfolios would not easily serve cross practice sharing. That is not necessarily a problem because cross practice sharing can be enabled in many ways. In the changing context of national learning outcomes for continuing professional development, how might learning be shared with other external audiences or stakeholders?

Participating practices are new to the action research process and still in the early stages of developing pragmatic approaches to recording and representing their learning. Portfolios, or parts of portfolios could serve both external audiences and the aim to share learning beyond the practice. However, for this to happen the purpose and audiences portfolios are intended to serve need to be considered, made explicit and supported.

As noted earlier, there has been an extension to stakeholders in education and training and they operate in climates of increased accountability. Different stakeholders have different priorities and these need to be identified and addressed at the design stage of a curriculum. The task of developing learning organisations is not the same as increasing capacity for placements, though it might help. With a focus on learning from work, participating practices were exploring how to make occupational experience more educational, and doing so with the intention of improving service. Creating a shared understanding of the different perspectives and priorities of a curriculum among stakeholders is key. The planned meetings with the Deanery, participating practices and the project team at the beginning, mid-point and end of the project were opportunities to create shared understandings. They were all cancelled because participating practices simply found it too difficult to attend external events. Developing shared understandings and negotiating priorities takes time. The project team acted as neutral broker to parties unable and perhaps reluctant to meet.

Stakeholder priorities can shift and this has implications for how success will be judged. For example, during the project the Deanery became more concerned with finding out about the conditions that helped or hindered practices develop as learning organisation. They still needed to increase placement capacity but began to reconsider how to approach practice-based development.

The feasibility report of the pilot study identified the purposes of participating practices, and the obstacles they cited to engaging with developing as learning organisations. Recruitment and retention issues affirmed these obstacles and uncovered other challenges. Participating practices showed how developing as a learning organisation involved shifts in how groups and teams approached their work. As we have identified, fundamental to this was developing trust and respect. These appeared to be pre-conditions to establishing a safe learning environment and open, honest communication. For working relationships to be trusting, respectful, open and honest involves 'wicked' competencies. Knight claimed:

> *'(Wicked competences) resist definition, shift shape and are never solved. Such soft skills are highly valued in the workplace …(They are) achievements that cannot be neatly pre-specified, take time to develop, and resist measurement-based approaches to assessment. '* (Knight, 2007)

He argued that measurement approaches to these complex and fuzzy competences are unsuitable and suggested that what was need is an:

> *'Understanding (of the) curriculum as a set of arrangements likely to favour the emergence, in cohorts of students and not in individuals, of certain outcomes. In this sense, the curriculum is a set of arrangements that increases the probability that certain learning will be evoked and that individuals following that curriculum will tend to become better in terms of those curricula intentions.'* (Knight, 2007)

Essentially Knight is arguing for a learning-driven rather than an assessment-driven curriculum with assessment at the level of programme rather than the individual.

Drawing upon assessment in higher education literature, Knight outlines the key features of assessment 'sensitive to' wicked competencies. These include:

- recognition that assessments are provisional judgments, based on evidence at-hand and they need to be represented as such.
- the design of coherent work-integrated programmes that take a progressive view of learning and dovetail learning design and assessment design.
- assessment that engage (learners) as participants. This supports life-time learning.
- recognition that feedback is crucial and comes from multiple sources. (Knight, 2007)

For the MPLO project, this perspective on assessment has two implications.

1 The focus on a learning driven curriculum accommodates the personalized and contextualized kind of development projects undertaken by participating projects and most forms of action research development. The development projects of participating practices drove their learning with facilitation focusing upon needs associated with that. Practice was driving learning.

2 Placing assessment at program level aligns with the evaluative nature of action research and focuses upon whether the curriculum supporting learning is appropriate to need and context. This provides a means of handling assessments of practice progress in climates sensitized to public scrutiny. A programme level assessment would involve determining the extent to which the 'Development of multi-professional learning organisations' project achieved its main aim: to develop learning organisations in primary care in the Eastern region. This forms the second order action research element of the project.

The action research approach prioritized the needs and main concerns of participating practices. The concluding quote from the portfolio of Practice 2 illustrates that this approach became valued by some practices (page 22). Not only were practices addressing their own concerns, they were also learning how to formulate their learning needs and be increasingly self-directed in how these were addressed. The focus was not on individual learning but how groups or teams contributed to outcomes of development plans. Sometimes outcomes were broadly defined, such as- improving communication. They could also be more specific, such as, introduce weekly forty-five minute 'Team Talk' sessions for administrative and secretarial staff.

