Report on the current state and value of Deanery-managed CPD in primary care

A UKCEA-funded study

Authors:

Dr Rebecca L Baron
Associate Director of Postgraduate General Practice Education
Dr Steven J Agius
Senior Research Fellow in Medical Education

North Western Deanery **NHS**

1st October 2007

Contents

Acknowledgements

Forward

GP CPD is currently under threat. There has been a 20% decline in the number of GP tutors recently. Since the introduction of the GP appraisal system in 2002, UKCEA has observed the variability of the organisation and delivery of CPD across the UK. We therefore commissioned this study under the UKCEA targeted bursary scheme to explore different models of CPD that currently exist across the UK and to seek to make recommendations for the future. Drs Rebecca Baron and Steven Agius' study has uncovered the disparities between various organisations and they highlight the need for PCOs, deaneries and the RCGP faculties to work together at a local level. The benefits of local collaboration are amply demonstrated in the Celtic nations where Appraisal and CPD are inextricably linked and housed together in a single organisation. This leads to a uniform approach to educational needs assessment and delivery of CPD. In England, whilst the PCOs can provide the funding and organise the delivery of appropriate multi-professional education in their patches, the deanery can quality assure the educational development of CPD tutors. The RCGP's role will become even more important as the emerging new plans for licensure and recertification are likely to drive the demand for effective evidence-based CPD.

This report should be widely read, particularly by PCOs, deaneries and colleges, as well as the GP appraisers and CPD tutors. This will generate the debate necessary to inform the GMC and the RCGP of the developments necessary as they formulate their relicensure and recertification procedures. Ultimately, effective Continuous Professional Development of GPs and their teams is the only way to ensure the patients receive the high quality care they deserve.

Dr Jas Bilkhu
Chairman, UKCEA

1. **INTRODUCTION**

The study was commissioned by the UKCEA to identify the current state and value of Deanery-managed Continuous Professional Development (CPD) across the four countries of the UK. CPD was defined by the Chief Medical Officer as:

> *A process of lifelong learning for all individuals and teams which enables professionals to expand and fulfil their potential and which also meets patients' needs and delivers the health and health care priorities of the NHS.[1]*

Over the last few years there have been significant changes which have affected the organisation of CPD. These include the new General Medical Services (GMS) contract with abolition of the previous Postgraduate Education Allowance (PGEA) system and the introduction of General Practitioner (GP) appraisal.[2] Both of these influenced demand for education as well as the role of GP Educators. Planned changes to revalidation are likely to influence this further.

This is set against a background of financial threats to educational support for CPD. Cuts in funding have threatened some of the GP tutor network, and similar cost pressures elsewhere could threaten CPD support. The Crump report (2004) stated that CPD for general practitioners is a principal role of Postgraduate Deaneries in England.[3] The Deaneries themselves are currently working to manage the immediate priority of changes to GP training as part of Modernising Medical Careers.[4]

This study explored the views and experiences of GP educators and appraisers to identify current organisation and good practice. Those questioned were employed by Deaneries and Primary Care Organisations (PCO). Using this information against a background of current literature a range of proposals are described to support the ongoing provision of CPD within the context of changes to revalidation.

A.   Aims and objectives

The *aims* of this study were to:

(i)   investigate the current situation and identify good practice in CPD across the four countries;

(ii)   explore GP educators and appraisers' perceptions and proposals for CPD;

(iii)   explore needs and views of PCO relating to GP development;

(iv)   propose a generic model for CPD that could be adapted to suit different areas. This would involve an understanding of service delivery and patient need.

The *objectives* were to:

(i)   undertake a literature search on the outcomes of CPD for general practice and within multidisciplinary environments;

(ii)   obtain qualitative evidence, using semi-structured interviews, from:

- Deanery CPD and appraisal leads on how CPD is organised in their Deanery and views on how they think CPD should be organised;
- Clinical Governance and Education Leads of PCO on the place of CPD and its quality assurance in appraisal and service development;
- senior colleagues involved in CPD policy-making at a national level.

(iii)   obtain qualitative evidence, using focus groups, from a sample of GP tutors working in a single region;

(iv)   obtain quantitative evidence by developing a questionnaire based on the literature search and qualitative data, for distribution to a national sample of GP educators and appraisers on how CPD is currently organised and views on how they think CPD should be organised;

(v)   analysis of the results and production of a report and publications.

The outcome of the study may help inform plans for revalidation, appraisal and CPD provision. The introduction of Specialist re-certification and a GMC-led CPD board is likely to influence the delivery and needs of CPD.

