Diana Moss
Moss Health Skills

An Evaluation of The Benefits of Practice-Based Learners to Service

September 2007

Abstract

Introduction. Since the NHS White paper The New NHS-Modern and Dependable (1997), successive health policy has directed a move towards primary care delivered services with emphasis on greater skill mix in staff. Reform in service provision relies on both expansion and changes in education and learning infrastructures to meet the development needs of the current and future workforce in primary care.

Aim The aim of this study is to identify the benefits practice based learners in general practice may bring to service. The intention is to use this information to influence resistance to change/adoption of innovation; engaging more practices in taking learners and contribute towards the learning of the health community as a learning organisation.

Objectives. The objectives were to establish, the contribution learners made to care delivery, the benefits to the practice, the benefits to the mentor/supervisor/assessors, benefits to service users/patients/carers, draw- backs and any association between these and the type of learner or length of placement.

Method. A semi- structured interview was designed and administered to eight mentors/supervisors/assessors in practices within the study group.

Results. Overall the results demonstrate benefits to service in providing practice-learning opportunities. Results also identify drawbacks. Of those in the study group 4 (50%) felt the benefits outweighed the drawbacks, 3 (37.5%) felt they did not and 1 (12.5%) felt them to be about the same.
A Force Field analysis examining the opposing sets of forces for and against the decision of practices to engage in practice based teaching, informs recommendations for the Health Authority/Deanery, PCTs and Universities.

Conclusion.

The benefits practice based learners in general practice may bring to service are identified and support the findings of previous profession specific research.

Acknowledgements

I am grateful for all the help and support received from the following people whilst carrying out this evaluation

Supervisor - George Boak

Colleagues in Primary Care Education and Learning Development

My family, -Andrew, Lisa, George and Ella

CONTENTS

Tables

Graphs

Graph 2- Number of placement sessions recorded by the administrator
1.10.05- 31.3.07

1. INTRODUCTION AND BACKGROUND

1.1 Aim of the study

The aim of this study is to identify what the benefits are to service in having practice-based learners in General Practice. The intention is to use the evidence to inform those commissioning education and training placements in their negotiations to encourage greater participation in developing learner placements. The results of a Force field analysis may then be used to reduce objections and sell the benefits of this change to practices. Engaging more practices will increase capacity to take learners and translate the vision of an innovative network of multi professional learning organisations into practice.

1.2 Background

Since the NHS White paper 'The New NHS-Modern and Dependable' (1997), successive Health policy documents (The NHS Plan (2000), 'Shifting the Balance' (2001), 'HR in the NHS Plan – more staff working differently' (2002), 'Choosing Health' (2004), 'Our Health, our care, our say' (2006)) have directed a move towards more care being delivered in local settings by a more diverse and flexible workforce, working in different ways.

For clinical and non-clinical education and development activity to deliver a workforce fit for purpose, these policies increase demand from service providers for practice-based learning in primary care. The NHS Career Framework (2004) and Learning for a Change in Healthcare-Widening Participation in Learning (2006) not only increase the number of placements needed, but also the breadth of learning outcomes to be satisfied e.g. from school learner placements to advanced clinical skills.

Reform in service provision thus relies on both expansion and changes in education and learning infrastructures to meet the development needs of the current and future health care workforce.

General practice is well placed to lend itself to such a learning infrastructure, but often resists engaging in such activity. It is my experience that some GP practices (independent contractors to the NHS), question the financial implications of providing placements; a role outside the scope and purpose of the General Medical Services contract. However, Health Authority (HA) and PCT commissioners of education and training have concerns about the consequences of payment for placements to independent contractors or independent sector service providers. Any such payments may reduce the total amount of education and training they might be able to purchase.

Stories relating to the benefits in having practice- based learners are ingrained in NHS culture. Department of Health guidance (DH) (Working paper 10 (1989) and Benchmark Pricing and National Standard Framework Contract for Professional Health Training (2006)) suggest there should be no payment, and make reference to benefits in terms of "future recruitment, maintaining morale and professional knowledge of existing staff"(Working paper 10 1989 para.7.15)

I was appointed to River Workforce Development Confederation in January 2003 to lead the development of education and learning programmes and infrastructures in primary care across the HA and its Shire counties. Part of the role was to manage the River Practice Education Centre Project, designed to test out models that might increase learning capacity in primary care to meet the agendas identified above. The Thirdshire Teaching Practices Network (developed within the project) has been particularly successful in increasing capacity and breadth of placement learning for learners of all types. Other practices express a range of views on being involved in similar networks. In my experience the most commonly held belief influencing a decision by practices not to participate, is that having learners on placement is costly to them and that these costs outweigh any benefit. Identifying the benefits learners may bring to service might influence their future decisions to participate in new changes (Moss Kanter 1989).

Thus the initial question in this study is: What are the benefits to service in having practice- based learners?

1.3 Justification and motivation

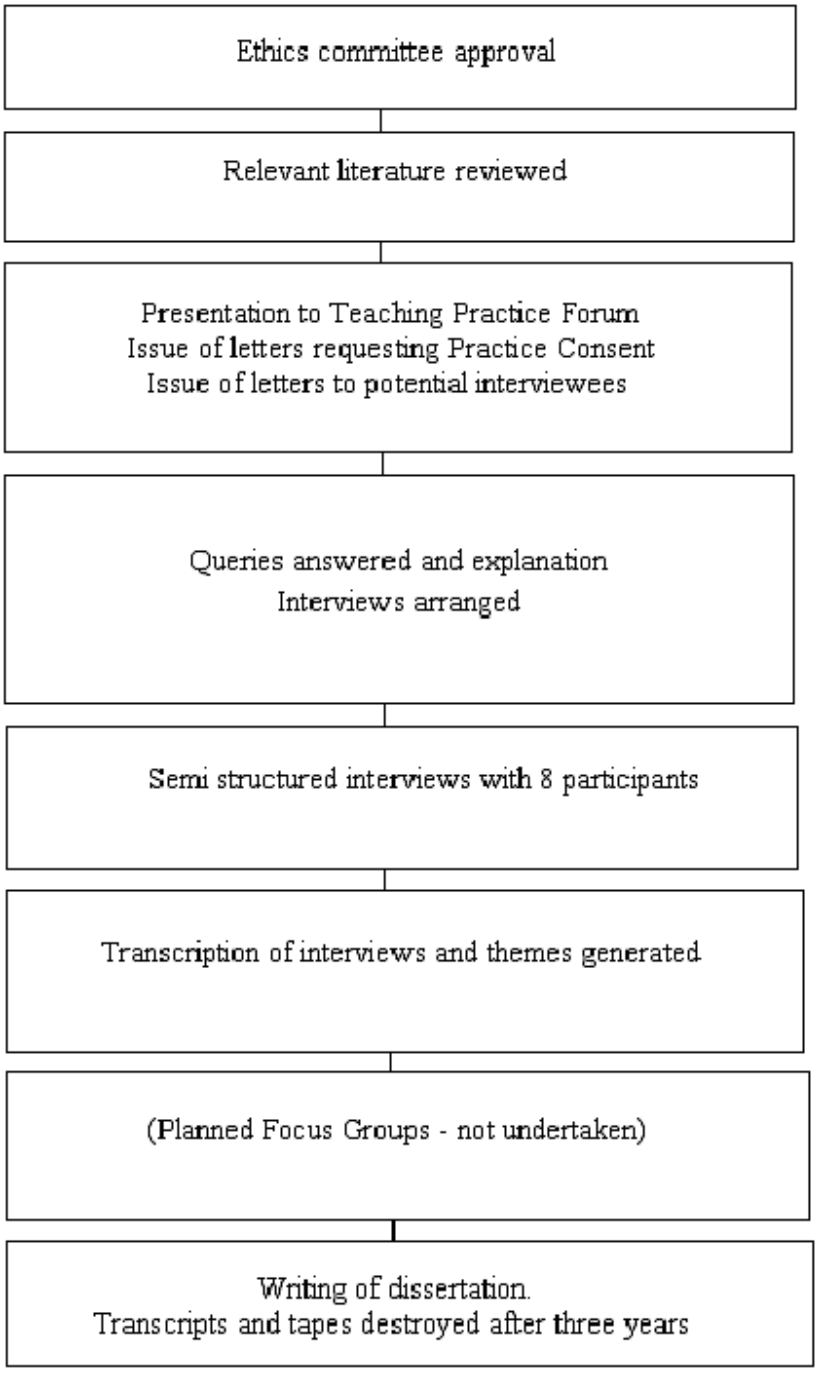
This research sets out to identify the benefits to general practice in providing practice-based learning opportunities. On the grounds of these results, the HA might lead the changes necessary to increase participation by general practice teams in providing multi-professional practice learning opportunities. The three practices investigated within this study were part of the River Practice Education Centre Project 2003-2006 in the Thirdshire PCT Teaching Practices Network. As such, this study recognises that the mentor/assessor/ supervisor experiences of the benefits to service identified, relate to these specific practices.

Four practices (A B C & D) in the Thirdshire Teaching PCT Network had no prior experience of practice-based learners and were approached to take part in the study. Practice D did not take up the offer to participate..

1.4 Research protocol

This flowchart summarises the research process undertaken.

FLOW CHART OF RESEARCH PROTOCOL



2. LITERATURE REVIEW

A review of current literature was initially undertaken using computerised databases, including generalist search engines such as Emerald and Google scholar, as well as the

specialist health data bases 'Cumulative Index to Nursing and Allied Health Literature' (CINAHL) and medical databases: MEDLINE, PUB MED and PROQUEST. The latter were chosen for their comprehensive listings of nursing, allied health professions and medical research relating to clinical placements. Entering single words returned a vast number of papers; difficulties in definitions and interpretation of terms and words e.g. mentor, were experienced.

Focussing the search by combining related areas (e.g. 'community learners', 'practice learning', 'mentoring in practice', 'Learner placements') was more helpful in finding literature that formed some of the reviews of practice- based learning/placements. The most valuable source of relevant research came from tracing citations and references to discover unpublished research.

Secondly, it was necessary to place the research literature in the context of contemporary DH policy and emerging strategy.

The literature reviewed is summarised in Table 1 (Appendix 10).

2.1 Overview of the literature

Hoping to identify themes indicating benefits and costs to service, the search for published British studies of practice placement costs and benefits found little on the subject. Despite a widely held (NHS) belief that there are benefits in having practice-based learners, literature collected and reviewed revealed limited research into what these benefits were. That which *had* been carried out, was often at least ten years old, unpublished and focused on one specific profession/ group of students (e.g. Occupational Therapists, Medical students).

Over 20 papers were reviewed, none of which focused on multi-professional learners in general practice. Walker and Cooper (1992) similarly found little British research, drawing on published articles from North America for their studies. However those benefits were to patients receiving care in the context of a different health system i.e. under insured patients benefiting from free health care, provided by learners.

Gopee N et al (2004) conclude that the focus of British research (into placement learning) is acute clinical settings with little documented in relation to primary care.

2.2 Benefits

DH guidance, Working for Patients (1989)- Working paper 10, addressed the education and training of non-medical healthcare professionals. This states 'great' benefits are to be gained by service providers, over and above the contribution learners make to direct service delivery, in terms of; future recruitment, maintaining morale and professional knowledge of staff. However the document fails to qualify the source of these claims. Unpublished work by Walker and Cooper (1992), identified the following benefits to service in having Occupational Therapy (OT) learners in fieldwork placements:

- Enhanced recruitment & retention of staff
- Improved staff morale
- Professional development of staff
- Enhanced status of unit (prestige)
- Marketing advantages
- Enhanced quality of care to clients

And identify other possible benefits:

- Student research and project work contributing to enhanced quality of service
- Partnership between education provider and service provider

Further, Walker and Cooper noted 'anecdotal evidence' that the culture within NHS units participating in student education was 'radically different' from those which did not. Ferguson et al (1993) condensed the benefits into four strands:

- Staff recruitment
- Staff morale
- Staff training and development
- Service and status

The North American study into nurse education by Hawken and Hillestad (1987) recognised the following 'intangible benefits':

- Prestige of being associated with a teaching facility
- Recruitment tool- access to education helping facilities to recruit
- Recruitment pool- students' availability as prospective staff members after graduation

- Job enrichment- participation in nurse education providing an added dimension to staff members' jobs
- Maintaining nursing skills- reinforced appropriate principles and tasks when students are around
- Impetus for analysing nursing care- students questions serving as stimulus for staff members
- Continued learning- staff encouragement to stay current in nursing and to seek additional education.

In preparing Nurses for registration, Ellis and Hogard (2001) indicated that academic programmes alone might have detrimental effects on students' ability to learn and practice. A study by Fearing and Newton (1999) in American, suggested nursing students benefited substantially from community placements, and recommended that these should occur early in pre-registration courses. This view is echoed in Modernising Nursing Careers (2006), supported by Morgan M. and inherent in the philosophy of the University of Lincoln Nursing programme to supply graduate nurses, who, on registration are prepared to deliver care outside hospital.

Benefits to patients of student teaching in general practice are reported in published and unpublished studies; Benson et al (2005), Lobo (2006), Corby (2006). These allude to additional attention, consultation time and expanded explanation of their condition.

Benson et al (2005) found no diminished patient enablement or satisfaction in medical student teaching in general practice consultations.

In studying one education provider, Lloyd Jones and Akehurst (1999) calculated a cost of 48p per hour per nursing student for community-based placements after accounting for mentor, direct supervision and professional development costs. In determining whether service providers should be paid for providing pre-registration nurse clinical placements, they concluded that there was no case for introducing a system of payments for nursing students. Their pivotal argument is the *value* to the service provider of the qualitative benefits. Earlier studies (Atkins and Williams 1995), (Ormerod and Murphy 1994), (Walker and Cooper 1992), (Ferguson et al 1993), (Follows 1993), (Hawken and

Hillestad 1987), all suggest that the benefits to service are sufficient enough to outweigh the associated costs.

Shalik (1987) undertaking a cost benefit analysis of final year OT student placements, found a mean benefit to service units for 12-week placements. This study suggested that higher costs in the first few weeks generally recovered between weeks three and five, with cumulative benefits as the placement progressed. Therefore, placements of less than 6 weeks are likely to have cost implications for the service.

In contrast, Business Solutions Consortium draft report (1990) in OT, calculated costs per student placement day to be £19.72, after a service contribution of 12% in year 1, 15% in year 2 and 50% in year 3 had been deducted (at helper grade equivalent). Although superficially attractive (to service managers), the idea that education providers could meet the placement costs was not supported by Walker and Cooper (1992). They concluded that student placements were not just a cost to service, but brought quantifiable benefits in terms of appreciable service contribution and indirect benefits from student-staff interaction (staff development and impact on the quality of service provision). Nor did they find placements necessarily had an adverse effect on patient throughput. In the event of costs being calculated for payment, they proposed a costing formula (appendix 1).

Ferguson et al (1993) progressed this formula into a worked example, to inform discussion about the costs and benefits to service in providing student placements. They suggest that the break-even value for these 'intangible' benefits depends on the variable net costs to service (appendix 1).

Might the benefits to general practice be similar? Mathers et al (2004) mention positive impact on practice infrastructure and resources from medical learners. Some practices in this study reported positive effects in allocations from the SHA (upgrading IT systems), whilst others felt negative effects, i.e. a presumption that SIFT (Service Increment For Training) alone was sufficient to support all teaching requirements. Funding from the medical school was considered insufficient and sometimes a deterrent in taking learners. However, they identified advantages in increased morale, variety in work life and stimulus for continuing medical education as a result of student questioning, increased reflective practice and re-examination of areas of work/knowledge. Improved standards

in record keeping and IT systems were also noted. Consistent negative factors were recognised in that advantages were, to some extent, offset by the additional workload of clinical teaching, administration, preparation, marking etc.