Action research lies along a continuum from beginning novices to expert practitioners. Participating practices were beginning to develop an understanding of how to engage with action research and the skills it requires. Portfolios showed that activities were seen in some practices as success in themselves. For example: some portfolios included power-point

presentations given by the project team facilitator as evidence of engaging in development as a learning organisation. The introductions of new working practices are also offered as evidence of success, for example, the introduction of 'Team Talk', a practice bulletin and 'The Knowledge Tree'. What needs to be strengthened is the articulation of answers to the question: *What effect have these activities had*?

To be fair to participating practices, they are at the beginning of evidencing this form of work-based learning and issues of reporting we have noted are typical of novice participants in action research.

That said, practices could justly respond that the need for a portfolio was not theirs' but the project teams. Practice priorities were about getting on with making the changes that would help their learning and practice. In the changing educational policy climate we may need to ask: *What is the balance between private and public learning*?

The MPLO project took continuing professional development into the real, messy and pressured realities of primary care. It has prompted us to reconsider how to support work based learning which involves teams and groups.

Looking at this research and development project through an assessment lens has been part of anticipating what national learning outcomes for continuing professional development might mean for such an initiative.

Currently, completing practices engage in self-assessment, reflection and evaluative approaches to their practise. If these are to be further developed it will require careful thinking about reporting and audience. Participating practices did not want to be burdened with too much writing, particularly of an academic kind. Their preference was to integrate documenting and reporting their learning with the kind of approaches they were using in their day job, such as minutes of meetings, bulletins, postings on Internets and coffee conversations.

5.2.2 Conclusion

The policy and practice contexts in which group, team and whole practice development takes place continues to unfold with implications for supporting learning in a climate of increasing accountability. Space for learning, in terms of time and safety are under pressure. In this report we have suggested how to better support practice engagement with this form of work based learning and examined key issues in taking into account the different perspectives of stakeholders.

The need to build trust and respect for individuals to enable multi-professional and collaborative learning is a central learning theme of this development project. Experience of this project suggests there is work to be done in this area.

With a renewed national educational and training emphasis on continuing professional development, we have anticipated assessment issues by examining the project through an

assessment lens. Improving assessment will involve balancing individual practice needs and preferences with those of external stakeholders. The balance and boundaries between private and public learning may need to be revisited. As Knight suggests, adopting a programme level approach to assessment, particularly of 'wicked competencies' appears to be a promising way forward for initiatives such as developing multi-professional learning organisations. This would shift assessment to include a more organisational level, enable a longitudinal view of program success' and, as *Liberating the NHS* suggests, '*place accountability in the right place*'.

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Appendices

Appendix 1: Project development activities, processes and adjustments

Appendix 2: Contacting practices - the pilot

Appendix 3: RCGP learning organisation criteria

Appendix 4: Model self-assessment questionnaires

Appendix 5: Modified self-assessment questionnaires

Appendix 1: Project development activities, processes and adjustments

Year	Activity	Adjustment/new activity	Comment
June to mid-September 2009	Organising and making initial visits to explain the project and seek to establish informed consent	Time frame and once at the practices discovered they had only expressed interest whereas we had received an email saying they had said 'yes'. Time frame for organising and visiting had to be compressed: August to mid- October 2009	Had to wait for invitation letters to be sent out by the Deanery and then for information from the Deanery regarding practice responses
November 2009 to July 2010	Requests for access to all staff groups acknowledging constraints of time available for this. Some practices did have protected time for staff development for non-clinical staff the agenda of such sessions was already full. Although the project had funds to support such activities the practices were prioritising the time and space for other activities. Practice based interviews to benchmark initial perceptions within practices of learning organisations and snapshot attitudes to and experiences of work based learning. Communicating with the Deanery: project access to practices about research.	In several practices the lead contact person blocked this. July 2010 the Deanery agreed to send a letter signed by SD and AM. The text of the letter was drafted and agreed by mid-September but it was never sent although reminders were sent to the Deanery.	The working environment of the Deanery is predominantly part-time. In July 2010 redundancies were announced and the Deanery informed us there was very little administrative time allocated to the project. By December 2010 the letter had still not been sent. Management of the project budget and payment of team members not explained in full at any time.
October 2009 to March 2010	Developmental practice visits: Supporting practices form a learning plan/project, which will focus their development.	Many practices found it very difficult to respond to requests to develop a 'wish list' with their staff regarding things to change, things to learn and things to celebrate from which they could develop a learning plan.	
Feb- May 2010	Workshop to explain Digital Stories	Replaced with visits to individual practices.	Practices could not spare time for a workshop.
Feb 2010 ongoing	Website development	Website development to support development activity and sharing	Security issues and firewalls Plan to create a 'Virtual 'practice'
November 2009 – March 2010	Visits to facilitate understanding and implementation of values, skills and systems supporting learning organisation approaches and culture and what might constitute evidence of such.	Ongoing and variable adjustments according to practice needs and changing circumstances such as staff illness or changes of staff.	Developing their use of questionnaires to identify evidence of less easily measured qualities and practices.
April 2010 – ongoing	2 Templates to choose from so that they could develop their questionnaires distributed in May 2010. They would be used three times: July 2010, October 2010 and February/ March 2011. Practices chose one and edited it. Staff kept their own copy of each one and were anonymised.	Questionnaires as means of collecting evidence of responding to staff perceptions and needs, as a developmental tool and evidence that certain characteristics of a learning organisation are/are not present in their practice.	Some practices edited and distributed them in the original time frame but others were late.
	Not all PCTs within the Eastern Deanery funded Protected Time for staff training and development, which involved the closure of the practice.	Communicating with the deanery: primary care practice funding.	Funds were available from the project.