2. **<u>SUMMARY OF FINDINGS</u>**

This section presents a brief summary of our findings, based on qualitative and quantitative evidence collected from the sample. They are given more detailed consideration in Chapters 5 & 6.

a.   GP Educator role

The loss of GP tutor networks is widely perceived as a retrograde step. A GP/CPD educator is able to facilitate development of education, support of GPs and links with appraisal and revalidation. A post which links across Deaneries, The Royal College of General Practitioners (RCGP) and PCO would improve co-ordination and potentially maximise potential outcomes for development and patient care.

b.   Developing educators

The educator workforce needs to be developed and supported. Deaneries have traditionally been the site for educator development. If they are to continue to do this they will require the resources to do so. If the post-Certificate of Completion of Training (CCT) educators are going to be supported elsewhere, for example by the RCGP, then an appropriate system for their induction, training and employment would need to be developed.

c.   Joint working

Shared working between Deaneries, the college and the PCO would help to ensure that educators are supported, and the provision of education is focused upon the needs of the population identified by the PCO. Shared working will facilitate the developments necessary for appraisal and revalidation.

d.   Co-ordination with plans for revalidation

The new plans for appraisal and revalidation are likely to drive the demand for CPD. The plans for specialist re-certification may have a significant impact on the perceived need of GPs for CPD. This is an opportunity to ensure CPD provision underpins the needs of General Practice as it develops, and actively contributes to patient care.

e.   Provision of education

The development of co-ordinated education for GPs within an area seems to be a valuable approach, and can be a cost effective method for providing high quality education. The ability to recognise different methods of learning and educational delivery will support the educational needs of GPs. Maintaining an appropriate balance will depend on having appropriately trained educators in place.

f.   *Electronic platforms*

A dominant outcome from the study was the importance of e-learning. A priority should be the proactive development of electronic platforms to facilitate web-based learning tools and information portals, as well as e-portfolios. The latter will enable collation of learning logs and other information to underpin the role of educators and support an individual's revalidation. The introduction of e-portfolios in GP training is likely to further drive the need for both electronic learning and collection of evidence.

3.   **LITERATURE REVIEW**

We reviewed literature relating to CPD in primary care, secondary care, allied health professions and other professions. A pertinent selection of the literature reviewed is considered here.

(i)   Cultural determinants of CPD

A dominant theme in the literature related to the requirement for changes in culture and learning behaviour of professionals. The literature is often pragmatic, recognising the need for change that has a neutral effect on budgets and political structures, often based on current systems.

Howard and Valentine[5] propose a new paradigm of educational governance to secure assured, high-quality professional development in primary care. They draw on the work of Knowles, who wrote extensively about self-directed learning, and Davies and Nutley's critical analysis of the concept of learning organisations, in order to elucidate the argument for managed CPD. The authors contend that, whilst evidence exists around the framework and methods to support and quality assure CPD, there remains a crucial need for skilled and organised facilitators which is consistent across the country.

Kennedy[6] proposes a framework for analysing the various models of Continuing Professional Development in the teaching profession. She considers the circumstances in which the various models of CPD might be adopted, and explores the forms of knowledge that can be developed through any particular model. The paper also examines the power relations inherent in the individual models and explores the extent to which CPD is perceived and promoted either as an individual endeavour related to accountability, or as a collaborative endeavour that supports transformative practice.

(ii)   Quality and appraisal

The National Clinical Governance Support Team (NCGST) has developed an advisory framework that identifies quality parameters for NHS medical appraisal. In their study of quality assurance of GP appraisal, Lewis and Evans[7] describe a large-scale GP appraisal system and analyse the quality of that system through internal and external mechanisms. The quality parameters tested map to the NCGST advisory framework and to internally developed quality criteria and attempt to demonstrate how these can be achieved in practice.

Jelly *et al*,[8] in a study conducted within the Northern Deanery, reviewed GP appraisal delivery by primary care trusts in England applying the NCGST QA framework. The background to the work was that GP appraisal had been implemented in a variety of different ways in the UK and quality assurance of these models was now underway – an essential process if appraisal was going to contribute in any robust way towards revalidation. The authors call for research into PCTs' perceptions of how successfully GP appraisal is being delivered compare with views of GP appraisers and appraisees, and

suggest that more formal outcomes of the appraisal process need to be defined and measured.

(iii)   Educational provision

Woods *et al*[9] have explored the experiences and impact of implementing a primary care workforce development strategy on appraisal, PDPs and identification of CPD needs for health professionals in primary care. They found that appraisals were used as the primary mechanism to identify not only the CPD needs of individuals but also to link them strategically to particular roles within the organisation and to the needs of the practice setting.

Following an evaluation of the use of *Professional Development: a guide for general practice*, Curtis *et al*[10] have highlighted the importance of effective facilitation for CPD, supported by greater accessibility through the use of the internet, and inter-practice collaboration to promote best practice.

Lyons, Holmes and Leigh[11] consider the future of general practice CPD educators, providing a brief history of GP tutoring around the United Kingdom, identifying some of the new challenges facing this role and providing some vision of where the role of the tutor in primary care might be going. The authors identify a series of cultural challenges and changes for CPD educators and the organisations that represent and support them. They argue that GP tutors were pivotal in supporting, facilitating and developing the CPD of their professional peers, and that it is imperative that this support and leadership continues.