Ferguson et al (1993), Walker and Cooper (1992) report concern at the time of their research for the consequences to service if Regional Health Authorities had to pay for student placements- potentially reducing the total amount of education and training that could be purchased. Similar concerns are currently expressed (by HAs and PCTs) should payment be made to independent contractors (general practice) or independent sector service providers (Spouse, J. 2007), (River Health Community Workforce Groups 2006). Morgan, M.(2007) noted the governments' lack of power to force GP practices to help train nurses "A lot of placements will need to be in GP practices, but we have no control over GPs. We are either going to have to find a solution to this or stop talking about it." (April 2007)

2.3 Department of Health initiatives and policy.

Current Health policy (Creating a Patient-led NHS, 2005) encourages commissioning 3rd sector/independent sector service provision. These providers, for the most part, recruit staff educated and trained within the NHS. New service ambitions to meet the workforce modernisation agenda, depend on a skills set often reliant on medical (GP) supervision for clinical skills/practice training e.g. advanced clinical skills for examination, diagnostic, case management and non medical prescribing. If new services are to be commissioned (delivered by new roles) and long- term policy realised, it will be necessary to engage more practices/ independent providers to take learners on placement (Morgan 2007). However, "The Benchmark Pricing and National Standard Framework Contract for Professional Health Training, DH' (2006), Operational Implementation Guide, Paragraph 4.3.9 on Placement Fees, states categorically, "Providers shouldn't be paying placement fees including to General Practitioners."

Working for Patients (1989) -Working paper 10 recommendations, directed that education provider contracts stipulate the provision of clinical (fieldwork) placements. Recognising that units providing such placements bear some associated cost, it also stated

(paragraph 7.15) that it hoped service would not press for reimbursement because of the 'advantages' of having students on placement.

This was despite worries that student nurse contribution to service delivery would be significantly reduced by Project 2000, (the university-based system of nurse education accepted in 1988) based on the philosophy that nurse learning in clinical practice should be supernumerary. Literature relating to life long learning; 'Working Together-Learning Together –A Framework for Lifelong Learning for the NHS' (2001) and 'HR in the NHS Plan – more staff working differently' (2002), extend the notion of the clinical learning environment to that of learning organisations. Both these documents identified the need for a sustainable learning infrastructure supported by mentors and supervisors. The Centre for the Advancement of Inter-Professional Education (CAIPE 1997), advocated the commissioning of local, practice based learning, facilitating multidisciplinary and interagency education to be a key initiative in workforce development. It was against this backdrop and to assist in meeting these challenges that the River Practice Education Centre Project was born. DH guidance, 'Learning for a Change in Healthcare' (2006) describes unacceptably few opportunities for support staff to participate in learning and advocates widening participation as a major element of service reform and transformation.

The demand for training places in general practice supporting the Modernising Medical Careers programme is also projected to increase greatly (Watton 2005) as 'Foundation doctors' apply for GP training programmes ('Modernising Medical Careers: The facts 2006').

Key themes emerging from my literature review are that despite limited British research, similar benefits to service have been identified from nursing, occupational therapy and medical learner placements. Little research has been undertaken into benefits from learners in clinical support or non- clinical roles. Findings from research into the cost/ benefits to service in having practice- based learners are divided, some of which remains unpublished. One might speculate whether study results inconsistent with Health policy guidance on education, remained unpublished due to their potential damaging effects on the sponsor.

DH workforce guidance, projects that there will be greater number and wider range of learners in the future; necessitating more practice- based learning in primary care. Whilst education guidance does not favour payment for practice- learning, it seems clear that those commissioning education and learning (in primary care) will need to find means of engaging general practice and independent sector service providers.

3. DESIGN AND METHODOLOGY

3.1 Method

This research study comprised semi structured interviews with mentors, assessors and supervisors in the three practices to ascertain their perceptions of the benefits to service in having practice- based learners.

In justifying the choice of method and methodology used in this study and how these relate to my theoretical perspective and epistemology, my preference is to adopt the approach described by Crotty (1998). My epistemology (assumptions about the best way to create knowledge) is constructionist; assuming that the world is socially constructed, that I am part of the system being studied and cannot be divorced from it. The theoretical perspective of symbolic interactionism underpins this qualitative research; understanding and explaining the human world based in the assumptions I bring to the research. My methodology is that of grounded theory and research method semi-structured interview. As such I am examining each situation and developing my ideas through induction from the data collected.

My initial assumption is that there are benefits to service in having practice-based learners and my research set out to identify these. The findings may suggest the benefits that might be accrued from such activity in other practices.

This contrasts with the positivist paradigm that the world is objective, the observer independent and that science is value free. The positivist paradigm focuses on facts, seeks causality and laws, in order to formulate hypotheses that can be tested (Easterby –Smith et al, 2002).

Although my methodology is essentially qualitative, analysis of the results involves a degree of quantitative methodology, as Abrahamson (1983) suggests, distinction between the two approaches may not be method pure. Counterbalancing the strengths in using different methods may accommodate flaws in either. Thompson (1999) suggests in reality, the distinction between qualitative and quantitative research is often blurred, and that many studies use a combination of two or more approaches.

Although circumstance-specific, identifying possible benefits derived from such activity i.e. what's in it for practices (Kennedy G. 1997) will help commissioners of education and training to lead the change towards a network of Teaching practices.

3.2 Ethics

The staff considered in this study may be independent contractors or employees of independent contractors to the NHS (General Practitioners). In order that I might approach their employees and potentially interview them on their premises (possibly within their employment time), I wrote to each of the eligible practices. This initial letter requesting permission to approach their employees was carefully worded to overcome organisational concerns and minimise sensitivity; the request for time was kept to a minimum, assured protection of their Teaching status and anonymity. The letter highlighted a positive approach e.g. "I am particularly interested in individual and organisational learning from having practice based learners" (Saunders et al 2007) and offered face-to-face meetings (with the practice team).

Individual letters of explanation were sent to prospective interviewees with the offer of telephone contact to answer any queries they might have (appendix 2). Verbal explanation was provided and written consent (appendix 3) gained in advance of all interviews. It was emphasised that participation was purely voluntary and that interviewees could withdraw at anytime. All interviewees were offered a copy of the final evaluation report.

This is a small study and as such practices and individuals might be easily identifiable. To protect both independent contractors (practices) and individuals (who might be especially vulnerable) from identification, I personally coded interview tapes, transcriptions and notes by practice and individual. The names of the Strategic Health Authority and PCT were altered to protect their identities and respect anonymity.
My duty as a researcher is to exercise ethical responsibility by not publicising or circulating information likely to damage the interests of individual informants. Individuals were assured that tapes and transcriptions would be destroyed once the study has been submitted.

3.3 Interview questionnaire development

Since I cannot observe everything I chose to undertake a qualitative interviewing as my method. This assumes that the perspectives of others are meaningful, knowable and precisely articulated. Michael Quinn Patton (2001) describes qualitative interviewing as providing the framework within which respondents can express their understanding in their own terms, helping to gather stories and finding out what is in and on someone else's mind. Quinn Patton (2001), Easterby- Smith et al (2002) and Jones (1985) all describe three approaches;

- Informal conversational interviews
- General interview guide approach
- Standardised open-ended interviews

Whilst each has strengths and weaknesses, they differ in the extent to which questions are determined and standardised before the interview and serve different purposes.
Informal conversational interview relies on the spontaneous generation of questions; it offers maximum flexibility to pursue information in whatever direction appears appropriate (Fontana & Fray 2000).
The general interview guide approach outlines a structured set of issues to be explored with each respondent before the interviewing begins, providing a basic checklist and guide but allows for some flexibility in probing.
Constant standardised open-ended interviews consist of a set of questions carefully worded and arranged with the intention of taking each respondent through the same

sequence and asking each respondent the same questions with essentially the same words, limiting flexibility to probe.

Such contrasting interview strategies are not mutually exclusive. I combined approaches in a semi-structured interview, enabling me to use a guide approach with informal conversational interviewing. This allowed flexibility to probe and explore areas in more depth and those unanticipated in my original line of inquiry (appendix 4).

Interview tool

To check that those areas I considered important were not solely of my own paradigm/understanding, I invited colleagues to check and to contribute further examples to my list of potential benefits, ranking the issues in order of importance (appendix 5). They judged some of my benefits less important than others. This investigation enabled me to use colleague opinion in determining the questions to ask.

After piloting with my first interviewee (R), a minor adjustment was made to the final question –"Is there anything else you would like to tell me?" providing an opportunity for the interviewee to have the final say.

3.4 Interview questionnaire administration

All staff directly involved in mentoring, assessing or supervising the learners were invited to take part in recorded semi-structured interviews relating to their experience and opinions. Interviewees were voluntary; self selected from within these particular practices and as such may not be a representative sample of mentor, assessor and supervisor experience.

Two practices were particularly difficult to engage. Even with additional letters and email, practice D exercised their ethical right not to participate. The practice participation rate (75%) may reflect a perceived pressure to take part, given the low number of practices eligible for inclusion in the study.

In order to capture words used by interviewees to provide the raw data (for interpretation and analysis) as fully and as fairly as possible I recorded the interviews as well as noting significant words/issues.

My use of the Dictaphone was explained to interviewees when gaining their consent and my notes helped formulate new questions during the interviews, clarify points made earlier in the interview and capture important quotes as another reminder.

Immediately after each interview, I ensured that the Dictaphone had worked and made any additional notes.

3.5 Data coding and analysis

I personally undertook all the transcriptions of recordings to help immerse myself in the data as the first step of the analysis.

Two methods were used to record the data; firstly, answers to structured questions (questions 5, 7 & 8) were recorded on frequency tables, and secondly, I developed a coding template for open-ended questions capturing qualitative data/ direct quotations under themes to enable analysis as described by King (1998) and Mason (1996).

I recognise these "authentic accounts of subjective experience" as described by Miller and Glassner (2004) may simply be repetition of familiar cultural tales, and context-specific to the interview, but do not discount the possibility of learning about the social world beyond this.

After transcribing the recordings, I annotated them from my written notes. Reading through the transcripts, statements were coded by broad theme with sub-themes subsequently added to capture specific areas of note (King 1998, Glaser and Strauss 1967)(appendix 6). Thus my initial template underwent several amendments to

incorporate the breadth of results before combining similar points. This method captured relevant points arising at different times during the interview.

Coding:

1-Contribution of learners to care delivery

2-Perceived benefits to practice

3- Perceived benefits to mentor/supervisor/assessor

4- Perceived benefits to service users/patients/carers

5- Perceived draw backs

(appendix 7)

Themes were cross- referenced to the literature reviewed (appendix 8) to assist with the data analysis.

To try to eliminate "anecdotalism" and bias (Silverman 2004) 'when data depends on a few well chosen examples', I enlisted the help of a colleague *S.A.* (with no connection to the project) who listened to the recordings, read the transcripts and coding to confirm that I had not been selective in my choice of quotations. She supplies a statement of confirmation (appendix 9).

According to Abrahamson (1983) using different methods in the same study prevents research becoming method-bound, counterbalances the strengths and accommodates the flaws in either method. Due to the small size of study interviewees it is not appropriate to analyse quantitative data, but it is used to illustrate pertinent points where possible. Finally a Force Field diagram and analysis (Lewin K 1951) examines the forces for and against the engagement of general practices in the delivery of practice-based learning. It identifies activities that may be undertaken by leaders of the change initiative to minimise resistance and sell the benefits in participating to practices.

3.6 Focus group

My original intention was to hold a Focus group for staff not interviewed, to triangulate (taking three reference points to check an objects location, Smith (1975), Todd (1979)) the evidence collected as proposed by Morgan D (1988). However, for logistical reasons, within the timescale of this study, it was not possible to organise such an activity (mainly female staff, working local to home, without transportation).

3.7 Limitations

It should be acknowledged that this study has many limitations. Firstly, there were only eight interviewees from three practices (within a discrete geographical area), already empathetic and commitment to having practice-based learners and the Thirdshire Teaching Practices model. As such, they had neither experience as a Vocational Training Scheme (medical) Training Practice nor previous experience of practice-based learners. The results are limited to the perceived view of mentors/assessors/supervisors in the study group and do not include first hand views of learners, patients or other stakeholders. Personal involvement in developing The River Practice Education Centre Project also introduces bias. Interviewees may know of me even if we had never met prior to the interviews. They may have had a preconceived idea of my ability to influence financial investment, affecting respondents' answers. Jones (1985) and Mayo (1949) highlight the importance of impartiality in listening to interviewees: what they say and what they do not, without helping them (the difficulty being, empathising with the respondent as a way of building trust). Another possible problem is that my further probing may have indicated to interviewees my area of interest (Jones 1985). Engaging others in conducting the interviews might have reduced any such bias.

Semi-structured interview was the preferred method of data collection, as it attempted to meet the objectives of the study question and allowed the asking of further probing questions. The interviews provided much rich data, especially as interviewees had opportunity to expand their views. However, organisation and conducting the interviews themselves was time-consuming, demanded considerable travel, transcription and data analysis time.

Denscombe (1998) identifies advantages in using a questionnaire (usually associated with quantitative research) as they afford wide coverage, are cheap to produce, may be pre-coded and reduce the likelihood of bias (being completed unaided). Disadvantages, however, include a potential low rate

of return, incompletion, limited answers and provides no opportunity to seek clarification, verify truth or understanding.

The focus group was not conducted for the afore-mentioned reasons.

A relatively small amount of data was collected in this study; there is scope to carry out much wider survey of practices. Since findings are from a limited study group results may not be extrapolated to be representative of other practices.

The scarcity of relevant publications or peer-reviewed papers is another limitation. Those available, tend to be based on small numbers in a specific context. Papers that *have* been through a process of peer-review carry some assurance of quality and rigour in the publishing journal, but absence of literature whether peer-reviewed or not, suggests a dearth of research on this subject.

4. PRESENTATION OF THE RESULTS

4.1 Survey respondents

A total of 8 mentors, assessors/ supervisors from differing professional backgrounds were interviewed from three practices A, B & C (D declined invitations to participate).

Table 2- Job titles of the respondents

Job Title	Number	Percent
Practice Manager	**3**	**37.5**
General Practitioner	**4**	**50**
Practice Nurse	**1**	**12.5**
Total	**8**	**100**

All interviewees completed the interview in full and proffered additional information beyond answering the questions.

4.2 Frequency analysis

Frequency counts (Rogers J. 1988) are reported below for questions 5, 7 & 8.

The small number involved in this study may mean these frequency tables are of limited value, and skews overall percentage reporting.

Frequency Count Question 7

Table 3- Rating of the benefit of practice based learners for mentors/assessors/supervisors

	(n)	%
No benefit	3	37.5
A little benefit		
A moderate benefit	**4**	**50**
Great benefit	**1**	**12.5**
Total	**(8)**	**100**

All interviewees from practice B rated the benefit for mentors, assessors or supervisors to be moderate (practice manager and one GP) or great (one GP). The other two rating 'moderate benefit' were clinicians (one practice nurse and one GP).

Frequency Count Question 8

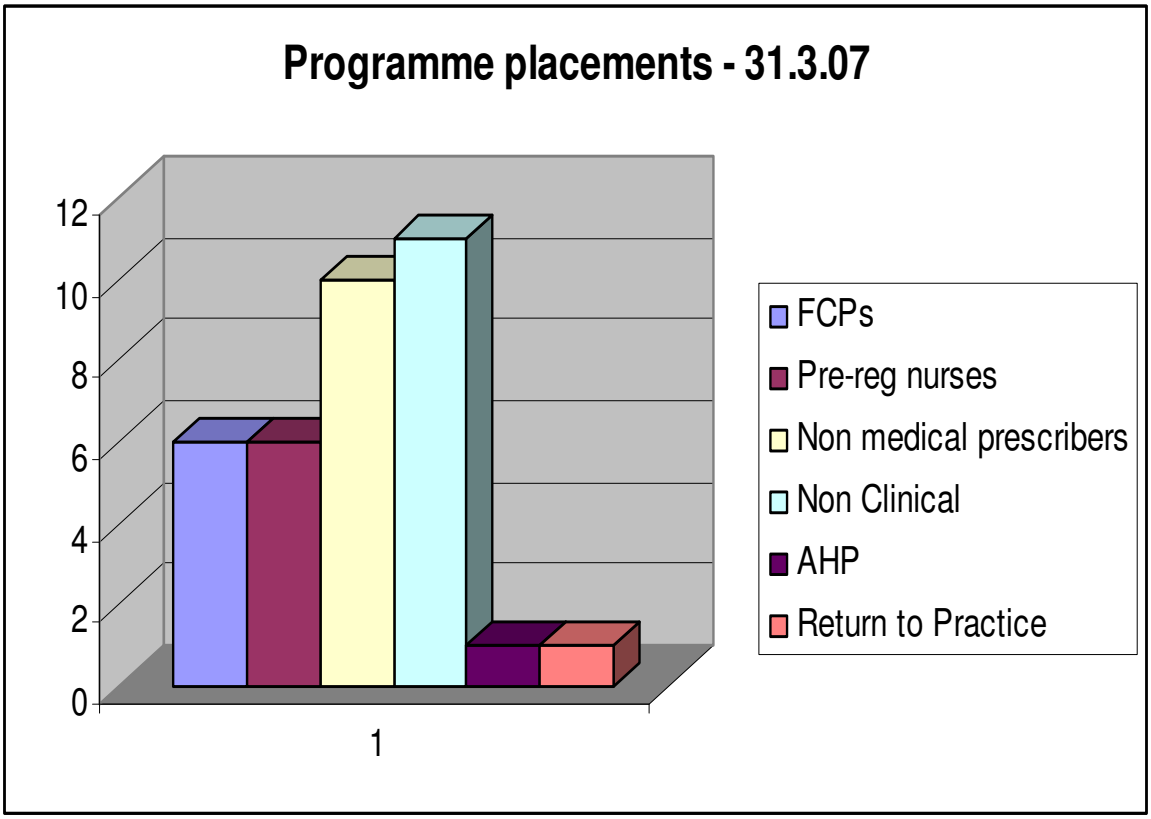
Table 4-Rating of the benefit of practice based learners for service users/patients/carers

	(n)	%
No benefit	4	50
A little benefit	**2**	**25**
A moderate benefit	**1**	**12.5**
Great benefit	**1**	**12.5**
Total	**(8)**	**100**

4.3 Practice based learners

The range and number of practice learners placed across all Third shire Teaching Practices recorded by the administrator (1.10.05 – 31.3.07) are detailed on graph 1 below. (Figures provided by practices in quarterly reports to the administrator.)

