SELF-DIRECTED LEARNING GROUPS: A VITAL MODEL FOR EDUCATION, SUPPORT AND APPRAISAL AMONGST SESSIONAL GPS

INTRODUCTION

With changes in the delivery of primary care, and to the General Practitioner (GP) contract[1,2,3] an increasing number of GPs in the UK are employed on a sessional basis.[1] These are most commonly salaried GPs who are employed by practices or primary care organisations, and locums. There are currently approximately 39,400 GPs in England, with over 8,000 employed as salaried practitioners, an estimated increase of over 900% since 2000.[4] However, there can be problems identifying sessional GPs in any one area.[5] This means that they can be excluded from information cascades about education and services, resulting in reduced educational opportunities and professional isolation. [3,6-10]

Peripatetic locum GPs, salaried GPs and GPs working small numbers of sessions, in particular, can be isolated through lack of contact with peers and more limited access to Continuing Professional Development (CPD) activities. Barriers to education can include time, financial costs, family commitments, lack of access to educational and clinical meetings within and outside practices and not having a forum to discuss difficult cases or significant events.[6,11] One study on the feasibility of evidence collection for revalidation found that locums were not always informed of significant events in which they may have been involved, limiting the learning opportunities arising from those cases.[12] Concerns have

[1] The term “Sessional GP” refers to fully qualified GPs (i.e. not GP registrars) who are not conventional partners in a practice. It relates to freelance GP locums, chambers-based locum GPs, salaried GPs contracted to a practice or a Primary Care Trust (PCT), GPs working exclusively for Out of Hours Organisations and GP retainers.

also been raised about a lack of support for locum doctors who have trained overseas and are new to the UK.[13]

Self-directed learning groups (SDLGs)[5,14-18] have evolved out of groups such as study groups set up to help trainees prepare for MRCGP exams, and Young Practitioner Groups, which included GPs in the transition between training and partnership.[19,20] These groups all have similar aims of education and peer support. More recently, another explicit driver for joining or forming such groups has been the need to collect evidence for appraisal and revalidation, including evidence of CPD. The term 'self-directed' refers to the fact that group members determine and deliver the educational content, there is no formal leadership and normally no external paid or unpaid facilitation. Activities may include case discussion, presentations by members on topics prepared in advance, courses attended, journal articles and discussion of audits and complaints.

The self-directed ethos differs considerably from other forms of group learning currently found in general practice such as 'practice-based small group learning[21,22] and Balint groups,[23] all of which rely on trained facilitators and may tap into educational and financial resources.

Previous studies have identified difficulties that have arisen in young practitioner groups which have impacted on their sustainability. Groups have reported having early difficulties with, for example, ill-defined aims and needs, and insufficient motivation[20] or later becoming 'cosy and stale'. This may have exhibited itself in poor preparation by members and falling attendance.[19,p104] A

recent study of Balint groups identified difficulties such as hidden agendas, rivalries and difficulties around individual physicians' needs, vulnerabilities and defences.[23] There is some guidance, but limited research, on factors that contribute to the success of SDLGs,[14-16] and a lack of research on their benefits and limitations.

This paper draws on data from a larger mixed-methods study looking at the support needs of sessional GPs and how these are being met through a range of formal and informal support systems, including deaneries, SDLGs, local sessional GP groups[2] and other organisations.[11] One objective of the study, and the focus of this paper, was to explore the role of SDLGs as a model for providing support and education for sessional GPs, and factors that make these groups successful.

METHOD

Focus groups/telephone interviews with sessional GPs

All (approximately 750) sessional GPs in the Northern Deanery, England, were invited to take part in either focus groups (two hours) or telephone interviews (30 minutes), according to their availability, in order to discuss their support needs and how these were being met, including through SDLGs. Membership of an SDLG was not an inclusion criterion as the study also aimed to identify any issues around joining or setting up a group and views on potential benefit. The topic guide and interview schedules were developed from the literature and

[2] Local sessional GP groups are geographically based, mainly self-funded groups run by volunteers to provide peer support, job vacancy information and education.

in consultation with advisers to the research and other experts in the field of support for sessional GPs.