In a review of the work undertaken by CPD tutors, conducted by Howard[12] in 2006, a series of activities were documented. This suggests the wide-ranging role and responsibilities of CPD tutors in different Deaneries. These activities include direct provision and facilitation of educational activities based on an assessment of learning needs; accreditation of educational activities; the development of personal learning plans for GPs; the development of practice development plans; the development and management of the appraisal system for GPs; an interface with secondary care educationalists and higher education institutions (HEIs); some shared provision and facilitation of educational events for the entire local health economy; development of capacity for foundation teaching in general practice; advice and influence over the organisational culture in PCO; the development and management of workforce development and retention schemes; advice and support in the management of poor performance in practice; and mentoring for GPs and advice about GP recruitment and retention.

Cunningham *et al*[13] have explored practice managers' perceptions of their role, given that they are often tasked with the organisation of practice-based Protected Learning Time (PLT) events for the primary care team. The authors concluded that practice managers need more support from within the team when planning and preparing PLT, and need help overcoming the existing barriers that prevent learning together with the whole team.

Primary care teams and primary care organisations who fund and commission PLT need to work differently if they are to improve practice-based PLT.

(iv)   Work-based learning and the multi-disciplinary team

Jones and Evans[14] have explored health professionals' perceptions of the concept of shared learning and of the belief that shared learning can improve professional relationships in practice. The main finding of their qualitative study is that shared learning events can give health professionals the opportunity to learn about other professionals' roles. Patient-focused, work-based learning within a multi-disciplinary team is the most realistic way of implementing shared interprofessional learning successfully.

In their research into training experiences, educational priorities and career plans for primary care staff, Lemma *et al*[15] found that training experiences of most practice staff were in clinical disease management and CPD related to practice development. Their study suggests that the educational priorities and career plans identified by primary care staff do correspond to the n-GMS contract priorities. They highlight the need to explore the perceptions and attitudes of primary care staff towards the developments in CPD.

(v)   The spectrum of CPD models

De Villiers *et al*,[16] in their study of small group learning for CPD, found that it improved participants' knowledge, clinical skills and patient care. The particular strengths of small group learning in CPD were learning practical skills and the ability to identify and focus on the specific learning needs of participants. Participants valued the ability to deal with one theme in-depth over a number of weeks rather than many topics superficially in didactic lectures.

In their Norwegian study of the feasibility, appreciation and cost of a tailored CPD approach for GPs, Hobma *et al*[17] found that GPs accept and are able to perform a CPD intervention that starts with a needs assessment and that subsequently supports the individual self-directed learning process. Appreciation of and participation in the intervention are dependent on the topic studied.

(vi)   The role of e-learning

Sandars[18] has explored the potential for using web quests to enhance work-based learning. Web quests offer a structured inquiry-oriented learning method that takes advantage of the vast range of information resources that are available on the internet. An important aspect is the development of transferable skills that are required for the effective retrieval and appraisal of information obtained from the internet. The author suggests that the work-based learning potential of web quests can be increased by modifying the original approach to include tasks related to identified learning needs.

Sandars and Langlois[19] have reviewed the literature on online collaborative learning for healthcare CPD, suggesting that, whilst there is increasing interest in it, there is usually low participation. There have also been few studies to guide further development and implementation in the healthcare context. They identify several common themes that are present across the studies, suggesting that there has been a lack of appreciation of the needs of users when these schemes have been introduced. The authors recommend further study of the impact of newer technologies and user-identified factors.

Lacey Bryant and Ringrose[20] have evaluated the Doctors.net.uk model of electronic continuing medical education. They argue that e-learning has the potential to improve accessibility of education, reduce costs and engage greater numbers of participants. E-learning is shown as forming an increasingly large component of continuing professional development for GPs in the UK. Despite the rapid adoption of e-learning for CPD by the medical profession, there remains scepticism about the learning outcomes of e-learning.

Dagley and Berrington[21] have provided evidence of the effectiveness of an electronic portfolio to support general practitioner's personal development planning, appraisal and revalidation. In Jones'[22] evaluation of a professional development course for primary care physicians, it was found that a course on the medical information available on the internet can encourage clinicians to use the internet and help change the manner in which they update themselves. Jones also found that improving accessibility to e-library resources should enable clinicians to make better use of the sources of medical information on the internet.

(vii)   The link between CPD and formal qualifications

Lynch and Gallen[23] have explored the role of higher degrees in general practice and the link to evidence-based education. They found that local initiatives deliver the aims of higher education for GPs from both a personal and an NHS system perspective. Work-based, quality-assured Masters degrees for primary care practitioners, in line with evidence-based educational theory, NHS governance needs and local GP requirements are attainable and effective. Such qualifications should be 'grounded in the wants, needs, culture and changing health climate within which GPs work.'