Graph 1.



Summary:

6 First Contact Practitioners

6 Pre-reg Nurses

10 Non-Medical Prescribers

11 Non-clinical = (2) Primary Care Apprentices & (2) Receptionists, (2) NHS management trainee (HR& Finance), school work experience, pre-university applicant, Modern apprentice

1 AHP = Physiotherapy

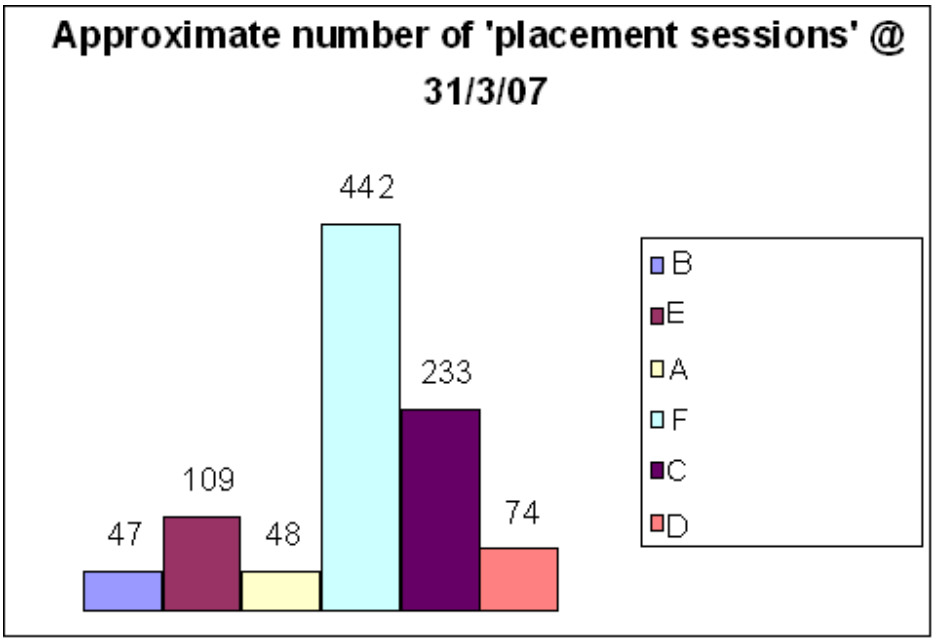
1 = Return to Practice

Those interviewed reported having learners in the practice from all disciplines (bar physiotherapy), although individual interviewees may not have had experience of all learners on placement in the practice. All had experience of learners on at least two programmes and one had had learners from four different programmes.

The number of placement sessions across all Thirdshire Teaching Practices recorded by the administrator (1.10.05 – 31.3.07) are detailed on graph 2.

(Figures provided by practices in their quarterly reports to the administrator). 'Sessions' are taken as half a day. A B C & D are those practices invited to participate in this study.

Graph 2



All three practices reported having more school work-experience, pre-university applicants and pre-registration nurses prior to 31st March than appear in the project administrator's data.

This discrepancy could be due to a number of factors; those interviewed may not have been involved with all the learners, some reported learners other than those recorded by the administrator (locally arranged school work-experience and direct placements from the University). Discrepancy may also have arisen due to human error in memory recall. The number and types of practice learners placed might be investigated further for accuracy.

4.4 The contribution of learners to care delivery

All interviewees in this study reported their learners to be supernumerary, 5 (62.5%) reported learners had delivered some care/services either with a mentor/assessor /supervisor or under their supervision.

Table 5- Contribution of learners to care delivery

Interviewee code	Yes	No
R	**X**	
S		**X**
T		**X**
U	**X**	
V		**X**
W	**X**	
Y	**X**	
Z	**X**	
Total	**5 (62.5%)**	**3 (37.5 %)**

All practice interviewees reported some contribution to care delivery but it was not possible to quantify the number of sessions learners contributed either jointly or under supervision.

Negative comments and those related to learners experience/stage of learning

Six out of the eight interviewees said some learners made no contribution to the delivery of care; *"…nothing because they have nothing they can do" (W)*. These comments related to the inability of inexperienced learners, novices or observers to be able to contribute to care. e.g. *"Overall usefulness depends on the learner, someone like a work experience learner –nothing*". Another felt that the placement was too early; *" the nurse who was there for 6 months just got to the point that she was fairly useful.. if we had more experienced trainees-but these are all just starting*" (W).

Other comments related to learners current specialisation *" her knowledge was in her own area of work (*District Nursing*), she realised she wouldn't be able to prescribe from the whole formulary…" (*V)

However, reports of positive contribution also related to the learners experience and stage in the learning programme: "*The experienced nurses have seen patients I selected for them, and then we have discussed their assessment, diagnosis and treatment plan. That's because I have confidence in their skills, knowing their capabilities and what they can do" (*R) and "*...The Practice Nurses let (nurse) students help with dressings and taking out stitches*"(R). Both GPs found advanced skills learners were able to see *"Some [patients] on their own, but under supervision."*

Table 6- Interviewees making negative comment and those related to learners experience/stage of learning

Interviewee code	Negative comments and those related to learners inexperience	Speculated that increased contribution might be made by more experienced learners
R	**X**	**X**
S	**X**	
T	**X**	**X**
U		
V	**X**	**X**
W	**X**	**X**
Y	**X**	
Z	**X**	**X**
Total	**7 (87.5 %)**	**5 (62.5 %)**

Four of those who said their learners made no contribution to the delivery of care speculated about potential contribution by more experienced learners e.g. Z: "*It might be different having a student (nurse) in their third year. Modern apprentices have helped with general task sand, fetching stuff"* and T: *"Second year students might add something to the equation."*

Frequency Count Question 5

Table 7 -How useful Practice based learners were thought to be to the overall service

	(n)	%
Not at all useful	**4**	**50**
A little bit useful	**3**	**37.5**
Fairly useful	**1**	**12.5**
Very Useful		
Total	**(8)**	**100**

4.5 The perceived benefits to the practice

Improved quality of service/care to patients

Three out of the eight interviewees (37.5%)(two GPs and one practice manager) made reference to improved quality in patient care. The practice manager and one GP were from the same practice (B). These benefits were described as immediate; patients receiving longer consultation, more thorough explanation of their condition, care management and treatment. R described patients- *" finding the information useful for their own understanding…and like the extra attention."*

Two reported that it focussed clinicians thoughts on the "*quality of their service"* and review of their practice *"sharpening… consultation and communication skills",* providing opportunity to " *refresh"* and attend to "*lapse in …habits."*

Another practice manager was of the opinion that *"… it makes the clinician think about the quality of the service they provide."*

These also reported learners having positive effect on the quality of care delivery in that it *"reminded and refreshed"* long qualified GPs *"especially as one has been a GP for twenty years."*

One GP (U) himself identified that "*patients do benefit from discussion over their prescription. They get longer time and get a better understanding and explanation.*"
One comment reported from a patient was *" they didn't mind having a student because there was better chance of getting the right diagnosis with two of them."*

Future recruitment

At least one interviewee from each practice suggested there might be enhanced opportunities to recruit from learners they had had on placement. This was seen as a long-term investment.

S reported, "*if we had a second year student nurse, we might employ her after she had qualified*" and (T) "*any gain might be from a long term investment in recruitment…"*

Table 8- Interviewees referring to future potential to recruit from learners

Interviewee code	Interviewees referring to future potential to recruit from the learners
R & S	**X**
T & V	**X**
W	**X**
Total	**5 (62.5%)**

Two practices (A & B) were planning a greater skill mix in practice staff as a result of considering new roles (one a nurse practitioner and one a health care assistant.)

Benefits in understanding new roles and influence over future remit of learners

Four respondents (R, S, Y, T) reported better understanding of new roles and increased confidence in those undertaking them. One alluded to mutual learning in the process: **"**

*understanding our Health Visitors' role in supplementary prescribing and what that demands meant that there was mutual learning… the doctors probably have more confidence in her now and what she can do"(*T) and reported better understanding of capabilities within new roles especially in the PCT. R felt she now knows *" what these people are capable of, I have a better understanding of PCT roles."*

One practice manager felt they were able to provide an NHS Management trainee with a more rounded learning experience, influencing their understanding of general as a future senior NHS manager; *"they were able to see how dispensing works and our standard operating procedures from a practice manager's point of view…it will help them understand how general Practice operates and think when they make decisions affecting us " (*S).

Two interviewees from the same practice suggested the experience had led them to reconsider their own plans for recruitment and incorporate greater skill mix: *"It has made me think about employing another nurse and whether we should have a health care assistant … could they be trained in what we need them to do?" (*S).

(Post script; the practice subsequently recruited a healthcare assistant and is using another teaching site to develop their skills and competencies to achieve effective skill mix.)

These two also recognised the potential for their own reception staff to develop skills in new areas e.g. clinical skills development.

However one respondent (V), a GP, reported less understanding and decreased confidence in the prescribing competence of community matrons; *"the business around non medical prescribing, she herself realised how dangerous her situation might be. I still don't know what they do."*

Table 9- Interviewees commenting on benefits in understanding new roles and influence over future remit of learners

Interviewee code	Interviewees commenting on benefits in understanding new roles (immediate)	Interviewees commenting on their ability to influence future working practices of learners
R	**X**	**X**
S	**X**	**X**
T	**X**	
U		
V		**X**
W		
Y	**X**	
Z		**X**
Total	**4 (50 %)**	**4 (50 %)**

Practice status, standing and prestige

Respondents from all three practices (100%) commented that they felt their practice status, standing and prestige had been raised. They felt it enhanced their profile with patients, knowing their service was *"good enough"* to be a teaching practice; R:*"It raises*

our profile with our patients in this community, them knowing we are good enough to have learners" And Y: *"Being a Teaching Practice makes us important to the patients.."* Two of the practices (B&C) viewed teaching as a positive contribution they might make to the next generation of health care workers, especially as neither was able to take medical learners due to restrictive premises. W said; "Our premises limit the students we can take" and went on to express disappointment in not having a medical student. *"We got right up to the last week before we were due to have a medical student from one of the London Schools…we were really excited …and then they withdrew the placement because we were one session per week short in being able to find them a room."*

Contribution to the learning community

All three practices cited altruistic reasons for taking learners. One said, *" I am a great believer in the value of general practice and want to show and share this with others"* (R) and felt it might be a route to achieve their ambitions to be a medical training practice.

W and T commented on their social responsibility in the community to be involved in school work-experience placements. Two respondents from practice C described personal experience of difficulty in finding placement opportunities for their children. W-*" …I've got children who have just gone to University, we couldn't find them placements, if you don't give someone the opportunity how can you expect someone to give your child the opportunity?"*

There was a sense of duty and commitment reported especially towards learners who made considerable effort, travelling difficult journeys for the learning placement. Engagement with the project brought improved communication with like-minded practices locally (through the forum) and better communication with education providers (university and postgraduate deanery as well as local schools). Practice B had considered offering training opportunities to those outside the health community. "*We could offer accounts training for GPs accountants because our GP had a particular interest and set the books up properly."* Their commitment to education is clear: *"The community benefit,*

no one is disadvantaged …even if they wait and surgery runs over, they all get seen…we don't cut down on patients, it takes longer. We extend surgeries for catch up time."
Another referred to a *"Social responsibility -so that's why we got so heavily involved with the schools…and its just gone on from there."*
Y reflected their commitment: *"…we have never -to my knowledge- refused a learner request. We have good relations with the school and community. Patients might have to wait longer but everyone gets seen and most don't mind waiting."*

Drawbacks to participating in the learning community

Both practices C & B reported the biggest drawbacks to be communication and co-ordination with education providers and processes. In particular, regarding regular communication with the University, Practice C felt they only had infrequent contact with the placement co-ordinator and that *"we just don't know what we are meant to be doing*". In relation to teaching and learning outcomes they had "*… no idea who we are going to be asked to take. So far we have agreed to have everyone…….. but there is no proper co-ordination…it just hits us…For the Modern apprentices we had no idea what they needed from us."* Practice B also mentioned communication being*"… the biggest thing for us…the schools are very good but at X University …we had a really embarrassing situation with one of our student nurses…it made us look bad."* Other references to academic processes included that *"the paperwork is so complicated I couldn't understand it. They keep making it seem so difficult even simple things by using complicated phrases, lots jargon, rubbish. I just give up. It put me off having a student. We don't have the time for all this form filling so I'd sooner not have one" (*Z).
Communication with local schools was not a problem.

4.6 The perceived benefits to mentor/supervisors/assessors

Stimulus to update their professional knowledge (clinical /non clinical), access training /professional development and review practice

All eight respondents (100%) reported benefits to mentors/supervisors/assessors. This contrasts with their answers concerning how useful practice based learners were thought to be to the overall service; 50% answering "not at all useful".

T went as far as to say he found it of "*moderate to great personal benefit"* in that it *"challenged*" his practice. V felt it "*makes you think about what you are doing…predominantly management plans, what you've done and why you've done it."* Reflection on professional standards of practice (R and T), increased awareness of standards for teaching and assessing (Y and Z), access to and investment in education careers (Z) and personal development, education and professional stimulation were all reported: *"I feel stretched in my consultation and time management"* and *"Having learners has stimulated my enthusiasm and improved the quality of my own work life"* (Y).

Several commented on their academic/educator professional development:

"Going to mentor days… took me back to learning- a bit scary" (Z). "*I have thought a bit more about training and development of myself and others in the practice simply because we have closer contact with XX"* (U) and Y, *"It keeps me on my toes, thinking about my skills, standards, what I teach, what others are teaching -the Forum, sharing. I have concerns about the standards of teaching and whether what we do is right. Its not like doctors where there are specific things. I enjoy teaching- we have never been a medical training practice. I feel we are providing a teaching service."*

Retention of interest, motivation and job satisfaction

Six out of the eight interviewees reported improved job interest, motivation or satisfaction including:

R: *"Think about what I am doing",* and Z: "*Its given me new interest, I'm proud of my profession so it makes me feel good about what I do."*

U stated, *"It helps me to feel valuable if you know what I mean sort of more important… I have an important role to play… that I can be of value to the next generation."* Y: *"It gives bit more interest to your life…"* and

T: *"Our staff are all very experienced and enjoy having learners, we have got more fulfilment and it adds interest. "*

R found it questioned the basis of their practice, *"asking 'what', 'why' etc… it stimulated my enthusiasm and improved the quality of my own work life."* I observed that V had

been motivated to find out more about teaching in rural settings and had accessed an Australian website to glean ideas.