Participants were recruited through emails distributed through the local sessional GP group (North East Employed and Locum GP group (NELG)), and by appraisal leads and GP tutors in the Northern Deanery. Reminder emails were sent two and four weeks later. Replies were sent direct to the University researchers (GM and CR, who also facilitated the focus groups and undertook the telephone interviews). Written consent was taken at the start of the focus groups, and verbal consent at the start of the telephone interviews.

Interviews and focus groups were tape-recorded, transcribed, and analysed using a framework approach.[24] Following familiarisation with the data, a thematic framework was identified from a priori, emergent and analytic issues, and then applied to the data. Finally, through data mapping and interpretation, the key themes were brought together to address the research questions. GM and CR read all transcripts to familiarise themselves with the data and were involved in the identification of the thematic framework. The interpretation of the findings was discussed with PW (GP tutor and adviser to the research).

Deanery educator survey

In order to gain views of educators from a wider sample than available in the Northern Deanery, GP educators in all 20 deaneries across the UK were contacted by email, via deanery networks, with a link to an electronic survey hosted on Survey Monkey.[25] This aimed to gather information on educational

and wider support offered by deaneries to sessional GPs, including through SDLGs. There was one reminder email. The content of the survey was also informed by literature and discussions with experts. Its usability was tested with four colleagues and it was subsequently piloted with three experts. Questions relating to SDLGs all had free text responses.

Sessional GPs were asked about the benefits/potential benefits of SDLGs and any barriers, difficulties or unmet needs they faced. GP tutors were asked about their roles in setting up or supporting SDLGs, and what feedback they received from them. All participants were asked what factors contribute to the success of SDLGs, including their sustainability and accessibility. All data collection took place in February/March 2010.

The free text sections of the electronic survey to Deanery educators were coded thematically by GM and CR.[26]

RESULTS

Focus groups and telephone interviews

A total of 38 sessional GPs across the region (12 male, 26 female) participated (17 in four focus groups and 21 through telephone interviews). Fourteen of the participants had been qualified as a GP for less than five years. Twenty-four were members of an SDLG and 14 of these were also members of a local Sessional GP group. The SDLGs in this study had been in existence from nearly a year up to four years.

Deanery survey

Thirty-four responses to the survey were received from 15 out of the 20 deaneries across the UK to which the survey was distributed. Twenty-three of the 34 responses were from educators/advisers who considered themselves to have a dedicated role in supporting the educational, professional or appraisal needs of sessional GPs. The remainder reported that offering support for sessional GPs was implicit in their role supporting education in the GP population in general, and so their data were included in the analysis.

Table 1 shows the overall themes identified from the data. The following sections are written to the main themes from all three sources of data.

Table 1. Overall themes

Themes and sub-themes

Group organisation
• formation
• format and content
• decision-making
Benefits of membership
• peer support
  ○ social and emotional
  ○ practical
  ○ professional
• education
• appraisal and revalidation
Attributes of success
• review
• personal attributes
• organisational attributes
Issues
• Support for SDLGs
• Sustainability

- Unmet needs
- Issues/barriers in accessing groups

Benefits of being in a Self-Directed Learning Group

Peer support

One of the main benefits of being part of an SDLG was peer support, including professional, social and emotional, and practical support. Groups provided a safe environment for sharing ideas and concerns which members may not want to discuss with staff in the same practice, such as a complaint, difficulties with employers, or workload issues. Groups were useful for gaining information about job markets and terms and conditions, and for discussing financial issues. This was particularly useful for those new to being a sessional GP or new to the area.

> *"…apart from the clinical stuff, it's nice to have some…a support network. A co-mentoring network, I suppose, where if there's been an issue at the practice or if there's been an issue with a patient or a complaint or a worry, then we can share that with our colleagues and peers and just make ourselves feel better"* (telephone interview ID 35)

The emotional support offered by groups, and their contribution to personal wellbeing, was particularly valued by some.