Mcdonough[24] has studied the accreditation of work-based learning in primary care for an academic qualification. The paper considers the background policy influences on CPD for three professional groups in primary care: general practitioners, nurses and practice managers. The author describes how there is a new emphasis on work-based learning in CPD and how work-based learning may be accredited through an academic qualification.

Riain and O'Riordan[25] describe the integration of small-scale practice-based quality improvement projects into a diploma course for general practitioners. The success of the projects is seen as being grounded in the opportunity that participants had to individualise the application of knowledge gained on the course.

Pitts *et al*,[26] in their evaluation of higher professional education courses for GP non-principals, demonstrate a high degree of satisfaction with such courses, with participants feeling well supported and valued as professionals. The evidence suggests that working with others in this way facilitated effective learning based around practical, current and real issues.

Baron *et al*[27] have explored the impact on effectiveness, retention and recruitment to additional roles of Master's degree-accredited professional education and development courses for GPs. They found that, after attending MSc accredited development courses, GPs clearly expressed their intention to retire later. Many participants have extended their role to become educators, appraisers, GPwSI and also become involved in PCO work. Participants also demonstrated a high rate of progression to further academic modules.

3.   **METHODS**

The study involved multi-strategy research in order to obtain a rich data set that could be triangulated to corroborate findings. A mixed qualitative and quantitative methodology was adopted.

A.   Data Collection:

We used semi-structured telephone interviews and focus groups designed to explore the overarching research question, i.e. what is the current state and value of Deanery-managed CPD in primary care? The semi-structured telephone interviews, each lasting approximately 20 minutes, were conducted (number in brackets) with:

(i)   Deanery CPD and appraisal leads, who were asked how CPD is organised in their Deanery and views on how they think CPD should be organised (15);

(ii)   Clinical Governance and Education Leads of PCO, who were asked about the place of CPD and its quality assurance in appraisal and service development (2);

(iii)   senior colleagues involved with CPD policy-making at a national level (2).

Two focus groups were conducted with a sample of GP tutors working in a single region. Each focus group comprised six participants.

Semi-structured interviews and focus groups were conducted using a schedule of questions. A typical schedule contained the following items:

1.	What is your involvement in CPD activity?
2.	How is CPD managed?
3.	What has worked best?
4.	What are the problems?
5.	Are there any examples of CPD activities that are measurable?
6.	Do you collect any evidence/compile reports on CPD activity? If yes, please describe.
7.	What is the Deanery's role in quality assuring the PCO process of appraising GPs?
8.	How *should* CPD be managed? *to include*:
	• Financial implications of the way CPD is managed;
	• CPD links with appraisal, assessment and revalidation;
	• CPD links with other Primary Care Organisations
9.	Any other comments about CPD?

Each interview and focus group was tape-recorded, and the recordings transcribed and anonymised prior to analysis, which was done with the aid of a qualitative data software package (NVivo). The co-author (SA) recorded reflexive field notes during and immediately after each interview and focus group to further inform qualitative analysis.

Qualitative data were used in conjunction with evidence from the literature review on CPD to inform the development of a self-completion questionnaire. The questionnaire comprised fourteen 5-point Likert scale items, where 1=Strongly Disgree and 5=Stongly Agree. The questionnaire was piloted on a small set of respondents who were comparable to members of the population from which the sample for the full study would be taken. Respondents were also asked to comment separately on the form and content of the instrument. The questionnaire was subsequently modified to take account of respondent feedback before being finalised for distribution to the main study sample. Respondents were asked to state whether they agreed or disagreed with each of the items (listed below):

1. CPD for GPs has improved in the past four years.
2. The quality of CPD provision is generally high.
3. The learning needs identified from appraisal are used in the planning of CPD.
4. My practice has a co-ordinated approach to the development needs of the whole Primary Care team.
5. It is easy to obtain information about CPD activities in my locale.
6. The internet is a useful resource for CPD.
7. Practice-based activities have made an important contribution to CPD.
8. The local faculty of the RCGP provides a significant amount of CPD in my area.
9. Additional CPD provision is required in my area.
10. A GP tutor network enables cost-effective CPD provision.
11. My Primary Care Organisation has contributed to the effective delivery of CPD in Primary Care.
12. The Deanery has contributed to the effective delivery of CPD in Primary Care.
13. CPD has a positive impact on patient care.
14. A managed system of CPD will help to deliver future NHS imperatives.

The questionnaire was made available electronically to 180 GP appraisers, appraisal coordinators and appraisal leads across the UK using the database held by the NHS Clinical Governance Support Team (CGST). For data protection reasons, the research team could not access the database directly, so the CGST circulated the questionnaire and supporting information electronically via its website and electronic newsletter on our behalf.

An attempt was also made to circulate the questionnaire via another electronic route to GP educators but this proved problematic for technical reasons and was abandoned. This was an acceptable decision for the research team given the size of the sample already made accessible to us via the CGST.