All but one (a practice manager), 87.5% of interviewees, made reference to retention of interest, motivation and job satisfaction

4.7 The perceived benefits to service users/patients/carers

Quality of care and confidence in clinicians

R and T made extensive remarks about the quality of care and confidence in clinicians. *" in terms of the quality… it makes the clinician think about the quality of the service they provide"* (T) and "*One said they had more chance of getting the right diagnosis with two!"*

R: *"Patients quite like the attention and to feel they are helping, they think all the learners are trainee doctors! Recurrent patients enjoyed seeing the new nurse practitioner …and developed a relationship with her…They benefited from the extra time it takes to teach and explain what you are doing and why."*

T: *"Patients benefit from discussion over their prescription, they get longer time, better understanding and explanation"*

Patient education

Two interviewees identified specific patient education benefits in improved understanding of their condition and of the new roles being developed.

R; "*Patients find the information useful for their own understanding…"* and*" tend to assume everyone is a medical student but some are interested in the new roles."*

W: *"If there's discussion over a prescription, time and understanding, more explanation"* is provided for the patient.

4.8 The perceived drawbacks for professionals and patients

Perceived negative effect for on professional/ patient relationship

Two doctors (Y and V) reported disruption to their patient relationship in consultations with a learner present.

Y: *"…The patients feel they are doing me a favour in having a student present rather than it being a benefit to them. Mostly they are listening and observing except when I am teaching examination. It means I have a different relationship with my patient –its not the same as being on my own…you lose the social bit…some patients feel they have not had the same professional relationship that they would have had in a one to one…It interferes."*

Perceived negative effect for staff

Increased pressure and stress to practice administration staff were identified in two of the practices. S: *"…I don't know how much further we can stretch, it is another strain,"* and from U, "*…practice manager and reception staff feel it: having a constant through put of learners."* However, T acknowledged *"The learners and patients are irregular so it can't be planned"* and V saw this as due *"…purely to the administrative staff and their capacity to take on extra organisation."*

GP R mentioned their own additional preparation time: "Time, preparation and thinking time , for example the clinical governance and probity issues are different for different learners. Makes me think differently about different structures and wider services."

4.9 Perceived negative effect for patients

Two GPs' comments related to meeting patients expectations of their consultation. V reported, *"Patients come with an expectation of their particular type of appointment. No matter how much the person sitting- in is a fly on the wall, patients won't get from that consultation what they wanted…socially and it can be artificial."*

Three interviewees mentioned time and overrunning surgery appointments. R said that this *"disadvantaged those waiting at our branch surgery."*

V gave an example; "we got so behind…. as often is the case in GP teaching- you tend to get engrossed and then have to have catch-up time…in the end I sent her for an extended coffee break while I caught up …so patients were waiting."

One practice manager felt there was no immediate benefit, but longer term through learner exposure to the reality of practices providing services to patients e.g. avoiding the pitfalls of "Choose-and-book!" S was *" not sure patients benefit, at least not now- perhaps if these people decide they want a health career. Some of the older patients don't*

care if there's a learner, some really like to tell their medical story, especially those who are lonely- they can go on." W cited a patient complaint, perhaps symptomatic of patient disempowerment: *"We did have one patient complain, although she gave permission to have a student there…she complained afterwards…she didn't want to say no…but was asked."*

Others whom mentors/supervisors felt had benefited by having a learner(s) in the practice:

Practice R in particular mentioned the benefits to the wider NHS family - *"The PCT has benefited- we have been performing a role for them,"* and from S: "*I guess there may be hidden benefits longer term to patients by having a management trainee…we suffer from people in higher management not understanding us."*

Practice payment

All but two interviewees referred to costs to their service. The two omitting any such comment were both GPs.

The language and intonation, reflected strong feelings of indebtedness by the PCT/ NHS e.g. from Y: "We *are giving all the time,* ***always give, give, give****…I don't know how much further we can stretch,* ***it is another strain.****"* S: *"It's at the cost of the practice. I know they have to learn****- its always our cost****."* And later, *"its our most experienced staff and doctors who have* ***these people****…so we lose out."* W stated, *"Because they are at the beginning they are* ***actually causing*** *quite a bit of work.*"

Comments also related to mentor, assessor and supervisor costs: W-*"…who pays for our practice nurse to go to the university for the mentorship preparation course and costs?"* Y highlighted that skills were then not used: "*Some of our staff have done training/assessors qualifications- NVQs but never used them-so that's a waste of time and effort."*

All three practices reported having used the project money from Third shire PCT to enhance their working environment or benefit their staff training. One GP commented

that it would be impossible to find a locum cover anyway. However, the practice appreciated the gesture of providing at least token payment.

Z confirms, *"Whatever they might think, the money hasn't gone into my holiday fund. It's impossible to have backfill- there just aren't people out there waiting. But the money goes into the Practice as a whole to improve it. It's not that we don't appreciate it –we do… that acknowledges/ recognises what we are doing."*

One respondent felt a degree of inequity in the project in terms of the number of learners allocated.

All three practices commented at one point or another that they didn't participate for the money and gave altruism or philanthropy as reasons for continuing to be engaged as a teaching practice. As W said *"… we knew when we got into it we didn't do it specifically for practice gain."* and T: *" there's no obvious tangible benefit to the practice but we are keen to support learners."*

W summed up these feelings: *"…we didn't go into it for Practice gain. If you are going into it for practice gain you're going into it for the wrong reason."*

4.10 Benefits outweighing the drawbacks

Opinion on whether benefits outweighed the drawbacks, was divided; Y answered that it was *"difficult to say… probably not,"* and W *"No, because we don't do it for Practice gain."* S also stated time costs outweighed benefits. However U answered, *"Yes* (benefits outweigh drawbacks) *because it's good to stir up the pool, look at new things, ways, ideas, keep up to date…new potential, it could be a way of recruitment."* Also, V: *"Most definitely yes the benefits do out weigh the drawbacks. We'd like to do more, have F2 medical learners. Learners- not to be a VTS training practice …we don't have the space or facility."* Whilst Z stated: *"About the same, it's new interest but caused more work all round."*

Table 10- Interviewee views on whether the benefits of having practice based learners outweigh the drawbacks

Interviewee code	Yes	No	Other
R	X		
S		X	
T	X		
U	X		
V	X		
W		X	
Y		X	
Z			X 'About the same'
Total 8	4 (50 %)	3 (37.5 %)	1(12.5%)

5. DISCUSSION

Overall the results of this study identify benefits to service in providing practice-learning opportunities, which may be used to encourage further and extended participation in a Teaching Practices Network. There are also drawbacks, many of which may be ameliorated by those commissioning education and training or those active in placing learners.

The results of this study provide five areas for discussion:

- The contribution of learners to care delivery
- The perceived benefits to mentors/supervisors/assessors
- The perceived benefits to service users/patients/carers
- The perceived benefits to service
- The costs

The contribution of learners to care delivery

The contribution to service delivery by advanced practitioners and students increased with learner and mentor confidence in their abilities; providing care under supervision or at 'arms length'. This observation is consistent with anecdotal evidence of the contribution to service by Vocational Training Scheme doctors in general practice towards the end of their training (River Deanery, unpublished).

Modernising Nursing Careers (2006) forecast that many Nurses will start their careers in community settings and predicts a likely increase in demand for learner placements in primary care. DH policy (2005) promoting the commissioning of health care services from new Providers, may render traditional (NHS) learning placements neither available nor appropriate locations to prepare the future healthcare workforce. 'Fitness for Purpose' (1999) noted that the cost of providing support to students (nurses) could be considerable and " by no means offset by the students service contribution" (pp50). The need for lifelong learning in the healthcare workforce (DH (2001, 2002, 2004), Gopee (2001), and Tight (1998)) also creates demand for post registration, support worker and non- clinical learning placements in primary care. Whilst interviewees speculated that experienced learners might make greater contribution to care delivery, findings from this study suggest this may not be the case when developing advanced clinical practice skills (beyond their normal scope of practice).

The Perceived benefits to mentors/supervisors/assessors

Ratings in Tables 3, 4 and 7 (derived from Likert scales in the semi structured interviews) show a generally poor perception of benefits to overall service, mentors/ assessors/ supervisors and to service users/patients/carers. However, in response to open questions, interviewees went on to outline a range of benefits.

Interviewees described benefits to themselves in; retention of interest, motivation, and job satisfaction. The process stimulated them to review their practice, update their professional knowledge (clinical /non clinical) and partake in training /professional development. These finding are similar to those of other studies (Walker & Cooper, Hillestad and Hawken Ferguson et al,) and consistent with Mathers et al (2004) who identified: increased morale, variety to work life and stimulus for CME. Working paper 10 in the Working for patients series, Paragraph 7.5 also mentions advantages of having students in terms of future recruitment and maintaining the morale and professional knowledge of existing staff. The document suggests that these advantages should be "great" and more than outweigh the "relatively minor" costs for units associated with providing placements

The perceived benefits to service users/patients/carers

Interviewees reported benefits to service users/patients and carers in improved quality of care, increased confidence in clinicians, better patient education and longer, fuller consultation. Likewise, Mathers et al (2004) felt patients enjoyed and benefited from learners; experiencing longer consultations with more expansive explanation.

The perceived benefits to service

Wider benefits to service were seen as the potential to recruit from learners and adopt greater skill mix. Benefits were described in better understanding the new roles introduced by PCTs, although for one GP this raised professional concerns. The opportunity to influence the future work practices of *NHS* staff, making them more aware of the impact of decisions on General Practice was also reported.

Practice staff described greater practice status, standing and prestige in being a Teaching practice and felt they were able to contribute to the wider learning community in a

mutually beneficial way. Clearly the forum organised by Third shire PCT has been valuable in facilitating Teaching practices discussion of standards
(in clinical care and teaching) and promoting participation in the learning community. This study indicates there may be enhancement both to NHS, Independent contractors and Universities in understanding others objectives.

Some of the cultural processes Sheaff and Pilgrim (2006) suggest are typical of learning organisations, have been mentioned by interviewees or observed in this study e.g. belief in human potential, recognising and valuing tacit knowledge, respecting work based competence, being open to diverse and flexible ways of sharing knowledge and experience, and engendering trust. Comparing the features of a learning organisation with organisational conditions being created within the NHS, Sheaff and Pilgrim conclude that contradictory processes of marketisation and bureaucratisation together with its complexity, prevents the NHS as a single system becoming a learning organisation. However they say it is possible for constituent organisations to achieve varying degrees of this status. I believe the Teaching practices, along with Thirdshire PCT go some way towards this.

The costs

Six interviewees made reference to the cost to their service. Lloyd Jones and Akehurst (1997) contended that in community settings, services incurred a small cost in providing mentorship, mainly due to the grade and experience of community mentors. Whilst General Practice is not the same as the community settings in their study, my experience is that the grade and experience of mentors are similarly high, especially medical mentors. Those embracing the NHS Knowledge and Skills Framework (2004) may score highly in the specific Dimension G1- Learning and Development, contributing to higher pay banding (Agenda for Change).

Suggestions in Working paper 10 (1989), that advantages in having learners should be "great" and more than outweigh the "relatively minor" costs for units associated with providing placements are supported by Forman and Fox (1993). They concluded that the perceived costs are not entirely detrimental to the service provider, in that mentorship and

supervision costs must be offset against the staff development benefits from such roles by qualified staff.

Payment to practices is contentious, whilst there is provision for payment for medical learners, the Benchmark Pricing and National Standard Framework Contract specifically states there should be no payment to service including general practice for taking learners on Professional Health Training commissioned programmes. However, at least one Deanery and several PCTs (across England) have paid for learners in general practice, in particular those on specific post-registration programmes demanding medical supervision e.g. non-medical prescribing, first-contact practitioners and advanced clinical skills programmes. Often from unsustainable local budgets, this has none the less fuelled the debate. Consequently, some practices refuse to take learners without reimbursement. Maben et al (2007) also note a lack of stable funding streams to support postgraduate nursing careers such as community matrons and nurse practitioners.

In order to release medical staff from clinical commitments to support learning of medical students in practice the "Service Increment for Teaching" (SIFT) levy is intended to compensate NHS Trusts and General Practitioners for teaching medical undergraduates, in reality, little of this money goes to General Practitioners or PCTs. Even so, Mathers et al found a dichotomy of opinion regarding resource implications of having medical learners. They conclude that for many practices, involvement in undergraduate teaching is a 'double-edged sword.'

Payment to general practice /independent sector for providing placement learning opportunities may be detrimental, reducing the overall capacity for HAs and PCTs to purchase education (Booth1992). However, the appreciation expressed of Thirdshire PCT token payment indicates that investing resources (even a small contribution), in either the mentor/supervisor/assessor or educator team demonstrates goodwill.

6. CONCLUSION

The development of Thirdshire Teaching practices has been an innovative move to supply the practice-based learning needed to deliver a modernised primary care

workforce. This study identifies and bears out the findings from profession specific research (Ferguson et al (1993), Walker and Cooper (1992), Hillestad and Hawken (1987), Mathers et al. (2004)) of the benefits to service in providing practice-based learning opportunities.

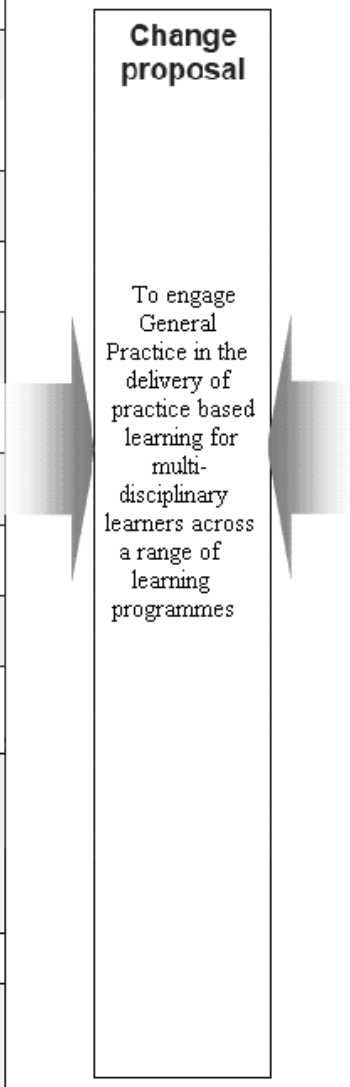
The Force Field diagram and analysis (Lewin 1951) below examines the opposing sets of forces in the change to engage general practices in the delivery of practice-based learning for multi-disciplinary learners across a range of learning programmes. It considers how the strength of restraining forces may be decreased and the strength of driving forces increased to affect change (paragraph 6.1 recommendations).

If more practices and independent sector providers are to be engaged in taking learners of all types, further work needs to be undertaken by the Health Authority/Deanery, PCTs and universities to encourage participation.

Force Field Analysis

For examining the forces for and against the decision of practices to engage in practice-based teaching

Forces FOR change	Score
Improved quality of service/care for patients	9
Potential to recruit from learners	4
Encourages better use of skill mix	4
Enhanced understanding of new roles	4
Influencing future work practices	5
Higher practice status, standing and prestige	7
Collaboration in a wider learning community	6
Increased patient confidence in clinicians	7
Improved patient education	6
Patients receive longer and fuller consultation	7
Retention of staff interest, motivation and job satisfaction	8
Stimulation to update professional knowledge (clinical /non clinical), access training, development and review practice	9
Altruistism	8
Financial resource to enhance the working environment or benefit staff training	7
TOTAL	91



Forces AGAINST change	Score
The limited contribution of learners to care delivery (due to inexperience and stage	4
Cost to service in time	8
Mentors/assessors/ supervisors experienced highly graded/paid practitioners	7
Cost of training and updating mentors/assessors/super -visors	3
Increased stress and work	4
Co-ordination of learner placements	5
Impact on patient expectations of their consultation	5
Patient waiting time	5
Disruption to the professional relationship between clinician and patient	7
Communication with the University and educational language	7
Preparation time	6
Funding seen as either poor or non-existent for some learners	7
TOTAL	68

Scale: 1= extremely weak
10= extremely strong

(Scores based on my experience)

6.1 Recommendations

Commissioners of education (HA or PCTs) should strengthen the forces for the change in:

1. Introducing accreditation of quality standards, (Lloyd Jones & Akehurst) to enhance practice status, standing and prestige.
2. Encouraging practices (without capacity, staff, premises or ambition to be a VTS Training Practice) to become a Teaching practice as a progression towards taking F2 learners, thereby helping to resolve the current crisis in finding medical placements.

Commissioners might reduce the forces against the change by:

1. Identifying a budget and awarding token payment to practice teams in recognition of their educational contribution
2. Developing a strategic approach to streamline co-ordination and administration of placement learning opportunities.

