



Keeping partners involved: a multi-professional education strategy for a primary care trust

Introduction - setting the scene

This story is about planning education and development for the whole workforce in a new Primary Care Trust. It highlights [strategies used to manage across old/new organisations, and different work groupings](#), through a time of major transition.

The Training Manager for the old community trust brought together a new broader group, and the first meeting was full of energy. However, everything was changing all around them, and at the next meeting, none of the wider group attended. Different actors had widely different ideas about what was important - from generic roles for staff in the future, and development required for these; to how to 'keep control' while involving a wider group.



The task was to draw up a unified Education and Training strategy and a Workforce Planning document that together would outline the philosophy, aims, process and budget required for the new Primary Care Trust for the following year. The proposal for funding was to go to the Workforce Confederation, which was also a new multi-professional organisation.

We will hear stories about what happened from the [Training Manager](#) who thought that this group was to be her key group, and was very disappointed when it fell apart'; from the [Director of Human Resources](#) who chaired the group, who was looking ahead to envisage new roles to match new services; from the [Assistant Director of Nursing](#), who was aware of submerged conflict and personal pain in the meetings and looking back would have wanted more transparency and explicitness about roles; and from Maureen, the [Primary Care Tutor](#), who worked with the Training Manager on the strategy, which in the event was only for the 'community' side of the Primary Care Trust. Their stories are about how to cope with ongoing transition and insecurity about roles and jobs, while continuing to get the work done.

Gill - Training Manager

This story is about a group who were initially 'well on board with us'. The storyteller is Gill, the Training Manager for a community trust, and she was trying to gain commitment of a much wider group to plan an education strategy and workforce plan for the new Primary Care Trust.

'All bridging - taking that walk to the other side'

The first meeting was attended by a GP ('much prized'), a social services representative, the educational dean, PCG tutors, the Director of Nursing, the Head of Therapies, the Director of Service Development and the Training Manager herself. She said that there was an 'OK ethnic mix' in the group: by this she meant a group that matched the local population. 'This was about making sure that we were all bridging, you know, taking that walk to the other side, to incorporate working together, as the NHS plan says that we must!' she said. She noted however that the people in the group were all managers 'representing' their staff: front line staff themselves were not in the group.

'We started to talk around what we wanted, and everybody was up and running with it. What a wonderful thing. Yes, we'll get a strategy of education for the whole of the staff groups. It would move on and we would be really good and all the rest of the stuff. So everybody seemed to be very agreeable about what would happen.

Moneywise - at this meeting we just started to talk about funding; and it became obvious that the people who were representative at the table didn't necessarily have money. And most of education costs money. So people started to go quiet, you know, when they were unable to contribute in that way. And they were just sort of listening. So from this very good idea this particular meeting - didn't go downhill, that was wrong. But barriers started to form.'

Doing the education strategy on her own...

So much so, that at the next meeting, none of the wider group attended, and the Training Manager ended up doing the education strategy on her own. . . 'So I've been, like, this person who's developed the education strategy for the Primary Care Trust, which shouldn't be done in isolation, but it was. I put the framework together.'



Reflecting on this, she realised that although this should have been her key group in fact she did not have control over it.

'It's quite frustrating in one way, because probably with my position in the Trust, this is my key group, which I don't have

control over, maybe. That's a strong word, I know, but maybe that's how I feel about it. I believe the group needs to go on, and I believe it needs to be, to cross professional boundaries, cross agencies, and in actual fact I'd like to see now some voluntary agency on there.'

She also reflected that her **own performance** in the group was hesitant, that the Service Development Manager seemed to control the agenda, and allow unfocused discussion, which prevented the group reaching a decision. She also reflected that members of the group were there because of their job titles and their official roles, not by 'what people could bring, their assets'.

She also reflected on who the 'users' were for the Education and Training strategy.... She said that since the head of therapies was present, as well as the head of dental, and the director of nursing disabilities, they represented their staff.

Rosemary - Assistant Director of Nursing

Rosemary, the Assistant Director for Nursing was also the lead on clinical education and training.