B.   Data Analysis:

With the assistance of qualitative data analysis software (NVivo), the transcripts from interviews and focus groups were analysed for recurring discourses and themes, or patterned ways of articulating experiences and points of view and conveying meaning, as well as contradictions in the ways that the participants discussed these issues. The research team acted as co-analysts, and a coding framework was devised as a result of their deliberations. This construction of codes was done by the co-analysts working independently, and deliberating together on interpretations until agreement was reached. Following this initial coding, the analysis developed concepts linking a number of these codes, which in turn were grouped into categories. The quality of the findings is highly dependent on the rigour of the data collection and subsequent analysis and interpretation. We attempted to minimise these limitations by using established techniques to ensure credibility, transferability, dependability and confirmability.[28]

Quantitative data derived from responses to the questionnaire were coded with reference to the variables that were being measured by the research instrument. The data were entered into a statistical package (SPSS) which allowed the data to be manipulated, and permitted identification of statistical relationships.

C.   Ethical approval

Full ethical approval was obtained for the study, through the National Research Ethics Service, from the Eastern Multi- Centre Research Ethics Committee (Ref: 06/MRE05/63).

5.   RESULTS

A.   Results from the qualitative data

We conducted:

- 15 interviews with senior representatives of Postgraduate Deaneries, drawn from the four countries of the UK. Each interviewee was closely involved in the management of CPD in primary care within their Deanery;
- 2 interviews with Clinical Governance and Education Leads within Primary Care Organisations;
- 2 interviews with representatives of key national bodies (the RGCP and the GMC) involved in policy-making for CPD; and
- 2 focus groups of GP tutors and other CPD educators currently employed by the North Western Deanery.

The interview and focus group transcripts were systematically analysed for recurrent themes and discourses. As a consequence of this process, we identified five major themes in the data, each of which will be presented in this section. The themes were (i) Infrastructure, (ii) Function, (iii) Diversity, (iv) Quality, and (v) Funding. These results are drawn from the interviews and focus groups, and therefore reflect the collective beliefs of the individuals who constituted our sample.

(i)   **Infrastructure**

a.   **Varying degrees of centralisation across UK**

We identified multiple models of CPD management across the UK Deaneries. These ranged from the highly centralised model, with CPD and appraisal being managed in-house, to the de-centralised model where a Deanery had minimal knowledge of, and impact on, CPD. Scotland, Wales and Northern Ireland tended towards the centralised model. Whilst considerable variety existed within the English Deaneries, the majority occupied the middle ground, with strategic oversight provided by an Associate Dean/Director, assisted by a team of GP tutors who had an operational, and increasingly strategic, role in their own locale.

Scotland

Scotland had a strategic national CPD group which agreed and wrote strategy across primary care for Scottish GPs, as well as organising large-scale educational conferences. Individual Deaneries often had an Associate Dean with responsibility for CPD development in their region, such as practice-based learning, mentoring, needs assessment and the actual programming of protected learning activity. Some Deaneries operated additional programmes, outwith protected learning time, such as day courses

which were locally organised in response to local needs. There were generally good links with appraisers to ensure that CPD activity was informed by the appraisal process.

All of the Deaneries in Scotland ran their own CPD programmes for GP and primary care. The content of these half-day courses was often generated from the needs identified through the appraisal process.

Wales

In Wales there were twenty-two CPD co-ordinators, one for each local health board, who concentrated on local and regional delivery of CPD events. They also supported the process of appraisal, which was a function of the Deanery, and the formulation of a core curriculum based on the amalgamated needs of individual GP's appraisal folders and PDPs. Their work was overseen by an Associate Dean with strategic responsibility for CPD.

The appraisal department was housed within the Deanery, which was seen as enabling the full learning cycle to be managed in one place. There was a computerised database, from which could be obtained the anonymised needs declared in GP's PDPs which formed the basis of CPD provision. There was a budget for twelve large CPD events every year, at which the average attendance was 40-60. There was also organised dissemination of CPD material via the Deanery website, so that course organisers could use and adapt 'off-the-peg' educational material. The Welsh Deanery operated its own internal and external quality assurance mechanisms for the appraisal process.

Northern Ireland

In Northern Ireland, a membership programme called Athena, for which members paid a fee, provided Deanery-managed educational events and services. The programme was loosely based on the model originally set up in Scotland, and was run by a network of tutors employed by the Deanery and overseen by an Associate Dean. Approximately a third of GPs in the province were members of the programme, and other non-members used the service as well. Within the Deanery (officially an Agency) was an educational consortium made up of representatives of all providers of CPD (including the RCGP, health boards, health promotion agency, pharmaceutical industry, university and others) which was tasked with making sure that CPD provision matched needs. Such needs were identified from the results of appraisal, which was managed from within the Deanery, as well as from national initiatives, requests from individual members and the results of course/event evaluations. Tutors then collectively decided what the priorities were and set about designing courses to match those. The Health Boards had a contract with the Agency to run the appraisal process. The Agency selected, recruited and trained the appraisers, and managed the process.