Universities/educators may reduce forces against the change by:

1. Improving communication and frequency of contact with placement providers.
2. Clearly specifying and communicating expected learning outcomes for placements.
3. Ongoing facilitation of a Teaching practices Forum for the discussion of standards and active participation in the wider learning community.
4. Rotating experienced learners around practice placements, specifying their competencies
5. Finally, practices may help manage patient expectation by providing information encouraging patient support for teaching, and explaining reasons for reduced access to clinicians.

6.2 Further research

This study generated both qualitative and quantitative data, albeit from a limited study group. Ambitions to further develop the Teaching practices network may be enhanced by use of the data to influence the involvement of more practices.

The study group has been small but there is potential to undertake further research regarding:

- Measurement of the value of these benefits; applying the formula devised by Ferguson et al to determine the relative weights attributed to non-financial costs and benefits to conduct a cost benefit analysis, identifying a value for the break end point.
- The actual costs of supervisor time
- The service contribution in delivered care by experienced practitioners. Lloyd Jones & Akehurst (1999) and Walker and Cooper (1992) indicate that the value of learners on placement with supernumerary status may be overlooked (and consequently underestimated by service providers).
- Verification of the claim by Walker and Cooper (1992) that learner placements do not necessarily adversely affect patient throughput.
- A strategy to ensure the supply of a future healthcare workforce fit for purpose and practice.

6.3 Personal learning

Conducting this study has been a challenge in terms of data collection through semi-structured interviews in a short time scale. I have gained greater appreciation of logistics and realistic time scales e.g. my initial intention to organise a focus group to triangulate the evidence collected, proved unfeasible due to transportation problems. Organising interviews with only eight people demanded persistence, even so, one eligible practice, declined to reply to invitations to participate.

In hindsight, I would reconsider the order of the questions asked in the semi-structured interview i.e. posing detailed questions before asking broad opinions. I acknowledge that asking how many sessions the learners spent at the practice within the interview was not helpful.

The template analysis and coding of transcripts proved lengthy, similar to Easterby – Smith et al (2002), I found the research process to be one of continuous focussing.

7. FINAL SERVICE EVALUATION REPORT

An edited version of the results, discussion and recommendations of this study will be circulated to River HA, the PCTs, Thirdshire Teaching practices and interviewees wishing to receive a copy.

8. BIBLIOGRAPHY

Atkins, S. Williams, A. 1995 Registered nurses' experiences of mentoring undergraduate nursing students. Journal of Advanced Nursing 21, 1006-1015

A Career Framework for the NHS 2004 NHS Modernisation Agency

Abrahamson, M. 1983 Social Research Methods, Englewood Cliffs, NJ: Prentice Hall

Avery, A. Savelyich, B. Wright, L. 2005
Drs views on nurse prescribing. Prescriber , vol. 15, no. 17, pp. 56-61

Benson, J. Quince, T. Hibble, A. Fanshawe,T. Emery, J. 2005 Impact on patients of expanded, general practice based, student teaching: observational and qualitative study BMJ 2005; 331 (7508):89

Bezzina,. P. Keogh, J. Keogh, M. 1998 Teaching primary healthcare: an interdisciplinary approach Nurse Education Today 1998 Jan. vol. 18, no1 p36-45

Beauchesne, M.A., Meservey, P.A 1999
An Interdisciplinary Community-Based Educational Model
Journal of Professional Nursing, Vol 15, No 1 1999

Booth, R.A 1992 Working for patients: further implications for nurse education. Nurse Education Today 12, 243-251

Cahill 1997 What should nurse teachers be doing? A preliminary study
Journal of Advanced Nursing 26 (1997)

CAIPE 1997 *Interprofessinal Education: What, How and When?* CAIPE Bulletin, Summer No 13

Crotty, M. 1998 The Foundations of Social Research, Sage

Chan, D. 2001 Development of an innovative tool to assess hospital learning environments *Nurse Education Today* 21,8,624-631

Connolly, J. 2003 "Exploring the Role of Workforce Development Confederations in Ensuring Clinical Placement Capacity and Quality for Pre-Registration Nursing Students"

Corby, E. 2006 Patient satisfaction survey Lincolnshire Teaching PCT

Denscombe, M.. 1998 The Good Research Guide, Buckingham, Open University Press

Department of Health 1989, Working for Patients: Education and Training-Working Paper 10. London, HMSO

Department of Health 1997 The new NHS Modern and Dependable Department of Health London

Department of Health 2000 The NHS Plan a plan for investment, A plan for reform Department of Health London

Department of Health 2001 Shifting the Balance of Power within the NHS – Securing Delivery Department of Health London

Department of Health 2002 HR in the NHS Plan- More staff working differently Department of Health London

Department of Health 2002 Working Together- Learning Together a strategy for lifelong Learning. Department of Health London

Department of Health 2002 Workforce Matters- A good practice guide to role redesign in primary care. NHS Modernisation Agency

Department of Health 2004 A Career Framework for the NHS 2004. Department of Health London

Department of Health 2004 A responsive and high-quality local NHS The primary care progress report . Department of Health London

Department of Health 2004 Choosing Health- Making healthy choices easier. Department of Health London

Department of Health 2004 The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process Department of Health London

Department of Health 2005 Creating a Patient-led NHS: Delivering the NHS Improvement Plan. Department of Health London

Department of Health 2006 Learning for a Change in Healthcare -First report of the National Director for Widening Participation in Learning. Department of Health London

Department of Health 2006 Modernising Nursing Careers: Setting the direction Department of Health London

Department of Health Modernising Medical Careers 2006 MMC: The Facts Department of Health London

Department of Health 2006 Our health, Our care, Our say: a new direction for community services Department of Health London

Department of Health 2006 Benchmark Pricing & National Standard Framework Contract for Professional Health Training. Department of Health London

Easterby –Smith, M. Thorpe, R. Lowe, A. 2002 Management Research- An introduction London Sage

Elkan & Robinson Is community –based teaching for you?
Patient Care 1998 Jul 15, vol. 32, no 12, p 72-4, 77-8, 83-4

Ellis, R. Hogard, E. Evaluation of the pilot project for clinical placement facilitation
Chester College of HE, School of Nursing and Midwifery

European journal of dental education: official journal of the Association for Dental Education in Europe, {Eur-J-Dent-Educ}, Feb 2006, vol. 10, no 1, p 44-51

Fearing, M. Newton, M. 1999 A nursing student community experience with public housing elderly, Gerontology and Geriatrics Education . 19,4, 57-66

Ferguson, B. Munro, S. Sanderson, D. Wilson, A. 1993 Evaluating the Benefits of Clinical Placements in Occupational therapy
York Health Economics Consortium

Follows, L. 1993 Cost/Benefit Analysis of Community Nursing Clinical Placements in the North Western Region. North Western Regional Health Authority, Manchester

Forman, D. and Fox, J 1993 The Cost of Clinical Placements. Health Services Management; March: 14-16

Fretwell, J.1980 An inquiry into the ward- learning environment. *Nursing Times.* 76, 16, 69-75

Glaser, B.G. Strauss, A.L. 1967 The Discovery of Grounded Theory. Aldine, New York

Gopee, N. 2001 Lifelong Learning in nursing perceptions and realities. *Nurse Education Today*. 21.8. 607-615

Gopee, N.Tyrell, A. Raven, S. Thomas, K. Hari, T. 2004 Effective clinical learning in primary care settings

Hart, G. Rotem, A. 1995 The clinical learning environment: nurses' perceptions of professional development in clinical settings. *Nurse Education Today.* 15, 1, 3-10

Hawken, P.L. Hillestad, E.A. 1987 Weighing the costs and the benefits of student education to service agencies. Nursing and Health Care May: 277-281

Hepner, L. Hopkins, L. 2000 Partnership 2000. A journey to the 21st century *Nursing Administration Quarterly* 24, 2, 34-44

Hillestad, E. A. and Hawken, P. 1987

"Weighing the costs and benefits of Student Education to Service Agencies"-Part 2 Nursing and Health Care; May 277-281

Jones, S. 1985 "Depth Interviews " in R. Walker, Applied Qualitative Research, Aldershot: Gower

Kennedy, G.1997 Kennedy on Negotiation Gower

Kennedy, G. 2004 The Essential Negotiator Economist Pocket Series 2004

Kennedy, G. 2005 Adam Smiths Lost Legacy Macmillan

King, N. 1998 "Template analysis", in G. Symon and C. Cassell (eds) Qualitative Methods and Analysis in Organisational Research. London: Sage
Kolb, D. 1984 *Experiential Learning* Prentice Hall: New Jersey

Kotter, J.P 1996 Leading Change Harvard Business School Press

Lloyd Jones. M, & Akehurst, R. 1999 "The cost and value of pre-registration clinical placements Journal of Advanced Nursing 30169-178

Lloyd Jones, M, & Akehurst, R. 2000 "Should service providers be paid for providing pre-registration clinical placements?" Journal of Advanced Nursing 32 432-436

Lewin, K. 1951 Field theory in Social science
Harper and Row New York

Lobo. B, 2006 Developing advanced clinical practice skills (unpublished)

Mason J 2002 Qualitative Researching, Sage: London 2nd ed

Mayo 1947 The Social Problems of an Industrial civilisation, London: Routledge and Kegan Paul

Miller, J. Glassner, B. 2004 "Finding realities in interviews" in Qualitative research Theory, method and Practice. Ed. Silverman D 2004 Sage London, Thousand Island Oaks, New Delhi

Mintzberg, H. Ahlstrand, B. Lampel, J. 1998: The strategy safari, New York: Free Press

Mintzberg, H. Waters, J. 1985 Of strategies deliberate and emergent.
Strategic management Journal 1985:2700

Morgan, D. L. 1988 Focus Groups as qualitative research Sage University paper

Newbury park, London, New Delhi 1988

Morgan, M. 2007 "Community shift jeopardised unless GPs help to train nurses" April 4:vol21 no30: 2007 Nursing Standard

Moss Kanter, R.1989 When Giants Learn to Dance- Simon & Schuster

Neary, M.1997 Defining the role of assessors, mentors and supervisors part 2. *Nursing Standard* 11, 43, 34-38

Nursing Standard (Royal College of Nursing (Great Britain): 1987), Nursing Standard 2004 May 26-Jun1, vol. 18, no 37 p33-7

Omerod, J.A. Murphy, F.A. 1994 One step along the way: the introduction of supernumerary status for RGN students in Foresterhill College, Aberdeen. Nurse Education Today 14, 30-37

Quinn Patton, M.2001 Qualitative Research & Evaluation Methods 3rd ed

Saunders, M.. Lewis, P. and Thornhill, A. 2007 Research Methods for Business Students Prentice Hall

Shalik. L, 1987 Cost benefit analysis of level 11 fieldwork in OT Therapy
AM J Occupational Therapy 1987; 41(10): 638-34

Sheaff, R. Pilgrim, D. 2006 "Can learning organisations survive in the newer NHS?"
Implement Sci. 2006; 1:27
Published online Oct. 30.doi: 10.1186/1748-5908-1-27

Silverman, D. 2004 Qualitative Research Theory, method and practice Sage London Thousand Oaks New Delhi

Smith, H. W. 1975 Strategies of Social Research: The Methodological Imagination, London: Prentice Hall

Smith, L.S. McAllister L.E. Snype Crawford C
Mentoring Benefits and Issues for Public Health Nurses
Public Health Nursing Vol.18 No. 2, pp101-107

Snell. 2002 The Learning organisation, sense giving and psychological contracts: a Hong Kong case study. Organisational Studies 2002, 23(4): 549-569)

Spouse, J. 2007 Sharing Good Practice, Skills For Health Conference, Westminster, March 2007

Thompson. B, 1999 Advances in Social Science Methodology Stamford, CT: JAI Press

Tight, M. 1998 Lifelong Learning opportunity or compulsion? *British Journal of Educational Studies 46,3,251-263f*

Todd, D.J. 1979 "Mixing Qualitative and Quantitative Methods: Triangulation in Action" Administrative Science Quarterly, 24, December: 602-11

Trent Practice Education Centre Project Final Report 2003-2006

Trent Strategic Health Authority, Strategic framework 2005-2010
Healthcare for the Modern World 2005

Walker, C.H.I. Cooper, F.M. 1992 "The Costs and Benefits of Clinical placements in Occupational Therapy: A Collaborative Study Within the Yorkshire Region" Yorkshire Regional Health Authority and the University College of Ripon and York St John; April 1992 (unpublished)

Watton. R, 2005 The training capacity of general practice British Journal of General Practice 559514: 402-403

York Health Economics Consortium 1993. Evaluating the benefits of Clinical Placements in Occupational Therapy York University, York

York Health Economics Consortium 1994 In the Balance? The Costs and Benefits of Clinical Placements in Healthcare Education. York University, York

9. APPENDICES

Appendix 1

Cost/benefit formulae

Cost benefits of Clinical Placements in Occupational Therapy

The University College of Ripon York St John, Yorkshire Regional Health Authority

April 1992

Walker C.H.I & Cooper F.M.

Unpublished

Page 78

4. Discussion

Paragraph 4.7 A Costing Framework

"A number of variables have been identified with regard to costs

- Salary grades of supervisory and coordinating staff
- Year of student placement
- Type of service unit

A value needs to be agreed for indirect benefits which are not covered by service contribution and include improved short term benefits like staff development and improved morale and the long term benefits of improved staff retention and recruitment. These may be greater than the miscellaneous 'other' costs which respondants to the finance questionnaire generally reported to be insignificant. This area requires further economic analysis

The suggested costing framework is:-

Per Placement Week:- salary (including clinical supervisors allowance) expressed as an hourly rate, multiplied by time in hours (of supervisory staff and clinical coordinators) minus service contribution (percentage of placement time spent undertaking salaried staff roles) plus agreed value of other benefits. The suggested formula per placement week:

(£ X T) – (S + B)

£ = Salary (including Clinical Supervisors' Allowance) expressed as an hourly rate

T= Staff time in hours

S = Service Contribution

B = Other Benefits

Elements which have not been included in this framework are 'other' costs to the service unit (Supervisor training, accommodation etc) which are negligible in most cases. Reduced patient throughput is also not considered to be significant cost to service units based on the findings of this study"

"Evaluating the benefits of Clinical Placements in Occupational Therapy" York Health Economics Consortium
Ferguson, B, Munro. S, Sanderson. D and Wilson A (1993)

Ferguson et al further developed this transferable formula for use in the event that practice learning placements might need to be paid for to establish the break even point

Cost/benefit ratio = e

$$e = \frac{£ \times T}{S + B} = \frac{C}{S+B} \quad \text{(where } C = £ \times T\text{)}$$

If e is smaller than 1, benefits outweigh costs
and
If e is greater than 1, costs outweigh benefits

£ = Salary (including Clinical Supervisors' Allowance) expressed as an hourly rate

T= Staff time in hours

S = Service Contribution

B = Other Benefits

Appendix 2a

Addressee

Date

Dear

re Service Evaluation of Thirdshire tPCT Teaching Practices

Between September 2005 and March 2007 your Practice has been taking learners on placement as part of the Thirdshire tPCT Teaching Practices Pilot, which was a new initiative provided by the Practice. With your agreement I would like to undertake a small evaluation of the activity as part of my MA dissertation. I am particularly interested in individual and organisational learning from having practice- based learners.

To canvass the views of those involved I would like your permission to invite those who have directly provided mentorship, supervision, teaching or assessment to take part in a short interview. I would also like to invite some of the wider Practice Team staff to participate in a small focus group activity.
Both activities will be anonymous and neither individuals nor Practices will be named either on transcripts or final dissertation document. All potential contributors would have the process explained fully and be asked to sign a consent form to say they have understood.
May I reassure you that participating in this exercise will in no way affect any future opportunities for individuals or the Practice to take practice based learners.

An evaluation report will be produced for the Teaching Practices, Thirdshire Teaching PCT, River Strategic Health Authority, River Health Communities and River Deanery. It will not be possible to identify individual respondents or Practices in the report.
The Practice is under no compulsion to agree to participate in this exercise and may withdraw at any time but your cooperation would be gratefully appreciated.

I would welcome the opportunity to present /discuss this at your Practice Team meeting when I can explain more fully and answer any queries. In order to undertake this piece of service evaluation within the given timescale I would be grateful if you could contact me with your response by the end of February.

Yours sincerely

Appendix 2b

Address

Addressee

Date

Dear

I understand that between September 2005 and March 2007 you took a learner(s) on placement at XXXX Practice.
This is a new initiative provided by the Practice. With their agreement I am undertaking an evaluation of the activity as part of my MA dissertation. I am particularly interested in seeking views on the benefits practice based learners in Primary Care General Practice bring to service.