Context and meetings

It was a time of transition and organisational restructuring; 'everyone was in limbo, and likely to have a different job shortly. We knew that whatever we decided was subject to change.'

The meetings:

- They were very rushed and pressurised, with people arriving late, no time to check assumptions or agree ground rules.
- Differences in perceived status and role meant some people may have not contributed. This may have been because they did not know whether they could contribute rather than because they did not want to. .
- This appeared 'to my white assumptions' to be more important than any issues about gender or ethnicity. There was no explicit discussion regarding gender or ethnicity.
- 'Everyone was very nice to each other; everyone was reserved at the meetings. We didn't have conflicts; differences in perception were spoken of outside the meetings. I am not sure whether they were sub meetings. I think people met outside to continue the work they needed to do to meet their deadlines.'
- Variable attendance was a real issue . There was a sense of 'where was the real business being done?' It all felt disjointed.
- It was chaotic and frustrating for some individuals , 'there was some personal pain.'

- The chair was covering for this role, as were several of the directors during this time of change, and did not know about the detail of the issues.

People involved - or not

People from primary care - i.e. the Primary Care tutors - had previously had a lot of autonomy. They had created their roles and did not want to lose them: they were proud of what they had developed, working on relationships with GPs and delivering programmes. Only one GP attended one of the meetings. Other primary care staff and community professionals, for example dentists and practice nurses did not attend. Their funding source had been different to that of the Community Trust.



The Community Trust was tied into contracts with university providers and had limited spare cash. Information and views from support staff were fed in through locality managers, but they were not directly involved. Users' views: there was some input through complaints and the governance process, but 'I wouldn't say we had a very sophisticated process for that.' Social Services were not involved at this point.

The strategy and the bid for funding from the workforce confederation

What was needed was a unified strategy that took account of different cultures, and of both clinical and organisational development needs. D noted: 'Leadership - that's all very well and good and exciting. But there was also a need for a need for basic clinical training, for example intravenous training, or for enteral feeding programmes.'

There was no clarity about who was leading on the bid to the Confederation. It has always been difficult to get accurate figures on the workforce; this was the first year putting together community and primary care. It was 'a tricky and potentially laborious process'.

What happened?

The strategy and the bid were completed, but did not feel very accurate. 'Everyone was dissatisfied at being part of something they knew wasn't right.' It was pulled together by one or two people, but did not have sufficient ownership, particularly by the Director of Nursing, who felt there were not enough clinical skills training. It wasn't related to the process for developing the Health Improvement Programme.

What happened later



'As it happened our data was more accurate than other Trusts and the Confederation used our data as part of a funding formula to calculate allocations. The new Primary Care Trust felt they were under funded, and appealed successfully for a review and more money. The reorganisation and restructuring in the Trust have now been completed with the development of dedicated posts and clearer roles overcoming some of the practical difficulties have been resolved.'

Key lessons in managing a transitional process, where everything is moving

D. reviewing the process said: 'we should have:

- started the process with ground rules about everyone having equal air time, and respecting each others' knowledge and contribution
- mapped out the people involved and made people's roles explicit
- explicitly pooled knowledge different people had
- been explicit that the strategy was an interim one
- had clarity about responsibility for producing the strategy and lead on the bid
- had a joined up process for both workforce planning and education and training.
- had a clear Director lead'.

Primary Care Tutor

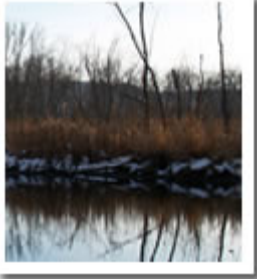
At the time of the transition from Primary Care Group to Primary Care Trust, Maureen was a Primary Care Tutor, one of three. She worked across 16 GP practices, with the GP tutor, helping with the process of enabling all practice staff to have access to development.