England

We found considerable variance across the English Deaneries in the way in which CPD was managed, particularly in comparison to the rest of the UK. There were, for example, a couple of examples of greatly decreased support for Deanery-managed CPD in recent times, which was seen as a retrograde step:

> *You almost certainly do need a central regional lead for CPD. I really do miss not having the Deanery support anymore. You have nobody else to share ideas with. Now that support has disappeared, it makes it very difficult.*

Many interviewees expressed a wish to develop a more strategic approach to CPD across the English Deaneries, as happened in the other 3 UK countries. A number of interviewees expressed the view that there was too much diversity and variety amongst English Deaneries to enable an effective national re-validation scheme to be established. It was suggested that there should be much greater cohesion, with a rational model such as that which existed, for example, in Scotland.

b.   Importance of GP tutor (or equivalent) network

The importance of the multiplicity of roles held by GP tutors was emphasised in many Deaneries, including appraisal, one-to-one teaching, mentoring, and retainer group activity. The role of the GP tutor had changed in many Deaneries from course provider to educationalist, with an increasingly strategic focus. Duties included providing advice about the process of education, and facilitating education in group form, particularly at practice level. There was a perception that the GP tutor role was changing to become more assessment-oriented.

Whilst the role of GP tutors (or equivalent) appeared to be established and relatively assured in 3 UK countries, we identified continuing uncertainty about the GP tutor role in the English Deaneries:

> *I would hate to lose the expertise of the GP Tutor network. Now, I don't really mind who owns and supports that network because it is always going to be the same bunch of people anyway, but having an organisation, be it Deanery, College or some other configuration…that actually values education is important.*

In some Deaneries, the GP tutors had a considerable degree of autonomy in managing CPD within their 'patch', although there appeared to be a general consensus that some form of structured co-ordination by the Deanery made their work more effective. The tutors were normally supported by an Associate Postgraduate Dean/GP Director. The importance of having such a regional lead person for CPD was repeatedly emphasised.

> *A critically important point is having a professional CPD tutor workforce who are both trained and supported by an organisation that has educational expertise.*

In most English Deaneries, the network of GP tutors was roughly aligned with that of PCTs, and the tutors undertook joint objective setting between themselves, the Deanery and the PCT. The Welsh Deanery had a network of CPD co-ordinators, one for each local health board. These individuals concentrated on local and regional delivery of CPD events. There had been problems with recruitment to vacant co-ordinator posts. The co-ordinators also supported the process of appraisal, which was an integral function of the Deanery, drawing upon the core curriculum and amalgamated needs arising from individual GP's appraisal folders and PDPs.

Where Deaneries could no longer support a tutor network, attempts had been made to develop CPD activity through the local faculty of the RCGP, but there remained a considerable sense of loss in terms of organisational memory and expertise:

> *I am very regretful that we no longer have a network that is able to coordinate [CPD], to respond both to national and regional initiatives within individual patches but also to take up and facilitate the provision for learning in their localities.*

c.   Differing levels of engagement by PCO

In the English Deaneries we found considerable variation in the level of support for CPD within PCTs. While most PCTs valued CPD in principle, this was not always accompanied by pro-active engagement or financial support.

> *I work with five different PCTs; two or three of them are obviously trying to put resource into CPD, trying to develop it, and a couple of them don't seem to be doing very much, frankly, they don't seem to see it as a priority.*

The re-organisation of PCTs compounded existing difficulties. Some PCTs were very supportive, and funded weekly sessions for tutors to cover PDP-related duties as well as locum costs for protected learning time.

> *The limit of it is that we have a network of GP tutors who are aligned with PCTs and we have moved to a situation whereby they undertake joint objective settings, between themselves, the Deanery and the PCT. So our involvement with CPD is through the GP tutors and their involvement is at the level with the PCT. Some PCTs have quite intense involvement with CPD, under protective learning initiatives, and some don't. It varies from place to place.*

Some PCO paid for cover for the monthly half-day of protected learning time, which was covered by the 'out of hours' service, enabling GPs to leave their surgeries and attend the education sessions.

> *The appraisal outcomes that are generated from the appraisal interviews go to the PCTs and the GP Tutors are informed or are involved in discussing with the PCTs what they do about the educational needs of the doctors in their patch.*

d.   Increasing use of IT as a management tool

We were informed of a number of web-based resources for CPD, which were viewed very positively. Some of these had been set up by dedicated individuals, others within central Deanery structures, to advertise relevant educational activities within a region and to provide a virtual support network for CPD. An example in England was www.CPDforum.org.uk which was interactive and enabled GPs to communicate electronically with their GP tutors, to provide information about their own personal learning needs which could be used to form the basis of CPD programmes.

Similarly, national web resources existed such as that for the Athena programme in Northern Ireland www.nimdta.gov.uk/general-practice/professional-development and the National Education Scotland site www.nes.scot.nhs.uk   These were seen as effective portals to disseminate and access information about CPD and the appraisal process.

e.   Belief that CPD should be embedded into a formal governance structure.