Appendix 2: Contacting practices - the pilot

Practice	Date	Number of interviews	Number of participants	Recording process	Duration (total)	Comments
Market Surgery 26 Norwich Road Aylsham Norfolk NR11 6BW	12th March 2009	4	4	D, A, N	2hr38m	Interviewed 1 GP, 1 Practice Manager, 1 Practice Nurse, 1 Administrator.
Old Palace Medical Practice 148 Old Palace Road Norwich NR2 4JA	17th March 2009	1	1	A, N	48M	Interviewed 1 GP.
Cornerstone Practice 26 Elwyn Road March Cambs PE15 9BF	20th March 2009	1	2	D, A, N	1hr10m	Interviewed 1 GP, 1 Practice Manager.
Campingland Surgery Beech Close Swaffham Norfolk PE37 7RD	23rd March 2009	1	3	D, A, N	55m	Interviewed 2 GPs, 1 Practice Manager. Approx 6,000 patients (2007). Approx 33% overweight or obese. From 2001 to 2008 the proportion of patients over 75 rose from under 12% to over 14%.
Newtown Surgery 147 Lawn Avenue, Great Yarmouth Norfolk NR30 1QP	1st April 2009	1	1	A, N	24M	
Firs House Station Road Histon Cambs CB24 9NP	30th March provisional	N/A	N/A	N/A	N/A	
Bungay Medical Practice 28 St Johns Road Bungay Suffolk NR35 1LP	N/A	N/A	N/A	N/A	N/A	Practice manager was eventually contacted, and agreed to reply with time for visit, but no response.

Appendix 3: RCGP learning organisation criteria

Criterion	Description
1	The nursing and other professional members of the team have appropriate qualifications and training and only carry out treatments which are within their competence.
2	All practice employed nurses have an annual appraisal.
3	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal.
4	All practice-employed non-clinical team members have an annual appraisal.
5	The practice will have a system for linking personal development plans for CPD to practice needs.
6	In-house educational events relate to the practice learning plan and there are opportunities for multidisciplinary training with all team members being encouraged to take part
7	The practice has a process whereby learning from events is shared with the practice team.
8	The team regularly audits work, covering a range of topics including clinical care, communication with patients and practice organisation.
9	The practice has undertaken a minimum of nine significant event reviews in the past three years which could include: any death occurring in the practice premises; new cancer diagnoses; deaths where terminal care has taken place at home; any suicides; admissions under the Mental Health Act; child protection cases; medication errors; a significant event occurring when a patient may have been subjected to harm had the circumstances or outcome been different (near miss).
10	The practice operates a policy to identify and learn from all patient safety incidents and significant events and to share learning points with all team members and also outside agencies who were stakeholders in the event.
11	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team.
12	The practice has strategies in place to mitigate major organisational risks
13	There is a disaster and recovery plan in place that covers the major risks identified in the Disaster Prevention Policy
14	The team treats all patients and staff equally and there is no discrimination on the grounds of age, race, gender, social class, condition or any other factor.
15	The practice strives to enable patients with complex problems to remain at home.
16	Members of the team are committed to working effectively together and respect each other's professionalism and different perspectives.