Building the new PCT: 'not a level playing field'

The aim was to develop a coherent and unified strategy for development for staff from both the old Community Trust, and from GP practices. There were problems however, as practice staff (with the exception of the GP), had never had access to the same level of education and training as staff in the Community Trust, where there was cover available for those 'released' for training courses, and also better funding. 'We knew before', said Maureen, 'but the process of the joint strategy brought home to use that there was no level playing field. We had to do some more work with primary care. Primary care wanted something wholeheartedly for them: they didn't want something that was cobbled together with the Community Trust.'

The process of developing a coherent strategy together During the transition

Because of this, it was decided to keep the 'community' and 'primary care' sectors separate for time being, in spite of the fact the Primary Care Trusts had actually come into being in April of that year. 'We kept the GP practices ticking over, with some Business Planning and other ad hoc courses'. Meanwhile, the community education and training



strategy was developed by the three Primary Care Tutors together with the Training and Development manager from the old Community trust. 'We were hesitant: we were in transit. We didn't know our remit. It was a strange experience. We knew it was interim for a year.' They worked with the Community Trust service heads; the group was chaired by the then Director of Human Resources. 'We pulled it together, sent out a draft to other people to agree or

disagree, and then put it to new Executive Committee, the Clinical Governance group and then it got a nod from the Board, who could live with it. They knew something else would be winging its way towards them soon.'

Everyone was in transition, and not everyone's mind was on the ball.' The Directors were all at risk; people at my level were waiting to hear. We didn't know who would be there when we got out at the end of the tunnel. It was more down than up. The Directors' were sorted by

September, but then everyone was at risk. It was too much.



Working life was an absolute mess. It's one way of not doing it . Many more posts could have been block transferred, but almost everyone had to apply for their jobs. I didn't get my job till December.' [Maureen is now Associate Director of Workforce

Planning.]

Bite-sized changes

They have had a consultant working with them on what needed to be done to level the field across both 'community' and 'primary care'. One change has been to commission places on a full time course to train four nurses from the acute or community sectors as Practice Nurses, while paying existing Practice Nurses to act as mentors. The latter have also been offered short courses to update them in what they see as priorities, for example assessment and triage of patients coming to the surgery. At the same time funding has been available for cover. Specialist Practice Teachers from the trust are working with the students, the mentors and the university for joint support of those four students.

Other staff from GP practices have identified particular skill areas where they need extra training, such as Marie Curie courses for smear tests, and training to help people with diabetes or asthma. Previously this kind of training was done in nurses' own time: now cover is provided. Gradually, Maureen feels that there is more equity in access to development.

Skill mix and more generic roles

Now a lot of attention is being paid to examining the service changes, and looking at what mix of skills is needed. There is a local project to look at what common tasks could be done by more staff from different specialisations, and looking at the idea of the skills escalator .



There are a lot of barriers: 'if you blur the boundaries too much, people get very confused and too frightened to do anything. There could be increased risk, and insurance issues. There are historical divides, and the national professional bodies. We can look at little bits of blurring.'

The Confederation: the service specifying what it needs

'There were very few people in the Confederation [at that time]. The Chief Executive spent 6 months covering her old job as Chief Executive of the Community Trust. Now we are starting to notice procedures tightening. The Confederation is there to support trusts: in fact we are the confederation.'

There are subgroups on Quality, on Education Commissioning, on Performance Management and on Strategic Development: these all report to the Board. There are also Borough subgroups, which have members from social services, the independent and the voluntary sectors as well as health trusts and someone from the Deanery.

The existing contracts with universities are up for review. 'Before, we were much weaker. Now the universities are starting to realise. We want more work based and on site courses, more multi-disciplinary education. The 'bums on seats' attitude is starting to change. It took a lot of working. There are still a few wranglings. But now we are seeing real changes'.

Maureen is now Associate Director of Workforce Planning and is Vice Chair of the Quality Subgroup. She is developing review methods for the contracts, starting from her experience both in primary care and in the Community Trust.