There was a general view that CPD should be embedded into a formal governance structure, with strong links into the local health networks. CPD would need to be supported in turn by an organisation which placed significant value upon it.

> *In the wake of the Donaldson report, there is need for clarification on the governance of CPD and appraisal, particularly the Deanery v. Royal College role. What is needed is a single body to take control of CPD and determine policy.*

It was recognised that this need not necessarily be the Deanery – it could be the Strategic Health Authority, the RCGP or some other organisation, as long as it pro-actively supported education.

> *CPD should also be embedded into a formal governance structure, with strong links into the local health network. Where Deaneries have got rid of their tutor network, this has resulted in a loss of organisational memory, and the loss of the network that supports CPD.   Ideally, CPD should be established as part of the SHA role – it should sit within the SHA, with tutors directly appointed by that body.*

It was suggested that tutors felt more valued and supported when working as part of a wider educational community, rather than a management community.

(ii) **Function**

a.   Individual development

There was universal agreement within the sample about the critical function of CPD in ensuring successful and effective practice as an individual GP.

We identified a perception surrounding the gap between what a GP wants to do in terms of CPD and what they ought to do; a gap between what individuals identify as their learning needs and what national bodies think the learning needs might be. The importance of securing appropriate access to CPD for sessional, part-time or locum GPs was also highlighted.

b.   Practice development

We identified a widespread belief in the positive benefits of ensuring that personal and practice development plans are symbiotic. Great care should be taken by all concerned to ensure that one informs the other, and vice versa.

> *I think the bit that we are missing from all of this now is the practice development plan because at the moment, unfortunately, I think appraisal is far too confidential and far too closed within practices and it would be much better if it was opened up and then common learning needs were identified and well woven into practice professional development plans.*

Some Deaneries had developed a system whereby the GP tutors, often working with their Clinical Governance lead, encouraged practices to have a whole *practice* development plan as well as individual PDPs. Whilst the principle of whole practice CPD was supported, the importance of challenging doctors must continue to be done credibly, and this required a lot of medical content specific information.

> *Another arm of CPD activity is the development of peer appraisal done in groups. That is led by the GP Tutor working closely with the clinical governance lead, encouraging practices to do group appraisals rather than individual appraisals, and mapping those activities to a practice-based plan rather than just a few doctors' individual personal development plans.*

The importance of recognising the effectiveness of uni-professional education, and the need to maintain a balance of activity (multi- and uni-professional) within CPD programmes was highlighted on numerous occasions.

> *Developing primary care education in its broader sense, rather than just thinking about doctors, has been laudable…although with the development of the relatively new and much overdue GP curriculum, if one wants to challenge doctors you do need quite a lot of content-specific information and understanding in order to do that credibly.*

c.   Responsive to appraisal outcomes

In Wales, the appraisal department was housed within the Deanery. A computerised database was maintained from which access to the anonymised needs declared in GPs' PDPs was possible. This information formed the basis of the Deanery's CPD provision. The Deanery had an on-line system for GPs to book their appraisal and access an electronic version of their appraisal folder.

English Deaneries had been heavily involved in developing portfolio learning and Personal Development Plans (PDPs), with GP tutors providing formative feedback to those doctors who had elected to participate. This process directed their CPD activity and was seen as a strong foundation upon which to build the appraisal process In many Deaneries, there was a general view that the majority of GPs valued the formative routes that appraisal was taking: being self-directed, with guidance and support available from the tutors, in the reflective cycle.

In the English Deaneries, outcomes generated from individual appraisals were normally fed into the PCTs, and GP tutors were involved in discussing with PCTs the educational needs of the doctors in their patch. As already documented in these results, the level of response from PCO varied considerably. There were some reports of private organisations and consultancies being brought in by PCO to develop the appraisal process. There was a fairly widespread belief that appraisal and the revalidation process would inevitably make CPD more prescriptive.

> *One of the problems with the appraisal process, although it is well organised and so on, is that if people decide that their learning needs are very limited, there isn't anything that imposes any sanctions on them. At present, people can choose to do that, so it could be that people are not actually taking up the opportunities that they should, and there can be a gap between what people identify as their learning needs and what nationally we would think the learning needs might be. I think in time that may be addressed because the appraisal process is likely to become more performance managed than it is at the moment.*

d.   Facilitates professional networks

We identified concerns about isolation, with many GPs finding it difficult to attend regional or national educational events. A solid programme of local events made this much less likely to occur. Isolation, particularly for newly qualified GPs, was also lessened by the fact that regular and accessible CPD events enabled networking and social interaction with colleagues.

e.   Dealing with underperformance

The critical role of dealing with underperforming doctors, who often required tailored professional development support, was cited on a number of occasions. Deanery

structures were widely perceived to be the most appropriate for dealing with the retraining of people who were underperforming.