To canvass the views of those providing mentorship, supervision, teaching or assessment I would like to ask for your co-operation in taking part in a short interview. This should last no longer than 45 minutes and would be arranged at a time and venue to suit you. Although interviews will be recorded, you will not be named either on the transcripts of the tape or final dissertation document. Both the audio tapes and transcripts will be destroyed once the dissertation has been accepted by the University. May I reassure you that participating in this exercise will in no way affect any future opportunities for yourself or the Practice to take learners.

An evaluation report will be produced for the X Teaching PCT, XX Strategic Health Authority, XX Health Communities and XX Deanery. However I emphasise that it will not be possible to identify individual respondents or practices in the report.
May I stress that you are under no compulsion to participate in this exercise and may withdraw at any time.

If you would be happy to take part please contact me by phone on the number below by XXXX and I will return your call to explain more fully and answer any queries you might have.

Yours faithfully

Appendix 3

EVALUATION STUDY CONSENT FORM

- Name of Evaluator: **XX**

Title of study: "**What are the benefits to service in having Practice based learners in Primary Care General Practice?"**

Please read and complete this form carefully. If you are willing to participate in this study, ring the appropriate responses and sign and date the declaration at the end. If you do not understand anything and would like more information, please ask.

- I have had the study satisfactorily explained to me in verbal and/or written form by the evaluator. **YES / NO**

- I understand that the study will involve my participation in an audio taped semi structured interview/recorded focus group **YES / NO**

- I understand that I may withdraw from this study at any time without having to give an explanation. This will not affect my future employment/learning opportunities/opportunity to take learners **YES / NO**

- I understand that participating in this study will in no way affect any future opportunities for myself or the Practice to take learners **YES / NO**

- I understand that all information about me will be treated in strict confidence and that I will not be named in any written work arising from this study. **YES / NO**
- I understand that any audiotape material of me will be used solely for research purposes and will be destroyed on completion of your research. **YES / NO**

- I understand that you will be discussing the progress of your research with your supervisor of the Faculty of Business and Communication, York St John University. **YES / NO**

- I would like to receive a copy of the report **YES / NO**

I freely give my consent to participate in this evaluation study and have been given a copy of this form for my own information.

Name:……

Signature: ……Date: ……

Practice Code:

Staff Code:

Appendix 4

Practice code:

Practice staff code:

Pilot
Semi Structured interview questionnaire
(Practice mentors, supervisors, assessors)

1. Type of learner(s)

In what type of learning/development programmes were your learner(s) engaged?

E.g.
a. First Contact Practitioner
b. Pre Reg. Nurse
c. Non Medical Prescriber
d. AHP
e. Primary Care Apprentice
f. Receptionist
g. NHS Management Trainee
h. School work experience
i. Pre-University applicant
j. Modern Apprentice
K. Others (Please specify)

2. How many learners of each type did you mentor/supervise/assess?

a. First Contact Practitioner ( )

b. Pre Reg. Nurse ( )

c. Non Medical Prescriber ( )

d. AHP ( )

e. Primary Care Apprentice ( )

f. Receptionist ( )

g. NHS Management Trainee ( )

h. School work experience ( )

i. **Pre-University applicant ( )**

j. **Modern Apprentice ( )**

K. Other (Please specify) ( )

3. Length of time at the Practice (in sessions) for each:

4. Were your learners entirely supernumerary?
(specify for each)

Y/N

If no how much time (in sessions) would you say they (each):
Delivered care/services jointly?

Number of sessions:

Delivered care/services alone?

Number of sessions:

5. On this numerical scale please indicate how useful you think Practice based learners have been to the overall service?

1=Not at all useful 2=A little bit useful 3 =Fairly useful 4=Very useful

1	2	3	4

6. What benefits has the practice derived from having Practice based learners?

e.g. Improving the quality in service

Challenging work practices

Improving communication with "outside" contractors/agencies/education providers/PCT/Secondary Care

Improved understanding and increased confidence in new roles

Educators learning from learners etc

Can you give any specific examples?

7. How would you rate the benefit of practice based learners for yourself?

1=No benefit 2=A little benefit 3 =A moderate benefit 4= Great benefit

1	2	3	4

Why do you give it this rating?

Can you give some examples of benefits you derived from the experience?

8. How would you rate the benefit of practice based learners for:
Service users/patients/carers?

1=No benefit 2= A little benefit 3 =A moderate benefit 4= Great benefit

1	2	3	4

Why do you give it this rating?

Can you give some examples?

9. Are there others whom you feel might have benefited or been disadvantaged by having a learner(s) in the Practice (please specify)

Can you give some examples?

10. What do you believe to be the drawbacks/difficulties (to the practice) of having practice based learners?

11. Do you think the benefits outweigh the drawbacks/difficulties?
Y/N

12. Would you like to receive a copy of the report?

Y/N

Thank you
XX

Appendix 5

Benefit	**Priority**
Motivation of mentor, supervisor, teacher	
Reduced age of Practice "front of house" appearance	
Learning new practices/ways of doing things-from outside	
Developing teaching skills	
Improving the quality in service	
Diversity	
Freeing up time-contributing to service delivery	
Improved perception of the practice by patients and service users	
"Boot strapping" clinical practice / updating	
Improved Practice team communication	
Maintaining staff interest	
Challenging work practices	
Helping others	
Recruitment of potential employees	
Income generation	
Improving communication with "outside" contractors/agencies/education providers/PCT/Secondary Care etc	
Stimulating an interest in learning	
Improving communication with other Practices	
Peer support and peer group learning	
Improved understanding of new roles/new ways of working/services	
Increased confidence in practitioners working in new roles and their abilities	

Please rank your top 5 priorities as you see them benefiting the Practice

Are there others that should be on the list?

Appendix 6a

Excerpt from transcription **Interviewee T**	Notes/ Themes
"We are a rural practice so students have to travel to get to us…."	**Semi structured interview question**
Were your learners entirely supernumerary? ….Did they only deliver services with a member of your staff? Or did they deliver any services on their own?	My jargon! **Clarification of question- simplification**
"No…I think it is from a practice point of view that they are observing and receiving from us…"	Theme 1 **"receiving from us"**
What benefits has the practice derived from having Practice based learners?	**Semi structured interview question**
"Having students is very positive, if we have the space, we just don't have the premises and rooms. They (GPs) thoroughly enjoy having students. They say it really 'Shapes them up' …not their diagnostic skills but their consultation skills, communication skills, a refresher a bit, they can lapse…habits"	**Report of others comments** **Theme 2**
Can you give any specific examples?	**Theme 2,3,4**
"Well I think in terms of the quality…I'm sure it makes the clinician think about the quality of the service they provide" *"I would be a little more generous than saying students were not at all useful- a little bit useful, given from the practices learning"*	**Semi structured interview question**
How would you rate the benefit of practice-based learners for yourself?	**Theme 2, 3,4**
"Non really but the GPs said they were reminded and refreshed by having the students especially as one has been a GP for twenty years…	
We would really like to have medical students but don't have the space What they did find was that the understanding of our HV role in supplementary prescribing and what that demands meant that there was mutual learning…. I mean the doctors probably have more confidence in her now and what she can do"	

Why do you give it this rating of no benefit? "Well there's no obvious tangible benefit to the practice but we are keen to support learners"	**Semi structured interview question** Theme 2
How would you rate the benefit of practice-based learners for service users/patients/carers? "Any gain might be from a long term investment in recruitment. Because we are small we have a premises problem so cannot offer to take student doctors, but we can contribute in a way. It's the culture of the practice and we have highly skilled nurses"	**Semi structured interview question** **Theme 2, 3 returned to earlier points made**
Highly skilled nurses? *"Yes they are all very experienced and enjoy having learners, we have got more fulfilment and it adds interest having learners…Patients do perhaps benefit from discussion over their prescription, why they are changing . They get a longer time and get a better understanding And explanation"*	**Theme 3, theme 4**
Do you have any examples? "One patient said they didn't mind having a student because there was better chance of getting the right diagnosis with two of them"	**Theme 4**
Is there anyone … "The community benefit but no one is disadvantaged.even if they have to wait and surgery runs over they all get seen…. we don't cut down on patients, but take longer. We extend surgeries for catch up time"	**Contribution to learning community-building social capital**
What do you believe to be the drawbacks/difficulties (to the practice) of having practice-based learners? "The learners and patients are irregular so it can't be planned"	**Theme 5**

Do you think the benefits outweigh the drawbacks/difficulties? *"We are a rural practice 10-15 miles from town so learners have to travel"* "Our premises limit us and there's no free space so there's a lot of hot disking. We did hope to have a final year medical student from a London Hospital but they needed study space and we were one session short per week and at the week before they were due to come the University changed their minds because of the quality assurance…we were disappointed"	**Theme 2** **Prestige and status** ***Disappointed*** **Prompting/probing open question** **Theme 2**
Any other examples of benefits or drawbacks *"The practice staff benefit from the money being used to buy our own staff training… they have been individually"* *"I think the benefits and drawbacks are neutral, a balance with the financial recompense- an incentive"*	**Theme 2**
Is there anything else you would like to tell me? *"I don't think I should be saying this but compared to some of the others we have been paid quite well for the number of learners we have had. Some have had many more than us. But we don't do it for the money"* *"We could offer accounts training for GPs accountants because our GP had a particular interest and set the books up properly"* *"Second year students might add something to the equation"*	

Theme 1- Contribution of learners to care delivery
Theme 2- The perceived benefits to the practice
Theme 3- The perceived benefits to the mentor/supervisor/assessor
Theme 4- The perceived benefits to service /users/patients/ carers
Theme 5- The perceived drawbacks
Theme 6- Learning Community
Theme 7- Other

Appendix 6b

Excerpt from transcription **Interviewee W**	**Notes/Themes**
" L…all has been inexperienced, probably different if they had something. To my knowledge non-has delivered services. *Overall usefulness depends on the learner, someone like a work experience learner who is not used to the practice –nothing* *Someone like the nurse who was there for 6 months just got to the point at the end of 6months that she was fairly useful…I suppose if we had more experienced trainees-but these are all just starting out so no."*	**Theme 1**
The student nurse, you said was "*fairly useful"*, why did you say that?	**Probing**
"She was some use I suppose-calling in the patients for the Nurse but mostly nothing because they have nothing they can do"	**Theme 2** **Theme 3**
Were there any other spin offs?	**Probing question** **Theme 2 –potential future recruitment**
"I mean in the future perhaps…if we had a vacancy and she'd qualified, then we might want to employ her"	**Semi structured interview question**
What about benefits from having practice learners for yourself?	**Theme 5** **Language, resentment**
"No…. No I think a lot of the learners we have had are all at the beginning of the process, so because they are at the beginning there is nothing that they are adding. Because they are at the beginning they are **actually causing** quite a bit of work. The Primary care apprentice didn't add anything because he didn't know what he wanted to do so I don't think we actually gained a great deal from it"	**Theme 4** **Theme 2 potential future benefits** **Theme 5**
In terms of the benefits for Service users?	**Semi structured interview question**
"Probably no benefit. I think if you had a second year student or something like that they can bring quite a lot into the equation but when they are so early on in the process they don't have much experience"	**Theme 5 issue of patient consent** **Semi structured interview question**

Has anyone else benefited or been disadvantaged by having placement learners? *"We did have one patient complain or though she did give her permission to have a student there…she did complain afterwards…she didn't want to say no but complained afterwards…but they were asked"* What do you consider the biggest drawback? *"Communication with the person asking you to have the placement…the University. We actually find the schools very good but the University less so. No continuation, if you have someone for 6 months, to have someone come in at least on a monthly basis to make sure what you are doing meets their expectations"* "Did you have set learning outcomes before they came? *"Some of them yes, some of them no it depends on the student"* Do you think the benefits outweigh the drawbacks? *"I would say no because of the fact that they don't do anything but that doesn't mean to say we wouldn't carry on doing it because we knew when we got into it we didn't do it specifically for a practice benefit"* Why do you think the Practice have done it then? *"The main reason we have got into things like work placements…we tend to have six school placements per year because …well I've got children who have just gone to University and we couldn't find them placements. X's son wanted to do veterinary science and had to spend a day at an abbatoire and they couldn't get him in any where in the end he had to go up to Yorkshire, but you can't get a place at University*	**Theme 5 Communication difficulties with University** **Probing question** **Semi structured interview question Theme 5 No benefit** **Probing** **Altruism Theme 7** **Building social capital and contributing towards a learning community "Social responsibility" Theme 6** **Clarification of benefit and prompting for more information Potential theme 3 & theme 2 benefit to the practice**

without doing this …and if you don't give someone the opportunity how can you expect someone to give your child the opportunity. The GPs were equally. They have children of the same age and were of the same understanding. ***Social responsibility*** *so that's why we got so heavily involved with the schools…and it's just gone on from there.* *…Things like reception, well we've learnt from past experience that when we've needed to teach new receptionists…well there's just no where to send them…Things like just teaching the receptionists to take bloods…. phlebotomy, there's no where to send people. We want to be able to get learning ourselves"* So are you hoping to benefit as a practice yourselves in the future? *"Ear syringing or some things like that- yes…. the practice will stick with it…we didn't go into it for Practice gain. If you are going into it for practice gain you're going into it for the wrong reason…."*	

Theme 1- Contribution of learners to care delivery
Theme 2- The perceived benefits to the practice
Theme 3- The perceived benefits to the mentor/supervisor/assessor
Theme 4- The perceived benefits to service /users/patients/ carers
Theme 5- The perceived drawbacks
Theme 6- Learning Community
Theme 7- other

Appendix 7

Themes

1. The contribution of learners to care delivery

1.1 Negative comments and those related to learners experience/stage of learning

T "Almost nothing at all"
T "Second year students might add something to the equation"
T "Sat in with GP…Community Matron sat in with the Practice Nurses"
R "Nothing we don't gain anything from them…."

W " l…..all have been inexperienced, probably different if they had something. To my knowledge non has delivered services.
Overall usefulness depends on the learner, someone like a work experience learner who is not used to the practice –nothing just sat in"
Someone like the nurse who was there for 6 months just got to the point at the end of 6months that she was fairly useful…I suppose if we had more experienced trainees-but these are all just starting out so no."
S –Non
Z "No the students nurses are able to assist with patients when they are coming to the end of their placement. They aren't allowed to see patients on their own but they do help. Because they have all been in their first year there is a limit to what they know or can do-little really"
W "She was some use I suppose-calling in the patients for the Nurse but mostly nothing because they have nothing they can do"

Z"It might be different if we had a student in their third year (nurse). The modern apprentices have been able to help with general tasks, fetching stuff and helping. They are really only with me for taster sessions to see what the Practice Nurse does. Its good because they have no idea but they have no life experience. Some patients are of a similar age, quite young and it might have been embarrassing- I always check if they mind having a student and use my discretion if I don't think it right for the MA to be there"

R"The experienced nurses have seen patients I selected for them, and then we have discussed their assessment, diagnosis and treatment plan. That's because I have confidence in their skills, knowing their capabilities and what they can do.."
"The Practice Nurses let students (nurses) help with some clinical things like dressings and taking out stitches"

Y "Always with someone never on their own so not at all useful"
W"Probably no benefit. I think if you had a second year student or something like that they can bring quite a lot into the equation but when they are so early on in the process they don't have much experience"

W"No use at all"

Positive and those related to learners experience and stage of learning
W "She was some use I suppose-calling in the patients for the Nurse but mostly nothing because they have nothing they can do"
U "Some on their own but under my supervision"

1.2 Cost to service provider
T "No…I think it is from a practice point of view that they are observing and receiving from us…"

W "I suppose if we had more experienced trainees…… but these are all just starting out so no"
S " He stood behind the receptionist and watched what happens which I suppose was useful to him"

S- "He was a management trainee with no experience of primary care so he just took information and observed experiences away"
S "The time it takes to explain …makes the work take so much longer"
"The money we had through the project doesn't cover our costs- the practice has lost out "
W Because they are at the beginning they are **actually causing** quite a bit of work. The Primary care apprentice didn't add anything because he didn't know what he wanted to do so I don't think we actually gained a great deal from it"

Y We are giving all the time, always give, give, give…I don't know how much further we can stretch, it is another strain "

A 2"Its at the cost of the practice. I know they have to learn, its always our cost"
"its our/ the most experienced staff and doctors staff who have these people…so we lose out …"
W "…who pays for our practice nurse to go to the university for the mentorship preparation course and course costs…?".
Z "Time .space, money; the nurses room is quite small and theres not really enough rooms for a student to go to read or watch a video- the common room if its free but then people are going in and out"
Z "Well if we could afford another nurse but then theres not the room, even if we had one. I don't know what the practice gets but its not enough not even for a part time nurse like that"

U"The new staff (receptionist) feel its good to have someone newer in the practice……busy practice, practice manager and reception staff feel it….having a constant through put of learners"
Y Some of our staff have done training/assessors qualifications- NVQs but never used them-so that's a waste of time and effort"

T "They gained from the practice learning observation"

2. The perceived benefits to the practice

2.1 Improved quality of service/care to patients

R- "Patients are interested in what is said about their condition" "patients find the information useful for their own understanding….and like the extra attention they feel they get" " they tend to assume everyone is a medical student but some are interested in the new roles"

T"Well I think in terms of the quality…I'm sure it makes the clinician think about the quality of the service they provide"

T"I would be a little more generous than saying students were not at all useful- a little bit useful, given from the practices learning"

T "Non really but the GPs said they were reminded and refreshed by having the students especially as one has been a GP for twenty years……..