Nazreen - Director of Human Resources

Nazreen, the Human Resources Director's Viewpoint

Skills for the Future

When the Primary Care Trust was set up, a new group started to look at the current and future workforce needs to ensure an integrated approach. The task is a complex one: to look forward to see what future workforce needs will be over the next five years, based on predictions about changes in how health and other care is provided. Up till now, the tendency has been for workforce planning to be only 'number crunching', and the aim of service managers has often been just to maintain their complement, rather than to think what skills are needed and how these skills can be provided. The new group needs to look at how primary and community care can be integrated. What skills will be needed? For example, where the aim is to provide more rehabilitation for older people in the home, there will be a need for more therapy. What are the implications of this for the number of District Nurses, or rather for the kind of skills needed for developing care and treatment? This is



also the case beyond health. For example, currently there are classroom assistants and healthcare assistants. How far can these two roles be combined to meet children's needs? All this has to fit too into national developments in changing professional boundaries.

The group needs to move to a more meaningful approach, building information about the future into their plan.

How well does this new integrated group work?

The group needs to move to a more meaningful approach, building information about the future into their plan. Everyone in the group has a common goal: the need for a more integrated approach to workforce planning and development. There are committed Primary Care tutors, who cover support staff within GP practices, and a GP tutor, who is himself a practising GP as well as providing support to GPs in the new PC Trust. The pressure on his time means that it is difficult for him to attend.

Issues in this story

Multiple perspectives: who is creating a single story for the partnership effort?

Everyone here is telling a different story, all of which are real for them. The Human Resources Director, reflecting a longer term strategic overview, is looking 5 years ahead to consider how boundaries will change between professions. The Training Manager is coping with her role within a much broader partnership than before: how to 'keep control' in a nebulous new partnership, and how to keep involvement, when everything around is moving. Using the analogy of the orchestra, she commented: 'When the conductor is unclear, what is the effect on the players?' So the question is posed: is there a conductor in this partnership and who is it? To change the metaphor slightly, all the players are giving their best performance, but do the actors agree what the play is about? No one seems to be saying: 'Let's take a step back? What is the purpose of this?' So the partners retain their personal perspectives about the direction of joint efforts and these are not really shared.

Building ownership of a virtual organisation

The Workforce Confederations are intended to 'take the lead in visioning the future Healthcare Workforce'. More, they have been set up to help provide integrated services for users and patients. But the pressure of immediate targets make it hard for those who hold this vision to communicate it to the other players. How can purposes be made explicit, and shared, given such different perspectives? As well visioning the future workforce, and putting the user at the centre, the Workforce Confederation is also a 'club' for participating member organisations rather than a funding body 'out there'. The Primary Care Trust is one of these participating members, which should take up its membership actively, and communicate what the Confederation is. The Confederation is an example of a network or a virtual organisation, whose numbers are growing. Building ownership and belonging within a virtual organisation requires thinking through by leaders, so they work with the invisible team as well as the visible members.

Managing quick wins in a long term strategy

This case illustrates clearly the enormous difficulties for leaders of clarifying the long term while completing the short term: the tensions of the interim strategy. The case perhaps indicates the importance of building in at least some information about the future into the plan, to build some commitment to that which hasn't yet happened. But the plan also

must acknowledge that decisions might be undone, and the need to keep the service going in time of transition. Here the need was for interim work to be done to create more of a 'level playing field' between 'primary' and 'community'. This needed to be clear to everyone. These were actions which were important whatever decisions were taken later. This illustrates the idea of the 'trumpet of opportunity': taking actions now that could contribute to a range of different scenarios. The case also highlights ideas of 'pre-figuring' change, which means actually enacting the process desired before the decision point itself can be reached.

Who is involved in decision-making?

User involvement in this case was also complex. If the users of the Education strategy are taken to be staff in the Primary Care Trust, can their managers 'represent' their staff's interests? And what about end-users, the patients? What should or could their involvement in the Education Strategy be. The case also raises questions about how to assess the adequacy of involvement, for example of people from black and ethnic minority groups. Is it that one or two individuals from ethnic minorities at a level above the frontline is sufficient? Or is there an aspiration that decision-making meetings have ethnic representation in proportion to the communities served?