Royal College of General Practitioners (RCGP) learning organisation criteria. From the RCGP *Modular Quality Practice Award*, Version 13, Module 5: Learning Organisation (2010).

Appendix 4: Model self-assessment questionnaires that could be adapted by participating practices

Questionnaire 1: adapted from *Leadership and Teambuilding in Primary Care* (Mullins and Constable, 2007).

Developing Learning Organisations, M Teggin **Identifying and Anonymising Perceptions of Strengths & Weaknesses** **Purpose:** ***Collecting a Variety of Types of Evidence for Triangulation & Archiving the Development of a Learning Organisation Culture over Time.***				
My Whole Team/ Working Team Perception Please erase whichever of Whole Team/ Working Team (above) does not apply. Please tick in one box for *each* descriptor. Please keep a copy for your own records. You will be asked to repeat this questionnaire again and you may be able to see changes over time. Please send the electronic copy to: **********		**All of the Time**	**Some of the**	**Rarely**
Tasks & Goals	○ Well understood ○ Agreed ○ Accepted ○ Clear assignments made and sense of ownership by team members			
Commitment & Accountability	○ All tasks and agreements are taken seriously ○ Team members hold each other accountable for actions/ consequences/results ○ Team members question each other on inappropriate behaviour ○ Team members question each other regarding lack of attention or poor attitude ○ Each team member is aware of the team's function and objectives ○ Each team member periodically evaluates or measures the team's performance ○ "We" NOT "I' create and sustain the team			
Communication	○ Participation in discussion and involvement in action is high ○ Range of communication between team members is good ○ Depth of communication, including feelings and ideas is good ○ Conversations, both formal and informal are valued as opportunities to learn from each other ○ Team members engage in actively listening to each other ○ No-one feels they are being held back ○ No-one feels they are holding back ○ Everyone feels their ideas are fully listened to			
Differences & Conflict	○ Balanced critiques (not criticism) are made about ideas, processes and methods ○ Judgements are NOT made about people or about personalities ○ Differences are encouraged so that all thoughts are aired and differences can be accepted ○ Conflict is not allowed to develop into a dysfunctional event			
Organisation	○ Meetings are well prepared, well run and recorded ○ Minutes are issued promptly according to agreed time schedule ○ All team members take responsibility to agree the Minutes of meetings ○ Decisions are owned, documented and circulated			
Decision -making	○ Decisions are well-informed ○ Agreed outcomes from sub-teams are viewed as beneficial and contributing to whole team ○ Teams can reach consensus agreement ○ Teams can accept the team leader's decision if no consensus			
Vision	○ Team has shared visions of purpose with whole team and all team members ○ The visions can inspire and energise the team members ○ The visions are agreed and documented and communicated ○ The visions are referred to whenever appropriate during meetings and decision-making processes			
Working Environment	○ No-Blame attitude throughout whole team ○ Supportive and complementary ○ Mistakes are seen as learning opportunities ○ Learning from mistakes is an important aspect of personal responsibility for each individual ○ Risk-taking /Trying things out is encouraged ○ Well-organised team meetings ○ Efficient administration ○ Effective management ○ Effective IT ○ Organisational processes enable effective activity			

Questionnaire 2: Adapted from *Is Yours A Learning Organisation?* Garvin, D., Edmondson, A., Gino, F., Harvard Business Review, March 2008.

Multi-Professional Learning Organisation Project **********Medical Practice

Exploring Evidence that this is a Learning Organisation - Basis for Questionnaire Design (based upon HBR).

- Please respond to all these statements by giving a score of 1-5 where 1 is a Low score and 5 is High score.
- Some statements are positive and some are negative.
- Please keep a copy of your questionnaire when it is completed You will be asked to repeat this task at intervals over the next 12 months, so that you can observe any changes over time.
- Please return the completed form to: **********

Part 1. Evidence of a Supportive Learning Environment

A Safe Environment

1. It is easy for you to speak up about what is in your mind within your part of the Practice Team
2. It is easy for you to speak what is in your mind within your particular team in the Practice.
3. If you make a mistake it is often held against you.
4. People in your team are usually comfortable about talking through problems and disagreements
5. Keeping your 'cards close to your chest' is the best way to survive in your team.
6. People in your team are eager to share information about what does and does not work.

Appreciation of Difference

1. Differences of opinion are welcome in your team.
2. Unless an opinion is consistent with what most people in your team believe, it will not be valued.
3. Your team tends to handle differences of opinion privately.
4. The Practice will not address differences of opinion in the whole group.
5. It is comfortable to speak in whole Practice meetings.
6. In your team, people are open to alternative ways of looking at issues and events.
7. Everyone in the Practice treats everyone else with respect.

