Partners in Practice

Getting better: education and the primary health care team

R V H Jones

This is the sixth in a series of articles focusing on the current tasks and functions of the primary health care team

The words "getting better," when applied to any activity, imply that the job to be done is known and that there is agreement as to what is good and bad.

For centuries general practitioners virtually wrote their own job descriptions.[1] It was not until the 1960s that an outline definition was published[2] and the 1980s before attempts were made to define standards.[1] Primary health care teams are an even more recent development. There is still confusion over what constitutes a primary health care team and there are no agreed criteria by which a team's performance can be measured.[3]

In most practices, however, there is a recognised group of people—general practitioners, district nurses, practice nurses, a manager, health visitors, and clerical and secretarial staff—who normally work together from the same building to service the health needs of the same registered population. At a time when more practices are analysing what they are doing and looking at what the results are and what they would like them to be it is appropriate to consider the educational needs of these teams and how education may improve their performance.

Educational needs of individuals

It is usually assumed that the professional education of nurses, health visitors, midwives, therapists, social workers, and general practitioners has equipped them for work within primary care. This may well not be so. Moreover, before their appointment to a practice, few practice managers, receptionists, and secretaries had until recently trained for their jobs in a medical context. In addition to filling basic educational gaps continuing education in the form of updating knowledge or of learning new techniques and skills is essential for everyone working in primary health care.

For staff employed by a practice the responsibility for recognising and meeting their educational needs rests squarely with the general practitioner. This applies to all staff but is particularly important for practice nurses, most of whose daily work has not been covered during their professional training. For professional staff attached to practices but employed by health authorities responsibility rests with the authority. Health authorities differ in the extent to which they acknowledge this responsibility, and difficulties concerning funding and protected educational time for attached staff can arise as they participate more in audit and educational activities in the practice.

Educational needs of the team

The members of the primary health care team, with their diverse skills, roles, and tasks, have in common that they work within the same organisation and that collaboration and cooperation is a major aspect of their work.

In the past general practice was carried out by an individual doctor working in isolation. The importance of understanding the principles of management and their relevance to maintaining high standards of performance and motivation[4] have only slowly been appreciated by general practitioners, as small practices have turned into medium sized businesses.[5,6] Most general practitioners learnt nothing about management during their medical education, and neither did their staff. Although practice management is now an integral part of vocational training, there is a need for continuing education.

Another consequence of the increasing size and complexity of general practice has been that the need for good teamwork has become more evident. The recent shift of emphasis from hospital to community care for people with long term disability and incurable disease, together with increasing realisation of the complex implications for service of an aging population, have sharply focused attention on the current deficiencies in teamwork within primary health care teams.

Requirements for adult education

Adult education should:

- Be relevant (directly related to daily work)
- Be learner centred (meet learners' needs)
- Be problem based
- Be interactive
- Build on learners' experience
- Challenge learners to commit themselves to a decision
- Provide a logical approach
- Provide feedback
- Lead to further study

Meeting educational needs

SKILLS

There is no one method for meeting educational needs: needs are different, people are different; some may appreciate one educational method, others heartily dislike it. However, updating basic knowledge and skills through courses with lectures and discussion or with supervised practice of skills are appropriate and effective. Most health professionals feel comfortable with this familiar, non-threatening method. Courses