U We would really like to have medical students but don't have the space

T"One patient said they didn't mind having a student because there was better chance of getting the right diagnosis with two of them"

U*"Patients do perhaps benefit from discussion over their prescription, why they are changing . They get a longer time and get a better understanding and explanation"*

T"the doctor I work for trained 20 years ago and I know he said it helped him keep up to date and kept him on the ball"

T"Well I think in terms of the quality…I'm sure it makes the clinician think about the quality of the service they provide"
T "The GPs sharpened up… has a positive effect on their practice"

"I would be a little more generous than saying students were not at all useful- a little bit useful, given from the practices learning"

T "Having students is very positive, if we have the space, we just don't have the premises and rooms. They (GPs) thoroughly enjoy having students. They say it really 'Shapes them up' …not their diagnostic skills but their consultation skills, communication skills, a refresher a bit, they can lapse…habits"

2.2 Future recruitment and enhancement of current staff working lives

S"I suppose if we had a second year student Nurse then we might employ her after she had qualified"

T"Any gain might be from a long term investment in recruitment. Because we are small we have a premises problem so cannot offer to take student doctors, but we can contribute in a way. It's the culture of the practice and we have highly skilled nurses"

W"I mean in the future perhaps…if we had a vacancy and she'd qualified, then we might want to employ her"

2.3 Benefits in understanding new roles and influence over future remit of learners

S "They were able to see how dispensing works (rural practice) and our standard operating procedures-from a practice managers point of view"

"They were with the admin team; on reception, saw what the secretary has to do, how choose and book is meant to work" "How the computers work" "How we receive path lab reports electronically and how they are processed…it will help them (PCT/DH) understand how general Practice operates and think when they (PCT/DH) make these decisions that affect us …."

"Fully understand GP members of staff"

W *"Ear syringing or some things like that- yes….the practice will stick with it…we did'nt go into it for Practice gain. If you are going into it for practice gain you're going into it for the wrong reason…."*

S – "It has made me think about employing another nurse and whether we should have a health care assistant …. could they do/be trained to do what we need them to do"

(Authors post script; the practice has subsequently recruited a healthcare assistant and are using another teaching site to develop the skills and competencies needed to achieve effective skill mix)

R "Feel I now know what these people are capable of"
"I have a bit better understanding of PCT roles"
Y "Thinking about Advanced Clinical Skills for nurses and recognising their new jobs, extended and supplementary prescribing –what and why I prescribe as I do"
T "Role understanding of supplementary prescribing and demands …..gave them mutual confidence"
T "What they did find was that the understanding of our HV role in supplementary prescribing and what that demands meant that there was mutual learning….I mean the doctors probably have more confidence in her now and what she can do"
T "Non really but the GPs said they were reminded and refreshed by having the students especially as one has been a GP for twenty years……..

We would really like to have medical students but don't have the space
What they did find was that the understanding of our HV role in supplementary prescribing and what that demands meant that there was mutual learning….I mean the doctors probably have more confidence in her now and what she can do"

V*"the business around non medical prescribing, she herself realised how dangerous her situation might be. I still don't know what they (*Community matrons) *do."*

*"unfortunately her knowledge was in her own area of work (*District Nursing*) and she realised she wouldn't be able to prescribe competently from the whole of the formulary…" (*V)

2.4 Practice status, standing and prestige

R"It raises our profile with our patients in this community (rural practice)*, them knowing we are good enough to have learners"*

Y"Being a Teaching Practice makes us important to the patients, they like it"

W "Way to contribute with limited premises"

W"Our premises limit the students/learners we can take. We got right up to the last week before we were due to have a medical student from one of the London Schools….we were really excited …and then they withdrew the placement because we were one session per week short in being able to find them a room of their own"

T" Because we are small we have a premises problem so cannot offer to take student doctors, but we can contribute in a way. It's the culture of the practice and we have highly skilled nurses"

2.5 Practice payment

T"I don't think I should be saying this but compared to some of the others we have been paid quite well for the number of learners we have had. Some have had many more than us. But we don't do it for the money"

S"We have used the money to buy things for the staff sitting room, giving something to them"

T"The practice staff benefit from the money being used to buy our own staff training… they have been individually"
"I think the benefits and drawbacks are neutral, a balance with the financial recompense- an incentive"

U "Having some money helps, of course it will"
Z "Whatever they might think the money hasn't gone into my holiday fund. Its impossible to have backfill- there just aren't people out there waiting. But the money goes into the Practice as a whole to improve it. It's not that we don't appreciate it –we do see that the thirdshire PCT acknowledges, recognises what we are doing"

2.6 Contribution to the learning community (immediate)

R "We would like to be a medical training practice and have student doctors and this might be getting us there"

Y "More communication with other practices involved in the scheme through the teaching practices forum"

U "Helped communication with education providers –the Deanery."

T"The community benefit but no one is disadvantaged ..even if they have to wait and surgery runs over they all get seen….we don't cut down on patients, but take longer. We extend surgeries for catch up time"

W "Learners are desperate…they travel a long way" by bus to X and then train to Y and then have to walk

W"Not really to the patients….I've got children who have just gone to University and we couldn't find them placements and if you don't give someone the opportunity how can you expect someone to give your child the opportunity?"

T "Its sort of our responsibility to the community …social responsibility so that's why we got so heavily involved with the schools"

T*"We could offer accounts training for GPs accountants because our GP had a particular interest and set the books up properly"*

W *"Some of them yes, some of them no it depends on the student" Learning outcomes before student came*

W *"The main reason we have got into things like work placements…we tend to have six school placements per year because …well I've got children who have just gone to University and we couldn't find them placements. X's son wanted to do veterinary science and had to spend a day at an abbatoire and they couldn't get him in any where in the end he had to go up to Yorkshire, but you can't get a place at University without doing this …and if you don't give someone the opportunity how can you expect someone to give your child the opportunity. The GPs were equally….they have children of the same age and were of the same understanding.*

Social responsibility *so that's why we got so heavily involved with the schools…and its just gone on from there.*

…..Things like reception, well we've learnt from past experience that when we've needed to teach new receptionists…well there's just no where to send them…….Things like just teaching the receptionists to take bloods….phlebotomy, there's no where to send people. We want to be able to get learning ourselves"

Y "For students getting here is a tet in itself. Some of these young people travel a difficult journey so they are committed….its part of our duty to teach"

Z "The schools have to come to do a mandatory Thirdshire Education Business Alliance (TEBA) Health and Safety check on us and then we have Thirdshire Nursing people coming in to do their placement audit and the XXX for the XX

learners. We spend all our time having these people, what started off as being helpful is getting impossible we have patients and they all call on our time and there's…."

Z"The student nurses came with such a complicated assessment document our Practice Nurses really couldn't take this all on…they haven't the time not to assess them on all those things."

Y "The local Community we have never (to my knowledge) refused a learner request. We have good relations with the school and community. Patients might have to wait longer but everyone gets seen and most don't mind waiting"

R " I am a great believer in the value of general practice and want to show and share this with others"

2.7 Drawbacks to participating in the learning community

Z"The paperwork is so complicated I couldn't understand it. They keep making it seem so difficult even simple things by using complicated phrases a lots jargon, rubbish. I just give up. It put me off having a student. We don't have the time for all this form filling so sooner not have one. I don't mean to be funny, but you know what I mean?"

2.71 Communication and co-ordination with education providers and processes

W *"Communication with the person asking you to have the placement…..the University. We actually find the schools very good but the University less so. No continuation, if you have someone for 6 months, to have someone come in at least on a monthly basis to make sure what you are doing meets their expectations"*

W "There's lack of continuity on a three monthly basis"

"Communication is our problem with the placement co-ordinators or whoever…we just don't know what we are meant to be doing"

"…the communication has been the biggest thing for us…the schools are very good but XXXX …we have had a really embarrassing situation with one of our student nurses…it made us look bad…"
"….I have no idea who is we are going to be asked to take. So far we have agreed to have everyone we have been asked to have…but there is no proper co-ordination…..it just hits us……..For the Modern apprentices we had no idea what they needed from us and

V *"…purely to the administrative staff and their capacity to take on extra organisation."*

2.8 Potential opportunity to influence future workforce

S " It is a good chance to influence PCT people, if they are in powerful positions they have some idea of what we have to do and how the practice works. Perhaps they will think more about things and what its like for us to be told to do this and then that and have new systems all the time. They will see that things like 'Choose and book' don't work for us or the patients…I used to be able to refer to the consultant at XXX now I don't have that choice and patients don't understand why they can't just go locally. It simply doesn't work"

S "good to get these people when they are starting their careers to influence them to think about us in service"

T "The GP had a real thing about accounts so he set ours up properly right at the start. It would help the accountants GPs use if they came to see a good system working, because they don't know what we do"

2.9 Altruism

Altruism

W *"I would say no because of the fact that they don't do anything but that doesn't mean to say we wouldn't carry on doing it because we knew when we got into it we didn't do it specifically for a practice benefit"*

T "Well there's no obvious tangible benefit to the practice but we are keen to support learners"

T "Non really but the GPs said they were reminded and refreshed by having the students especially as one has been a GP for twenty years……..

We would really like to have medical students but don't have the space

"Our premises limit us and there's no free space so there's a lot of hot desking. We did hope to have a final year medical student from a London Hospital but they needed study space and we were one session short per week and at the week before they were due to

come the University changed their minds because of the quality assurance…..we were disappointed"

T" Because we are small we have a premises problem so cannot offer to take student doctors, but we can contribute in a way. It's the culture of the practice and we have highly skilled nurses"

W"…we didn't go into it for Practice gain. If you are going into it for practice gain you're going into it for the wrong reason…."

Z "It was hard work the things you take for granted routinely and having to explain why we are doing it, helps focus and makes you think –is there a better way of doing it?"

3. The perceived benefits to mentor/supervisors/assessors

3.1Stimulation to update their professional knowledge (clinical /non clinical), access training /professional development and review practice

R"Think about what I am doing"

"I didn't know they should have been on some sort of training to take students, how should we know, no one told us…where do we get this information…..but if they are willing then we can arrange for them to go"

Future other

Y " *I can see we'd perhaps have some agreement on standards …I have no idea if what I include in my teaching the same things as my colleagues down the road….how do I know if my standard is good enough?"*

S "I suppose it helped me to focus on the basics of what we do"

Z Going to the mentor days…it took me back to learning- a bit scary I hadn't been through university-not as a full time student but I'm getting used to the library and stuff on line- very scary getting into the system but once you know its easy really

R -"Having learners has stimulated my enthusiasm and improved the quality of my own work life"
Y "I feel stretched further in my consultation and time management"
U "I have thought a bit more about training and development of myself and others in the practice simply because we have closer contact with XX"
Y It keeps me on my toes, thinking about my skills, standards, what I teach, what others are teaching -the forum sharing. I have concerns about the standards of teaching and whether what we do is right. Its not like doctors where there are specific things"

W"Ear syringing or some things like that- yes….the practice will stick with it…we didn't go into it for Practice gain. If you are going into it for practice gain you're going into it for the wrong reason…."

U"I suppose its good just to have a different member of staff around the place, its good for morale, helps people feel we are busy and there's lots going on"

V felt it "*makes you think about what you are doing…predominantly management plans, what you've done and why you've done it."*

U "A moderate benefit , it gets me thinking, different ways in which we can use staff and different ways of looking at problems and different techniques"

T"I would be a little more generous than saying students were not at all useful- a little bit useful, given from the practices learning"

T"I have thought a bit more about training and development of myself and others in the practice simply because we have closer contact with XX"

R"I feel stretched further in my consultation and time management"

3.2 Retention of interest, motivation and job satisfaction

R"Think about what I am doing"

Z"Its given me new interest, I'm proud of my profession so it makes me feel good about what I do"

U " It helps me to feel valuable if you know what I mean sort of more important….not important, I have an important role to play …., that I can be of value to the next generation"

Y "It gives bit more interest to your life…"
"the doctor I work for trained 20 years ago and I know he said it helped him keep up to date and kept him on the ball"

R"Ask what why etc"-questioning basis of practice

T*"Yes they are all very experienced and enjoy having learners, we have got more fulfilment and it adds interest having learners……"*

R -"Having learners has stimulated my enthusiasm and improved the quality of my own work life"
"I enjoy teaching- we have never been a medical training practice but enjoy teaching"
"I feel we are providing a teaching service"
"I feel stretched further in my consultation"
Z "It makes me explain why I am doing what I am doing, but I have to go into more explanation after the patients gone- this takes up time-I don't think they realise the …some of the connections (Student nurses & MAs) …Yes the relationship between the questions I ask and their lifestyle and health…I like the teaching…."
W "Adds …more fulfilment and adds interest"

T "Non really but the GPs said they were **reminded and refreshed by having the students** especially as one has been a GP for twenty years……..

We would really like to have medical students but don't have the space
What they did find was that the understanding of our HV role in supplementary prescribing and what that demands meant that there was mutual learning….I mean the doctors probably have more confidence in her now and what she can do"

4. <u>The perceived benefits to service users/patients/carers</u>

4.1 Quality of care and confidence in clinicians

T"Well I think in terms of the quality…I'm sure it makes the clinician think about the quality of the service they provide"
" One said they had more chance of getting the right diagnosis with two!"
"Only one of our patients have ever complained"
"Patients quite like the attention and to feel they are helping, they think all the learners are trainee doctors!"
R "patients find it really interesting" "No one complained" "Patients recognised the importance of training staff" "Recurrent patients quite enjoyed seeing the new nurse practitioner as their nurse ….and developed a relationship with her" "They benefited from the extra time it takes to teach and explain what you are doing and why"
T "Patients do perhaps benefit from discussion over their prescription, why they are changing . They get a longer time and get a better understanding and explanation"
"*All our patients get seen so we don't reduce the numbers, ,we cant stop patients, it just makes the surgery run for longer"*

4.2 Patient education *R- "Patients are interested in what is said about their condition" "patients find the information useful for their own understanding….and like the extra attention they feel they get" " they tend to assume everyone is a medical student but some are interested in the new roles"*
W "If there's discussion over a prescription, time and understanding , more explanation (to the patient)"

Y Patient like it, the attention, examination, diagnosis explanation and management. They feel they are helping the students- the next generation of health staff

5. Perceived negative effect on patient/professional

U "No benefit the patients feel they are doing me a favour in having a student present rather than it being a benefit to them. Mostly they are listening and observing except when I am teaching examination. It means I have a different relationship with my patient –its not the same as being on my own…you lose the social bit….some patients feel they have not had the same professional relationship that they would have had in a one to one (consultation)…..I suppose it interferes with it (personal relationship with patients)"

6. Negatives for patients

S "There was no direct benefit- a long term benefit through exposure to the reality of practices in providing services to patients e.g. The pitfalls of choose and book!