"I just find it really helpful and, you know, actually I think it helps your mental health as well because it relieves stress" (telephone interview ID 21)

"…and when I go home, every time I go away with a good positive feeling and I think that's important" (focus group 3)

Educational support

Educational content of group~~s~~ meetings was generally in the form of a member presenting on a topic either agreed in advance or selected by the presenter. Some meetings followed a "turn up and share" format with limited prior preparation and a focus on cases from day-to-day practice. Presentations were generally followed by a group discussion. Members valued receiving up-to-date clinical and professional information this way (e.g. presentations on hypertension, managing dealing with complaints) and valued presentations on journal articles and educational/training events that members had attended. An important feature of all groups was that members could present cases from their own practice, including significant events or difficult cases, and then discuss how other members would have dealt with them - a form of informal "benchmarking" increasingly recognised as important for areas of practice where there are no evidence based clinical guidelines.

"…mostly we talk about difficulties and about how each other might do things or deal with a case and we come from a number of different PCTs so we'll often use it to look at what other areas do about

certain things. Yeah, sort of…benchmarking about what else goes on" (telephone interview ID 26)

Many participants reported that presentations, handouts and minutes of SDLG meetings were used to provide evidence in appraisals.

"You just keep a record of what meetings you've been to and what, you know, what happened and what your learning actions were and what you've done as a result. It always seems to be commented on favourably at appraisal certainly" (telephone interview ID 36)

Tutors reported that they received feedback from SDLGs through individual appraisals, but that they received no formal feedback since the groups functioned independently and operated confidentially.

Currently we are not seeking feedback as they are independent. However I hear and see reflection and feedback at appraisals of sessional GPs and am impressed by the rigour. (Deanery Survey 25)

Formation and Success of SDLGs

Several participants reported that their group had been set up at the end of their registrar training, either through making contact with others at a similar stage or, more commonly, through existing MRCGP study groups. Some groups started as essentially a social or support group, with a more educational element developing later. Deanery survey results showed that tutors in many areas of the UK helped set up groups by facilitating networking of GPs within the same

area, disseminating information about SDLGs and successful models/guidance, and in some areas facilitating funding via PCTs. Some tutors described an initial involvement in a launch period, facilitating a group for a period of months, then withdrawing support once it was established.

> *At my meetings I ask people who are interested in meeting nearer home and put them in email contact. I offer to attend to help set up group and provide quality assurance if needed.* (Deanery Survey 10)

Following initial set up, several factors were identified that could affect the success and sustainability of groups. Particular aspects of SDLGs that enhanced their ability to provide peer support included their non-hierarchical structure with no designated leader, and informality regarding organisation and decision-making. It was felt that having too large a group would impact negatively on the peer support element and the group's flexibility.

> *"…I quite like the way there's not one person in charge…I think in terms of a sort of mentor and friendship sort of thing, that's kind of…I think it's quite nice…"* (telephone interview ID 27)

Most of the SDLGs had between six and eight members, which the majority of participants considered the optimal size – small enough to foster supportive networking, trust and participation in group discussions, but large enough to maintain momentum and viability even when some members were unable to attend every meeting. All participants stressed the importance of good rapport,

trust and commitment within the group, which had implications for recruitment of new members. Some felt that their group was successful because members were of a similar age and at a similar stage in their career.

> *"I think it's important as well to have people who you do like…that will otherwise deter you from attending. So I think it probably important to have people that you do like and you can have a chat with and you can speak openly with. And that you can trust…I think that if you have trust and commitment within the group then the rest of the learning just happens by the by really"* (telephone interview ID 35)

Members considered it important to have clear expectations and aims, clear ground rules and a structured format to the meetings. Group members valued the autonomy and independence of their SDLGs, thus being able to define their priorities, needs and ways of working. Some groups reported that they would not have more than one person from the same practice in the group, mainly in case this inhibited a discussion about a workplace-based issue.