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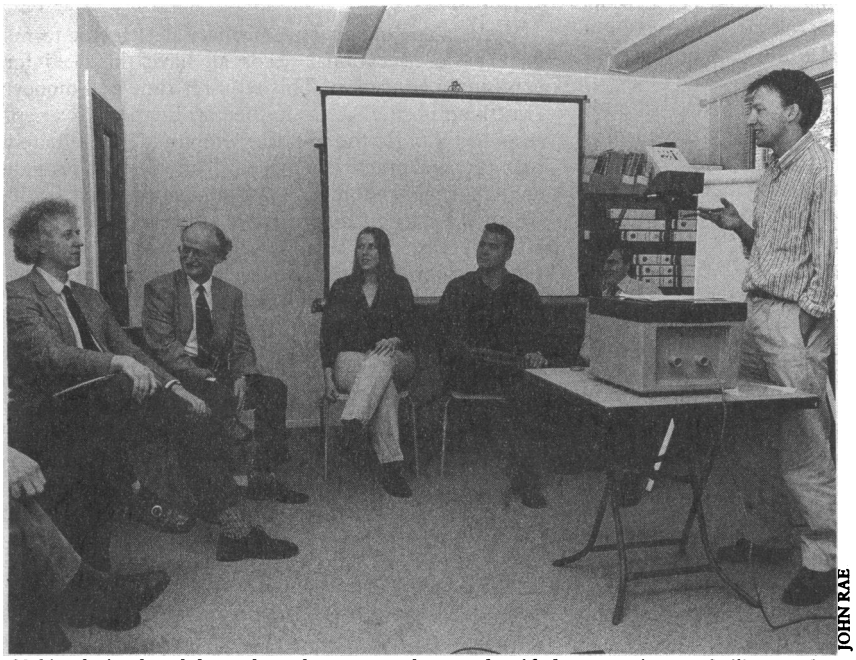

JOHN RAE

Multiprofessional workshops adopt a learner centred approach, with the tutor acting as a facilitator rather than a lecturer

along these lines are regularly advertised in professional journals and organised in postgraduate centres.

MANAGEMENT

Advertisements for management courses also appear in professional journals. As consensus agreement is an important component of successful change in management attendance by both a practice manager and a general practitioner partner is encouraged for most management courses.

TEAMWORK

The most difficult educational need to meet has proved to be that of improving teamwork. Improved teamwork requires a new awareness of colleagues' skills, roles, and expectations and changes in attitude and behaviour. Traditional "teacher centred" educational methods have been shown to be ineffective in changing behaviour among general practitioners.[7] In searching for an effective method[8] the emphasis has shifted to "learner centred" education,[9,10] in which the teacher's role is largely that of a facilitator. Surveys of mature students[11] and research into motivation of adults in education[12] have shown that adult education should fill the requirements listed in the box.

Methods and models for improving teamwork

As a means of improving teamwork learning together —multiprofessional education—should in theory be more effective than learning about each other at a distance. Take up of multiprofessional workshops if advertised as such, however, has often proved disappointing (British Postgraduate Medical Federation, personal communication). More recently several educational initiatives entailing members of different health professions cooperating in a joint task have proved more successful. The three examples of educational methods described below had different objectives, but one common outcome was improved teamwork.

(1) FACILITATORS IN PRIMARY CARE

In the Oxford region nurse facilitators were employed in a research project concerned with preventing coronary heart disease and stroke.[13,14] Their function was to advise and work with practices in a screening programme. Although the main objective of the project was to improve preventive care, it was found that coordinated planning and cooperation within the practices had increased.

(2) MULTIPROFESSIONAL WORKSHOPS

For some years the Lisa Sainsbury Foundation has been running one day workshops, which have been largely uniprofessional. There was a demand for certain subjects to be considered in greater depth, and since 1990 the foundation has organised some residential workshops on terminal care at home. To broaden the perspective within a workshop each interested practice should nominate both a nurse and a doctor to attend. The format of the courses is interactive, with the tutor acting as a facilitator rather than a lecturer. Feedback has been positive and the courses are fully booked.

(3) RESIDENTIAL PRACTICE WORKSHOPS

From 1987 Yorkshire Regional Health Authority, the regional adviser, Yorkshire Heartbeat, and the Health Education Authority have organised a series of residential workshops for general practices. The main aim was to reduce the incidence of coronary heart disease by encouraging health promotion in general practice. Other aims included encouraging understanding among professionals and teamwork. The programme has been fully described[15] and evaluated.[16]

Each practice nominated its own team of four to six members to attend, which might typically include a practice nurse, general practitioner, social worker, district nurse, health visitor, and practice manager. The main objective was that by the end of the workshop each practice would have produced an agreed plan of action, which they would implement. During the course most time was to be spent in practice discussion interspersed with short contributions providing information about, for example, local resources or the need for the plan to include evaluation and ways of doing this.