"No benefit- because they don't add anything for the patient, sometimes they (MAs) keep children busy if I'm doing something with a parent"

Z "I'm not sure patients benefit at least not now- perhaps if these people decide they want a health career. Some of the older patients don't care if there's a learner, some really like to tell their medical story, especially those who are lonely they can go on"

U "No benefit the patients feel they are doing me a favour in having a student present rather than it being a benefit to them. Mostly they are listening and observing except when I am teaching examination. It means I have a different relationship with my patient –its not the same as being on my own…you lose the social bit….some patients feel they have not had the same professional relationship that they would have had in a one to one (consultation)…..I suppose it interferes with it (personal relationship with patients)"

U"It depends on who the learner is and why they are here"

7 *Others whom mentors/supervisors felt had benefited by having a learner(s) in the Practice:*

R - "The PCT has benefited- we have been performing a role for them"
"We suffer from people in higher management not understanding us"

S- No … I guess there may be a hidden benefit longer term to patients by having a management trainee

8 Perceived drawbacks

8.1 Lack of service contribution from inexperienced staff

W "No….No I think a lot of the learners we have had are all at the beginning of the process, so because they are at the beginning there is nothing that they are adding.

W*"Probably no benefit. I think if you had a second year student or something like that they can bring quite a lot into the equation but when they are so early on in the process they don't have much experience"*

R- "Disadvantaged those waiting at our branch surgery….but didn't really impinge on anyone else"
T "The learners and patients are irregular so it can't be planned"

R – Time, slot in , Preparation and thinking time needed , the clinical governance and probity issues are different for different learners (staff group and employer) makes me need to think differently about different structures and wider services"

S "The drawbacks outweigh the benefits….time costs"

"We have used the money to buy things for the new staff room, so that's nice but it still takes a lot of energy and time that we are not compensated for"

8.2 Other
Stress

"…I don't know how much further we can stretch, it is another strain "

Patient consent/complaints
W *"We did have one patient complain or though she did give her permission to have a student there…she did complain afterwards…….she didn't want to say no but complained afterwards…but they were asked"*

U"*…., practice manager and reception staff feel it….having a constant through put of learners"*

V: *"Most definitely yes the benefits do out weigh the drawbacks. We'd like to do more, have F2 medical learners. Learners- but not be a VTS/GP training practice …we don't have the space or facility."*

Staff
U"The new staff (receptionist) feel its good to have someone newer in the practice……busy practice, practice manager and reception staff feel it….having a constant through put of learners"

Positive comment
"I have thought a bit more about training and development of myself and others in the practice simply because we have closer contact with XX"

R- "…they were able to witness the struggle we have with Choose & Book-if they understood what we are faced with perhaps they'd better understand when they devise these things"
"They need to understand (PCT/NHS managers) that choose and book doesn't offer our patients choice ……they could go locally before, but now it doesn't bring up that option!"

9 Benefits outweighing the drawbacks
Z "About the same, its new interest but caused more work all round"
Y Difficult to say probably not"
W "No because we don't do it for Practice benefit" "ethic …not for practice gain"
U "Yes (benefits outweigh the drawbacks) because its good to stir up the pool and look at new things, ways, ideas , keep up to date…new potential it could be a way of recruitment"

Interviewers observations of positives to practice

One practice decided, rather than recruit another Practice Nurse they would introduce greater skill mix, by advertising for a Health care assistant who could be trained through one of the other Teaching practise to take an extended role.
Thus the effect of their engagement in this initiative had broadened their consideration beyond traditional roles

Another had developed stronger links with a local university and education and training providers such that the practice manager and reception staff were considering accessing programmes for their own personal development

Taking Pre registration Nursing Students had forced the Practice Nurses to go to the University for Mentorship and Assessor training. Although reluctant they benefited from professional updating and their own continuous professional development as practice placement educators

R- GP
S -Practice manager
T -Practice Manager
U –GP
V-GP
W-Practice Manager
Y- GP
Z- Practice Nurse

Appendix 8

Themes and cross referencing grids for literature review

Matrix of research findings

Research Author	Theme 1 Contribution of learners to care	Theme 2 Perceived benefits to practice	Theme 3 Perceived benefits to mentors/ assessors/supervisors	Theme 4 Perceived benefits to patients	Theme 5 Perceived drawbacks
DH Working paper 10	•	•	•		•
DH Fitness for purpose	•				
Lloyd Jones & Akehurst	•				•
Mathers et al		•	•	•	•
Benson et al				•	•
Lobo B				•	
Corby E				•	
Allsop et al				•	
Avery et al			•		•
Smith et al			•		
Beauchesne et al			•		•
Sheaff & Pligrim		•		•	

Appendix 9

Validation statement re audio tape transcriptions and selections of quotations

From: XXXXXXXX
Sent: 08 July 2007 13:34
To: diana.moss@ntlworld.com

Dear Diana

I have listened to the audio type and read the transcriptions and your notes.
I confirm that they have been wholly represented in the results and analysis of themes.

SXXXXX AXXXXXXX

Appendix 10

Table 1 – Summary of Literature review

Author	Title. Reference	Focus	Methodology	Main findings
Jones and Akehurst	"The cost and value of pre-registration clinical placements for Project 2000 students" Journal of Advanced Nursing Vol. 30(1) July 1999, pp169-178	Calculation of costs of practice learning placements for pre registration student nurses in the context of project 2000	Student and mentor diaries kept for 1 week for an activity analysis Quantitative data was supplemented by Qualitative information from separate focus groups discussions with students and mentors	Calculated that providers benefi a rate of £2 per per nursing stud hospital placements incurred a loss per hour per n student for comm based placement
Elkan and Robinson	Is community –based teaching for you? (Patient Care 1998 Jul 15, vol. 32, no 12, p 72-4, 77-8, 83-4	Considering the increasing demand for practice placement learning in primary care sought to identify the issues and benefits for mentors	Semi structured interviews	Considered press on community se when supporting reg students (nur Identified increa number of "othe students in clinic area requiring support. Alludes to increa demand for community-base primary care preceptors Highlighted potential mentoring to f personal professional development
Atkins. S, Williams A	"Registered nurses' experiences of mentoring undergraduate nursing students "	Registered nurses experience of mentoring undergraduate nurses in a single health	Qualitative study with data collected through semi structured	Noted participan with real commit to mentoring app less concerned ab their role compet

	Journal of Advanced Nursing Vol. 21(5) May 1995 pp1006-1015	**authority.**	**interviews Purposive sampling of nurses, midwives or health visitors from both hospital and community settings**	**for their time. Th hospital environ with less flexibili seemed more disturbed by the burden of conflic roles. Identified need f mentor preparat conflicts betwee supporting and assessing activiti mentors, potenti enhance persona professional lear time and energy consuming natur mentoring, level commitment, sup from colleagues , reliance on lectu practitioners**
Mathers J, Parry J, Lewis S, Greenfield S	**What impact will an increased number of teaching practices have on patients, doctors and medical students? Medical Education 2004:38:1219-1228**	**The perceptions of primary care staff on the impact of increasing demand for medical undergraduate learning placements. Surveyed impact on students, patients general practitioners, other practice staff**	**Semi-structured interviews with three teaching practices, three about to become involved and one non teaching practice in the West Midlands practices**	**Emerging theme students experie the Black Countr working with dep populations, interviewees felt patients enjoyed benefited from th process. Positive impacts were elic on practice infrastructure Th was a dichotomy opinion regardin resource implica some felt teachin status had positiv influence in term resource allocati from SHA (upgr**

				IT systems). Oth felt negative effe that SIFT consid sole means neces to support teachi requirements Advantages ; inc morale, variety t work life and stir for CME as a res student questioni Improved record keeping. Encoura reflective practic re-examination o areas of work/knowledge Recognition that advantages were some extent offse additional workl clinical teaching, administration, preparation, mar etc. These were consistent negati factors. Money fr the medical scho considered insuff and sometimes a deterrent to taki learners. Patients experien longer consultati with more expan explanation
Gopee N et al	**Effective clinical learning in primary care settings 2004 Nursing Standard, 18.37.33-37**	**Effective clinical learning in primary care settings Nursing Standard, 18.37.33-37**	**Literature review on primary care settings as learning**	**Scarcity of litera pertaining to pri care learning.**

			environments	
Benson J, Quince T, Hibble A, Fanshawe T, Emery J.	**Impact on patients of expanded, general practice based, student teaching: observational and qualitative study. BMJ 2005; 331 (7508):89**	**Community based teaching for student doctors**	**Qualitative study of five practices in West Suffolk and southern Norfolk teaching doctors**	**Patients are gene supportive of stu doctor education diminished patie enablement or satisfaction was Patients' support conditional on adequate inform about reduced ac to the doctor.**
Lobo B	**Developing advanced clinical practice skills 2006**	**Developing advanced clinical practice skills 2006**	**Patients experience of teaching assessment, diagnostic and treatment skills to advanced practitioners (nurses)**	**Over whelming positive response benefits in consu time and explana**
Corby E	**Patient satisfaction survey of patient experience in having learners in primary care consultations Lincolnshire tPCT2006**	**Patient experience of learners in primary care Teaching Practices**	**Six practices given twenty five questionnaires each 50 returned (33%)**	**Patients felt they the attention they expected 94% did not min having a learner present 100% got the att expected "If anyt explanations wer clearer…" 6% thought they received a better service**
Bezzina P,. Keogh. J and	**Teaching primary health care: an**	**To determine the benefits to students in**	**Questionnaire of 14 questions**	**Development of primary health c**

Keogh, M	**interdisciplinary approach (Nurse Education Today 1998 Jan. vol. 18, no 1 p36-45**	**including primary care principles on a multidisciplinary basis in undergraduate programmes**	**with subsections (9 closed and 10 open –ended**	**services necessita role developmen AHPs, nursing a radiography and primary health c should be includ the curricula of health care profe**
Avery A. Savelyich B. Wright L.	**Drs views on nurse prescribing** **Prescriber , vol. 15, no. 17, pp. 56-61**	**To study the views of doctors with experience of supervising student nurse prescribers during their education. The objectives were to find out about doctors':** • **Reasons for being involved in nurse prescribing supervision.** • **Experience of supervising and working with nurse prescribers** • **Experience with clinical management plans** • **Views on scope, limitations and safety of nurse prescribing**	**Telephone interviews using structurecarried out on a selected sample of 12 doctors ; 6 from primary care, 6 from secondary care**	**Doctors appeare gain benefits in refreshing their knowledge altho there were perso costs reported in of time invested. Doctors were ge positive.**

Allsop,A., Brooks,L., Carr, C., Courtney, Y., Dale, C. Pittard, S., & Thomas, C. Clarke et al 2001	**Supplementary prescribing in mental health and learning disabilities** *Nursing Standard. No. 30, pp. 54-5*	**To examine patient's and collagues experiences of nurse prescribing in mental health and learning disabilities in one Trust in South Staffordshire.**	**Informal feed back from patients/clients and colleagues who have come into contact with a nurse prescriber**	**The relationship between nursing medical staff was reported as devel during the educa process and the continuing worki partnership was to be beneficial i terms of improvi efficiency**
Smith L.S,McAllister L.E. Snype Crawford C	**Mentoring Benefits and Issues for Public Health Nurses** *Public Health Nursing Vol.18 No. 2, pp101-107*	**The value of peer mentorship for Public Health Nurses Definitions, roles, benefits and responsibilities of mentors and mentees**	**Review of literature and generalised**	• **PHN and organisati benefit (H 1994)** • **Influences career developm (Angelini** • **Costs of recruiting retaining qualified may be re by mento** • **Costs can counter administr expenses incurred & Campb 1994, Rich 1999; Wa Clements** • **Mentorin lead to improved enhanced clinical competen personal satisfactio political s**

				empowerr and job satisfactio • **Client out and satisf improved** • **Mentorin facilitates multiskill and interr motivatio**
Beauchesne M.A., Meservey P.A	**An Interdisciplinary Community-Based Educational Model *Journal of Professional Nursing, Vol. 15, No 1 1999***	**Describes partnership between academia, community and service to meet the needs of underserved populations Identifies educational and service outcomes**	**Descriptive report of introduction of a new educational initiative**	**Educational outc – longitudinal community base experiences expa learning in both clinical practice research Service outcome Nurse practition cost-effective pro of care Need for effective links be community and academic institut for practical and pertinent learnin experiences**
Ferguson B, Munro S, Sanderson D, Wilson A	**"Evaluating the Benefits of Clinical Placements in Occupational Therapy" York Health Economics Consortium 1993**	**Whether placement providers should be reimbursed for placements Assume it is expected to be advantageous for providers themselves to have students on placement**	**Assessment of qualitative benefits of practice placements Questionnaires to Head Occupational Therapists in provider units and District Occupational**	**Devised an econo framework for determining the per placement w with regard to supervision and administration a service contribut made by student (based on Walke Cooper) They provide a v**

			therapists Questionnaires also to purchasers of OT services in DHAs The qualitative benefits were quantified through weighting each type of benefit to identify the "value" that would be taken by each intangible benefit for the costs to be equal Walker and Cooper methodology included a variety of interviews and taped group discussion	example which n be applied to oth clinical placemen They conclude th intangible benefi cannot be measu and valued direc and it would be virtually impossi address the ques by how much be outweigh costs. However they se establish the "br even value " of b to service; the po which the impact cost and benefit i neutral, implying "no compensatio principle Cite Walker, CH Cooper, FM (19 "The Costs and Benefits of Clini placements in Occupational Therapy: A Collaborative St Within the York Region" Yorksh Regional Health Authority and th University Colle Ripon and York John; April 199 (unpublished) Appendix A Study concluded service providers receive an "equit deal from Occupational Th clinical placemen conclusion which undermines argu

				for reimburseme placement provi Walker & Coope benefits: • **Enhance recruitm retention staff** • **Improve morale** • **Professio developm staff** • **Enhance status of** • **Marketi advantag** • **Enhance quality o to clients**
Walker, CHI and Cooper, F.M	**"Fieldwork Education: To charge or not to Charge?" 1993. British Journal of Occupational Therapy; 56 (2): 51-54**	**An examination of the arguments for and against charging for OT fieldwork experience**	**Qualitative and quantitative data generated from unit managers, profession managers, fieldwork co-ordinators and supervisors through telephone interviews**	**The authors did support the possi of separating education costs f service costs with service units, tog with the superfic attractive idea (t managers) that education costs c be met by the education provid They concluded t student placeme not just a cost to service, they brin quantifiable bene inb terms of appreciable servi contribution desp students supernumerary s They identified indirect benefits student-staff**

				interaction in ter staff developmen has impact on th quality of provisi Student placeme not necessarily h adverse effect on patient throughp and that the maj arguments put forward for char are not supporte Highlights the potential impact commissioned numbers (reduce the results of mo following the stu were to drive up price of contract They drew atten a need for more equitable payme clinical supervisc allowance to encourage furthe placement availa
DH				**KSF and AFC**
Hillestad, E, A. and Hawken. P,	**"Weighing the costs and benefits of Student Education to Service Agencies" 1987-Part 2 Nursing and Health Care ; May 277-281**	**A north American study into nurse education**		**Recognised the following intangi benefits: :** • **Prestige o being asso with a tea facility** • **Recruitm tool-acces education**

				facilities t **recruit** • **Recruitm** **pool- stud** **are availa** **prospecti** **staff mem** **after** **graduatio** • **Job enrichme participat nurse edu provides a added dimensio staff mem jobs** • **Maintaini** **nursing sk** **reinforcin** **appropria** **principles** **tasks whe** **students a** **around** • **Impetus f** **analysing** **nursing ca** **students** **questions** **as stimulu** **staff mem**

				• **Continue learning-s encourag stay curre nursing a seek addi educatio** **Concluded the g benefit was the opportunity to re and further that monetary value c not be put on intangible resou but felt the excha between student service agencies equitable**
Sheaff R. **Pilgrim D**	**"Can learning organisations survive in the newer NHS?" Implement Sci 2006; 1:27 Published online Oct. 30.doi:10.1186/1748-5908-1-27**	**Compares characteristics of a learning organization with current NHS organizations and those being created (1998-2006)**	**Literature search for texts defining and debating characteristics of a learning organisation. These were summarised and mapped onto current NHS organisations to identify the extent to which they achieve or approach learning organisation status**	**Open systems thinking,** **Team learning, Cohesive vision, Maximising indi competency, Negotiating cultu change, Community of learners, Dispers learning leadersh Open dialogue, Evidence based medicine and dy capability, Triple learning: argue t the NHS demons encouragement t learn , not too m nor too openly. Narrow technica learning encoura Managers not us permitted to com**

				other than supportively. Propose a solutio consonant with learning organiz is to allow man freedom to speak evidence about th learning from po introduction, its from local experi of implementatio