> *"I don't think you can have a blanket, sort of, 'This is how a group should run and this is what you should do'. I mean it's sort of up to the individuals how their group runs and what works for all of us isn't going to work for somebody else"* (focus group 4)

Several participants spoke of undertaking regular review of their group, either annually or in a more ongoing way, as a factor that contributed to success. This

included reviewing aims/priorities, activities and general functioning e.g. whether ground rules were being respected or needed to be changed; decision making; time management, and the ability of members to participate. Reviews had resulted, for example, in changes to format (e.g. introduction of journal meetings) and to process.

> *"So if we want to change a learning style…no, not really a learning style, but a teaching style we can do that, if we feed back…we have experimented haven't we?"* (focus group 3)

> *"… it [review] can be very structured or it might be not so structured. I just think the main thing is that you have a general time to talk about what people feel is working and what isn't, because we've definitely sort of modified things as we've gone along as a result"* (telephone interview ID 36)

A desire to network with other groups, to evaluate their groups against others and to share ideas was identified by some respondents, for example to promote sustainability.

> *"I think it would be quite nice to be able to share more between groups about how you resolve different challenges like, you know, obviously maintaining attendance is one…"* (focus group 1)

Some commented that having a mentor to attend the group, either regularly or occasionally, would be beneficial to help gain a different perspective on issues.

> *"I suppose another need is sort of like a more experienced GP like a mentoring person would be great…'cause we are all at the same level so we're looking at it from the same point of view. Maybe … they might be able to turn around and say, 'Oh you're not looking at whatever… point of view'"* (telephone interview ID 11)

Results from the deanery survey supported the views of sessional GPs on important features of SDLGs, such as their size. Personal attributes believed to help make SDLGs successful included self awareness, motivation, commitment to the group, willingness to trust and share experience, and a sense of group ownership and responsibility. Organisational attributes thought to contribute to success included having clear ground rules, a set day of the month to meet, planning ahead, review and feedback, and clarity of decision making.

Table 2 summarises factors considered to contribute to success, drawn from data from SDLG members and deanery educators.

Table 2. Factors contributing to the success of SDLGs

Personal attributes	**Organisational attributes**
Rapport and trust	Size (6-8)
Self-awareness and motivation	Similarity of experience (age) or status (sessional) of members
Commitment from members	Geographical proximity
Willingness to share experience	Agreed clear aims and ground rules
	Flexibility to tailor group to members' needs
	Non-hierarchical structure

	Autonomy from external authorities/sense of group ownership
	Set day of the month to meet
	Planning ahead
	Clarity of decision making
	Regular review and feedback

Limitations of SDLGs

Accessing SDLGs

The main barriers to accessing SDLGs identified by non-members were lack of knowledge of SDLGs operating locally, sometimes due to being new to the area, and their geographical location (e.g. living in a rural area or the group being too far away). Both members and non-members of SDLGs commented that a guide to setting up groups would be useful, as would a central database of other sessional GPs in the area to help with communication and recruitment (although some groups preferred to recruit by word of mouth or invitation only). Several group members voiced concerns about people dropping out, moving on or falling attendance, for instance due to maternity leave or wide geographical spread. Deanery tutors also thought that individuals new to an area or newly qualified needed help to find existing groups, without taking away groups' autonomy to recruit. This highlights a potential balance to be struck, between autonomy and formalisation of SDLGs.

Functioning of the group

Difficulties arose in a very small number of SDLGs when there was lack of consensus about frequency or timing of meetings, or when the group was too small to be sustainable and it was difficult to find new members. A

small number commented on issues around agreeing content and finding the right balance between informal interaction and educational content within the allotted meeting time, a balance identified by GP tutors as a key factor in the success of SDLGs.