The programme has gradually developed. The main objective that each attending practice should produce a plan remains, but the content of the plan has broadened to include topics chosen by the practice. Attendants during courses have shown increased understanding and tolerance within practice groups.[17] The response from participating practices has been enthusiastic. Evaluation has confirmed that in most practices the plans have been introduced successfully and that improved teamwork persists. These and similar workshops are now widely available.

COMMON FEATURES

Despite different origins in different settings and different objectives these three initiatives share common features—namely, that as educational exercises they are all learner centred, interactive, build on the learner's experience, and are relevant in that they relate to real problems or challenges in daily life. They have each included more than one profession or discipline, and as a result of each better cooperation, more coordinated planning, and improved teamwork have occurred.

Back to the practice

Of the three examples described, one involved a facilitator; in the other two members of the practices attended workshops outside the practice, thus gaining protected time. But similar opportunities can arise or be organised within the practice itself. In a recent article Essex and Bate describe an audit within their practice.[18] They conclude that the method they developed enabled a receptionist to audit aspects of the

practice cost effectively and that there was great scope for enlarging the receptionist's role. It is interesting to analyse the process which led to this conclusion from an educational viewpoint.

The first reported action was a decision to audit accompanied by the setting of goals by the medical partners. The receptionist and partners met regularly to identify difficulties. When insufficient information was available the receptionist conferred with the relevant doctor, health visitor, or nurse. The receptionist participated in redesigning the forms for collecting data. In effect within an audit exercise a multiprofessional interactive educational exercise took place in which a practice team were working together to solve a problem relevant to their daily work, the problem being quality control.

Education is generally accepted as an essential component of audit. Perhaps in general practice there is a mirror image: audit of a practice activity which concerns several professions provides an excellent and often unrecognised opportunity for multiprofessional education, better understanding, and joint planning.

Key points

- All general practice staff have a need for continuing education
- The general practitioner is responsible for meeting the educational needs of staff employed by the practice
- The health authority is responsible for meeting the educational needs of the staff it employs
- Multiprofessional workshops are effective in improving collaboration within primary health care teams
- Audit of practice activity by several team members may be the best way of improving teamwork

Maybe it is time the focus shifted from going away to learn to learning at home. The potential is there. Clearly the need will arise for comparison with others,[19] but as a first step in "getting better" it is worth consideration. Resources and guidelines are available. Many local medical committees and faculties of the Royal College of General Practitioners can provide help and guidance. Each family health services authority has its medical audit advisory group, which is able to provide advice and perhaps some initial funding. Perhaps it is time that medical audit advisory groups themselves became multiprofessional.

Conclusion

While some members of primary health care teams have basic educational needs all have the need for continuing education. This requires time and money. Health authorities differ in their willingness to accept responsibility for the staff they employ. Unfortunately many general practitioners are still unwilling to provide enough time and money for educating their staff, which is a strong disincentive for their motivation and effectiveness.

The major challenge, however, is to improve collaboration and cooperation within primary health care teams and between these teams and other health and social service professionals working in the community. Multiprofessional workshops with practice teams have been shown to be effective, but audit of a practice activity that requires the participation of several team members is a potent method of improving understanding and cohesion—members work together and learn together.

This series has been edited by Dr Mike Pringle.

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ANY QUESTIONS

What is the average duration of immunity produced by a clinical attack of hepatitis A? Are the degree and duration of immunity after a subclinical attack similar to those produced by a clinically obvious illness? Is the length of the immunity produced by the recently introduced vaccine known?

In developing countries hepatitis A infection is usually acquired subclinically in childhood; by school age most children are immune. Since symptomatic infections are rarely reported in adults this strongly suggests that asymptomatic infection in childhood provides long term protection. As standards of hygiene and sanitation improve, however, children escape early infection and sizable outbreaks may occur among adolescents and young adults.[1,2]

The accumulated data from several trials of the recently licensed inactivated hepatitis A vaccine show that it is highly immunogenic and suggest that antibody responses induced may well persist long after the administration of two doses of vaccine two to four weeks apart and a booster dose given some six months after the first. Nevertheless, the exact duration of immunity cannot be predicted from these studies and it is therefore important that long term surveillance is conducted to determine the duration of persistence of the antibody and whether additional booster doses of vaccine are required.—J E BANATVALA, *professor of microbiology, London*

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