Openness to New Ideas

1. In your team, people value your ideas.
2. Unless an idea has been around for a long time, nobody in your team will want to hear it
3. In your team, people are interested in better ways of doing things
4. In your team people usually resist untried approaches.

Time for Reflection

1. People in your team are over-stressed.
2. Despite the workload, people find time to review how their work is going.
3. In your team, schedule pressures get in the way of doing a good job.
4. In this Practice people are too busy to invest in improvement.
5. There is simply no time for reflection in your team.

Part 2: Evidence of Learning Processes and Practices

Experimentation

1. Your team frequently experiments with new ways of working together.
2. Your team recognises the importance of informal learning through spontaneous conversations.
3. Your team has a formal procedure for discussing, planning and evaluating new ideas.
4. Your team frequently uses simulations or developmental meetings to try out new ideas.

Collection of Evidence of Learning & Development

1. Members of your team spontaneously share learning experiences in their work.
2. Learning experiences on the job are shared with colleagues.
3. Anecdotal and narrative forms of sharing learning are valued.
4. Learning experiences are stored as a potential resource for the future.
5. Members of your team have opportunities to see how their work relates directly to patient well-being.
6. Members of your team have opportunities to see how their work supports other colleagues in the shared purpose of patient well-being.

7. Everyone in the Practice is aware of how their work is related to current changes and demands from the government and other external agencies.
Analysis & Reflection
1. Your team is able to benefit from discussion and debate.
2. Your team will seek out differences of opinion during discussions.
3. In discussions, your team never revisits or questions previously well-established opinions.
4. Your team frequently seeks to identify and discuss hidden assumptions that might affect key decisions.
5. Your team never pays attention to different views during discussions.
Training & Development
1. Newly hired employees in your team receive adequate training.
2. All experienced employees in your team receive periodic training updates.
3. All staff in your team receive training when new initiatives are launched.
4. In your team, everyone values discussion time about what is currently happening in your work.
5. In your team your value discussions with staff from other teams in the Practice.
Sharing Information & Learning
1. Within your team there are small forum groups and well as whole team opportunities to share information and learning.
2. Part-time and add-on staff are included in sharing learning and information.
3. External experts are welcomed.
4. Feedback from patients is valued and available to all staff.
5. Your team has a network of support and information sharing within the Practice.
6. Your team has a network of support and information-sharing with similar teams in other Practices.
7. Your team can quickly and accurately communicate new information to key decision-makers.
8. Your team has regular reviews about what is happening.
9. Your team is valued within the Practice.
10. Your team is able to cultivate open discussion, tolerance and systematic ways of thinking about the team's role within the Practice.
Part 3: Leadership That Reinforces Learning
1. Managers at all levels invite input from others in discussions.
2. Managers acknowledge their own limitations with respect to information, expertise or knowledge.
3. Managers ask probing questions.
4. Managers listen attentively.
5. Managers encourage multiple points of view.
6. Managers provide time and resources for identifying problems and organisational challenges.
7. Managers provide time, resources and venues for reflecting and improving past performances.
8. Some managers criticise views that are different from their own.
9. All managers demonstrate a holistic approach to Learning in different ways being valued within the Practice.