SDLGs were seen as complementing but not replacing other more formal educational activities such as in-house and external educational activities with peers. However the latter could be missed by locum GPs who were often employed to cover practices while staff attended training courses. Larger, local, sessional GP groups were a further source of educational support, often with external speakers (a model discussed in more detail in the full report[11]).

DISCUSSION

As found elsewhere in relation to participation in continuing medical education and small-group learning,[27,28] this study has confirmed that SDLGs provide important peer support and help reduce isolation, with benefits for morale and wellbeing. They also provided a 'safe' learning environment, adaptable to members' learning needs and styles, in which to keep up-to-date and share ideas and concerns, and to generate evidence for appraisals. Appraisal and revalidation were key drivers motivating some activity in groups, particularly where there were perceived concerns about opportunities to collect evidence (e.g. discussing significant events). Groups helped generate evidence of 'activity' and 'impact' of learning.[29] SDLGs have been identified in the RCGP

revalidation guidance[30] as one model for reducing professional isolation, sharing experiences and learning together. This study has shown ways in which SDLGs may significantly support sessional GPs to successfully engage in educational activity to provide evidence for appraisal and revalidation. Their contribution to wellbeing, morale and education may also contribute indirectly to patient care.

This study has identified important personal and organisational factors which contribute to the success and sustainability of SDLGs. This supports and extends the findings of earlier literature and guidance.[14-16] Self evaluation by the group is key to ensuring not only its survival but its efficacy and topics for review, such as aims and objectives, methods, ground rules, decision-making and time management, have been identified in this study and elsewhere.[14,15]

SDLGs functioned independently with no formal anchor to any organisation. This accounts for the common finding that many groups had no way to tap into the experiences of others' groups and to learn from them, though some expressed a wish for this, whilst still wishing to maintain their autonomy and shared values. SDLGs require no ongoing funding; however often rely on deanery educators, regional sessional GP groups or other local organisations to help facilitate their formation.

There is an important role for tutors to help facilitate the creation of SDLGs through events providing networking opportunities and information. Groups could possibly benefit from being able to learn from each other, whilst maintaining their independence and confidentiality.

We suggest that one possible approach would be for educators to provide a central anchor point for SDLGs to register with, submitting a report of their activities for 'accreditation' (for example, deeming these suitable to be counted as CPD credits for revalidation).[31] In turn this would allow deaneries to aggregate developing expertise of models which are successful and can be disseminated. A risk that may need to be considered, however, is a potential threat to the current autonomy of SDLGs.

Limitations of the study

There is a potential bias in the sample in that participants who volunteered to take part in focus groups and telephone interviews may differ from those who declined or did not respond in the study period. We aimed to target all dedicated educators in each deanery, however there was some difficulty in establishing who held this role in all cases within the timescale of the project.

What is already known in this area:

It is known that many sessional GPs experience isolation, lack of peer support and lack of access to educational and clinical meetings within their practice. It is also known that group-based educational activity for GPs has increased, and that SDLGs differ from other forms of small-group learning in the UK and elsewhere by not using trained facilitators, pre-set modules or financial support.

What this study adds:

There has been guidance on setting up SDLGs and attributes of successful groups have been identified but are extended in this study. The study has also

identified particular benefits of attending an SDLG for peer and educational support, and generation of evidence of “activity” and “impact” of learning, which is particularly relevant as revalidation is introduced for all GPs in the UK in the coming years.

Suggestions for future research:

Future research could:

Explore in greater depth the methods groups use to agree educational agendas, research topics presented, and formats used for discussions.

Examine what impact learning through SDLGs has on individual members’ practice and patient care.

Ethical approval

The study was approved by Durham University School of Medicine and Health Ethics Sub-Committee. The NHS National Research Ethics Service query line advised that NHS ethical approval was not required.

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Conflict of interest

GM and CR have no conflict of interest to disclose. PW is a GP tutor employed by the Northern Deanery. She worked in her educator role to set up local self-directed learning groups and is also the chair of the local sessional GP group.

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