Appendix 5: Modified self-assessment questionnaires

Modified questionnaire as adopted by Practice 1

Part 1	**Evidence of a Supportive Learning Environment** **A Safe Environment**					
1	It is easy for you to speak up about what is in your mind within your part of the Practice Team	1	2	3	4	5
2	It is easy for you to speak what is in your mind within your particular team in the Practice.	1	2	3	4	5
3	If you make a mistake it is often held against you.	1	2	3	4	5
4	People in your team are usually comfortable about talking through problems and disagreements	1	2	3	4	5
5	Keeping your 'cards close to your chest' is the best way to survive in your team.	1	2	3	4	5
6	People in your team are eager to share information about what does and does not work.	1	2	3	4	5
	Appreciation of Difference					
1	Differences of opinion are welcome in your team.	1	2	3	4	5
2	Unless an opinion is consistent with what most people in your team believe, it will not be valued.	1	2	3	4	5
3	Your team tends to handle differences of opinion privately.	1	2	3	4	5
4	The Practice will not address differences of opinion in the whole group.	1	2	3	4	5
5	It is comfortable to speak in whole Practice meetings.	1	2	3	4	5
6	In your team, people are open to alternative ways of looking at issues and events.	1	2	3	4	5
7	Everyone in the Practice treats everyone else with respect.	1	2	3	4	5
	Openness to New Ideas					
1	In your team, people value your ideas.	1	2	3	4	5
2	Unless an idea has been around for a long time, nobody in your team will want to hear it	1	2	3	4	5
3	In your team, people are interested in better ways of doing things	1	2	3	4	5
4	In your team people usually resist untried approaches.	1	2	3	4	5
	Time for Reflection					
1.4.1	People in your team are over-stressed.	1	2	3	4	5
1.4.2	Despite the workload, people find time to review how their work is going.	1	2	3	4	5
1.4.3	In your team, schedule pressures get in the way of doing a good job.	1	2	3	4	5
1.4.4	In this Practice people are too busy to invest in improvement.	1	2	3	4	5
1.4.5	There is simply no time for reflection in your team.	1	2	3	4	5
Part 2	**Evidence of Learning Processes and Practices** **Experimentation**					
1	Your team frequently experiments with new ways of working together.	1	2	3	4	5
2	Your team recognises the importance of informal learning through spontaneous conversations.	1	2	3	4	5
3	Your team has a formal procedure for discussing, planning and evaluating new ideas.	1	2	3	4	5
4	Your team frequently uses simulations or developmental meetings to try out new ideas.	1	2	3	4	5
	Collection of Evidence of Learning & Development					
1	Members of your team spontaneously share learning experiences in their work.	1	2	3	4	5
2	Learning experiences on the job are shared with colleagues.	1	2	3	4	5
3	Anecdotal and narrative forms of sharing learning are valued.	1	2	3	4	5
4	Learning experiences are stored as a potential resource for the future.	1	2	3	4	5

5	Members of your team have opportunities to see how their work relates directly to patient well-being.	1	2	3	4	5
6	Members of your team have opportunities to see how their work supports other colleagues in the shared purpose of patient well-being.	1	2	3	4	5
7	Everyone in the Practice is aware of how their work is related to current changes and demands from the government and other external agencies.	1	2	3	4	5
	Analysis & Reflection					
1	Your team is able to benefit from discussion and debate.	1	2	3	4	5
2	Your team will seek out differences of opinion during discussions.	1	2	3	4	5
3	In discussions, your team never revisits or questions previously well-established opinions.	1	2	3	4	5
4	Your team frequently seeks to identify and discuss hidden assumptions that might affect key decisions.	1	2	3	4	5
5	Your team never pays attention to different views during discussions.	1	2	3	4	5
	Training & Development					
2.4.1	Newly hired employees in your team receive adequate training.	1	2	3	4	5
2.4.2	All experienced employees in your team receive periodic training updates.	1	2	3	4	5
2.4.3	All staff in your team receive training when new initiatives are launched.	1	2	3	4	5
2.4.4	In your team, everyone values discussion time about what is currently happening in your work.	1	2	3	4	5
2.4.5	In your team your value discussions with staff from other teams in the Practice.	1	2	3	4	5
	Sharing Information & Learning					
1	Within your team there are small forum groups and well as whole team opportunities to share information and learning.	1	2	3	4	5
2	Part-time and add-on staff are included in sharing learning and information.	1	2	3	4	5
3	External experts are welcomed.	1	2	3	4	5
4	Feedback from patients is valued and available to all staff.	1	2	3	4	5
5	Your team has a network of support and information sharing within the Practice.	1	2	3	4	5
6	Your team has a network of support and information-sharing with similar teams in other Practices.	1	2	3	4	5
7	Your team can quickly and accurately communicate new information to key decision-makers.	1	2	3	4	5
8	Your team has regular reviews about what is happening.	1	2	3	4	5
9	Your team is valued within the Practice.	1	2	3	4	5
10	Your team is able to cultivate open discussion, tolerance and systematic ways of thinking about the team's role within the Practice.	1	2	3	4	5
Part 3	**Leadership That Reinforces Learning**					
1	Managers at all levels invite input from others in discussions.	1	2	3	4	5
2	Managers acknowledge their own limitations with respect to information, expertise or knowledge.	1	2	3	4	5
3	Managers ask probing questions.	1	2	3	4	5
4	Managers listen attentively.	1	2	3	4	5
5	Managers encourage multiple points of view.	1	2	3	4	5
6	Managers provide time and resources for identifying problems and organisational challenges.	1	2	3	4	5
7	Managers provide time, resources and venues for reflecting and improving past performances.	1	2	3	4	5
8	Some managers criticise views that are different from their own.	1	2	3	4	5
9	All managers demonstrate a holistic approach to Learning in different ways being valued within the Practice.	1	2	3	4	5

Modified self-assessment questionnaire as adapted by Practice 2

Part 1	**Evidence of a Supportive Learning Environment** **A Safe Environment**					
1	It is easy for you to speak up about what is in your mind within your part of the Practice Team	1	2	3	4	5
2	It is easy for you to speak what is in your mind within your particular team in the Practice.	1	2	3	4	5
3	If you make a mistake it is often held against you.	1	2	3	4	5
4	People in your team are usually comfortable about talking through problems and disagreements	1	2	3	4	5
5	Keeping your 'cards close to your chest' is the best way to survive in your team.	1	2	3	4	5
6	People in your team are eager to share information about what does and does not work.	1	2	3	4	5
	Appreciation of Difference					
1	Differences of opinion are welcome in your team.	1	2	3	4	5
2	Unless an opinion is consistent with what most people in your team believe, it will not be valued.	1	2	3	4	5
3	Your team tends to handle differences of opinion privately.	1	2	3	4	5
4	The Practice will not address differences of opinion in the whole group.	1	2	3	4	5
5	It is comfortable to speak in whole Practice meetings.	1	2	3	4	5
6	In your team, people are open to alternative ways of looking at issues and events.	1	2	3	4	5
7	Everyone in the Practice treats everyone else with respect.	1	2	3	4	5
	Openness to New Ideas					
1	In your team, people value your ideas.	1	2	3	4	5
2	Unless an idea has been around for a long time, nobody in your team will want to hear it	1	2	3	4	5
3	In your team, people are interested in better ways of doing things	1	2	3	4	5
4	In your team people usually resist untried approaches.	1	2	3	4	5
	Time for Reflection					
1.4.1	People in your team are over-stressed.	1	2	3	4	5
1.4.2	Despite the workload, people find time to review how their work is going.	1	2	3	4	5
1.4.3	In your team, schedule pressures get in the way of doing a good job.	1	2	3	4	5
1.4.4	In this Practice people are too busy to invest in improvement.	1	2	3	4	5
1.4.5	There is simply no time for reflection in your team.	1	2	3	4	5
Part 2	**Evidence of Learning Processes and Practices** **Collection of Evidence of Learning & Development**					
1	Members of your team spontaneously share learning experiences in their work.	1	2	3	4	5
2	Learning experiences on the job are shared with colleagues.	1	2	3	4	5
3	Anecdotal and narrative forms of sharing learning are valued.	1	2	3	4	5
4	Learning experiences are stored as a potential resource for the future.	1	2	3	4	5
5	Members of your team have opportunities to see how their work relates directly to patient well-being.	1	2	3	4	5
6	Members of your team have opportunities to see how their work supports other colleagues in the shared purpose of patient well-being.	1	2	3	4	5

7	Everyone in the Practice is aware of how their work is related to current changes and demands from the government and other external agencies.	1	2	3	4	5
	Analysis & Reflection					
1	Your team is able to benefit from discussion and debate.	1	2	3	4	5
2	Your team will seek out differences of opinion during discussions.	1	2	3	4	5
3	In discussions, your team never revisits or questions previously well-established opinions.	1	2	3	4	5
4	Your team frequently seeks to identify and discuss hidden assumptions that might affect key decisions.	1	2	3	4	5
5	Your team never pays attention to different views during discussions.	1	2	3	4	5
	Training & Development					
2.4.1	Newly hired employees in your team receive adequate training.	1	2	3	4	5
2.4.2	All experienced employees in your team receive periodic training updates.	1	2	3	4	5
2.4.3	All staff in your team receive training when new initiatives are launched.	1	2	3	4	5
2.4.4	In your team, everyone values discussion time about what is currently happening in your work.	1	2	3	4	5
2.4.5	In your team your value discussions with staff from other teams in the Practice.	1	2	3	4	5
	Sharing Information & Learning					
1	Within your team there are small forum groups and well as whole team opportunities to share information and learning.	1	2	3	4	5
2	Part-time and add-on staff are included in sharing learning and information.	1	2	3	4	5
3	External experts are welcomed.	1	2	3	4	5
4	Feedback from patients is valued and available to all staff.	1	2	3	4	5
5	Your team has a network of support and information sharing within the Practice.	1	2	3	4	5
6	Your team has a network of support and information-sharing with similar teams in other Practices.	1	2	3	4	5
7	Your team can quickly and accurately communicate new information to key decision-makers.	1	2	3	4	5
8	Your team has regular reviews about what is happening.	1	2	3	4	5
9	Your team is valued within the Practice.	1	2	3	4	5
10	Your team is able to cultivate open discussion, tolerance and systematic ways of thinking about the team's role within the Practice.	1	2	3	4	5
Part 3	**Leadership That Reinforces Learning**					
1	Managers at all levels invite input from others in discussions.	1	2	3	4	5
2	Managers acknowledge their own limitations with respect to information, expertise or knowledge.	1	2	3	4	5
3	Managers ask probing questions.	1	2	3	4	5
4	Managers listen attentively.	1	2	3	4	5
5	Managers encourage multiple points of view.	1	2	3	4	5
6	Managers provide time and resources for identifying problems and organisational challenges.	1	2	3	4	5
7	Managers provide time, resources and venues for reflecting and improving past performances.	1	2	3	4	5
8	Some managers criticise views that are different from their own.	1	2	3	4	5
9	All managers demonstrate a holistic approach to Learning in different ways being valued within the Practice.	1	2	3	4	5

Modified questionnaire as adapted by Practice 3

	Below are a series of statements. For each one, please indicate the extent to which you believe it to be true. Throughout the questionnaire, the scoring scale operates as follows: 1 – Rarely 2 – Sometimes 3 – Usually. Please keep a copy of your questionnaire when it is completed. This is because you will be asked to repeat this exercise twice more before the end of the project in May 2011 and, by keeping a copy, you will be able to chart whether or not there have been any changes over time. The questionnaire is anonymous but colour-coded according to the four following "teams": GP; Nurse; Reception; Administration. The purpose of this is to help the Project facilitator(s) detect whether or not any particular trends emerge by team. To support the anonymity of this exercise, please deposit your completed questionnaire in the collection box in the library. Please be honest in your responses. Thank you.	1-Rarely	2-Sometimes	3-Usually
1	At work, I am comfortable with being open about my mistakes and my weaknesses as I know they will not be held against me.			
2	I feel able to speak freely when discussing work-related issues with my colleagues and am not constrained by what I think I *should* say.			
3	The Practice routinely reviews the training needs of its team members and responds to those needs by arranging appropriate training.			
4	In my part of the Practice team, differences of opinion are respected and do not cause tension.			
5	In my opinion, everyone in the Practice treats everyone else with respect.			
6	I feel that new ideas are encouraged, valued and given due consideration across the Practice team at large.			
7	In my experience, the various parts of the Practice team are given the opportunity to influence the design and delivery of services in which they are directly involved.			
8	I find that members of the Practice team willingly share information about what does and does not work.			
9	When things go wrong, the Practice is able to confront the issue with honesty and openness and does not look for a scapegoat.			
10	In my opinion, the Practice has learned from previous incidents or past mistakes.			
11	This Practice recognises that there are valuable lessons to be learned outside of formal training and education events.			
12	I am clear about my tasks and goals and recognise my own responsibilities within the Practice.			
13	In my opinion, members of my own part of the Practice team are deeply concerned about letting one another down.			
14	Team members will challenge each other regarding inappropriate behaviour, lack of attention or poor attitude and commitment.			
15	My part of the Practice team is given the opportunity to learn about its colleagues' work and how it contributes to the collective good of the Practice and its patients.			
16	The Practice makes sure that there is protected time for the various teams periodically to review how their work is going.			
17	When team meetings end, everyone is clear about the resolutions that have been made and the specific courses of action they each have to take.			
18	Patient safety is a key priority within this Practice and it underpins every decision about service (re)design and delivery.			
19	I feel actively engaged in the channels and flows of communication within the Practice team.			
20	The quality of care delivered by this Practice is supported by reliable and effective *in-house* administrative systems.			
21	We each feel a personal commitment to delivering patient services in the most effective and efficient way possible.			
22	The component parts of the [[redacted]] Surgery team are aware of what is happening across the team at large and how it relates to current changes and demands from the government and other external agencies.			
23	The Practice provides time and resources for identifying problems and organisational challenges.			
24	Even if team members bring their own personal agendas to a discussion, once 'the Practice' has made a decision, everyone is subsequently committed to it.			
25	The [[redacted]] Surgery team has a shared vision to offer its patients high quality of care and functions effectively as a unit in order to deliver it.			

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