> *The remedial retraining of people who fail revalidation (or are otherwise underperforming in some way) sits best within the Deanery (this is helpful for indemnity reasons too).*

(iii) **Diversity**

a. **Value of wide range of CPD activities**

We identified a wide range of activities, including practice-based education; consultant/GP master class, weekly sessions, monthly 'protected learning time' meetings, large regional meetings, informal networks, and development of peer appraisal (done in groups).

> *There needs to be a mix of provision to match individual differing learning needs, and indeed the differing modalities that subjects can require.*

A wide variety of topics was covered at monthly/regional meetings which were usually selected by the GP tutors, and included outside speakers. These sessions tended to include a mixture of lectures, plenary sessions and small group work. Attendance at such sessions varied, but was often in the region of 200, predominantly GPs, with some Registrars, and Practice Nurses. The Northern Ireland Deanery ran a membership programme for which members paid a fee and in return received educational events and services. These were mostly course-based, although opportunities to take advantage of small group learning, mentoring and Myers-Briggs training had been provided.

We found numerous examples of Deaneries and PCO providing activities in the form of large-scale education meetings, held once a month with cover provided for on call so that a large number of GPs and members of the wider primary care team could attend. Monthly sessions were normally devoted to a particular clinical topic, and explored through multiple formats typically involving a short lecture, followed by small group work, and ending with a plenary session. Weekly lunchtime sessions tended to follow a more traditional didactic route because of time limitations, although interactive discussion was encouraged wherever possible.

We found evidence of the perceived importance of informal CPD activity, including academic/vocational professional conversations between colleagues, which should be recognised, perhaps through an accreditation system.

> *It's really important that, whatever we do, we don't stop the activity that is out there, the conversation that goes on in the locally organised breakfast club or that sort of thing because…there are absolutely no reasons why sensible academic/vocational professional conversations shouldn't be accreditable.*

b.   Importance of local programmes

We identified a great deal of support for local educational events, where GPs and consultants could meet and form professional links and networks in order to improve their practice. Indeed, the importance of an effective local programme for CPD was emphasised repeatedly.

> *My concern is that a lot of GPs who work very hard can't get away, can't get a locum and just end up working in isolation. That is one of the reasons why I do the work because you really do need to have education nearby that they can get to.*

Integration of CPD provision was generally seen as a positive thing. Unless all courses and activities were advertised through a central portal, however, it could be difficult to capture all the potential CPD that was available. The provision of specialised courses was normally non-local and necessitated extensive time and travel, which could be problematic given service obligations.

> *For the protected learning time we usually get 120 or so GPs, maybe another 20 of the Registrars and the rest will be made up of Practice Nurses so we get a fairly good turnout. With the lunchtime meetings it probably varies between 60 and 80 attendees and they would predominantly be GPs and Registrars.*

c.   Effectiveness of whole team-based activities

Team learning in practice was viewed as a priority during protected learning time in a number of PCO.

> *Practice-based learning can work extremely well, especially in larger practices, with weekly multi-professional meetings drawing on consultant input, and practice development plans. . This absolutely fits with adult learning because it is immediately important for the people who are there and they have control over the learning agenda.*

The importance of developing multi-professional CPD was emphasised on numerous occasions across the sample.

> *I think the other thing that needs to be done, which again has been variable across the Deanery, is multi-disciplinary education. Most practices need to learn together in the multi-disciplinary way, rather than just doctors or nurses learning separately. Obviously you do need some unidisciplinary education, but most education should be built on practice-based events.*

d.   Largely driven by appraisal/PDP outcomes (collated & synthesised by GP tutors)

CPD meetings were perceived as having become increasingly needs-based in recent years, devised by GP tutors in response to data from PDPs. This was generally viewed as fitting with the principles of adult learning. The content of learning sessions was immediately important for the people who were attending, so they had control over the learning agenda.

We found that the content of CPD events was often based on outcomes of appraisal sessions and PDPs. Topics were normally set by GP tutors in their patch, or by a collective of tutors and/or an Associate Dean/Director in the larger regional events. We found examples of open forums, sometimes with panels of experts, where attendees could ask questions and raise issues often arising from their recent experiences in surgery. Sessions could be based on particularly topical issues in the media, or areas which were contractually required. However, we did encounter a degree of resistance to the idea that synthesised appraisal outcomes alone were sufficient to dictate the content of a CPD programme.

> *The idea that you can simply add up all the learning needs that are identified through the 300 GP's appraisals and come up with a programme which meets people's needs is just bonkers, it just doesn't work like that. I think that it needs to be rather more sensitive than thinking you can simply compute learning needs and then put on a programme.*

e.   Support for strategic approach to provision

We found evidence of a wish within the English Deaneries to see a more strategic national approach to the provision and management of CPD. The positive impact of well-managed CPD provision within a Deanery, and its close relation to the appraisal process, was emphasised on numerous occasion:

> *The Deanery has introduced all different forms of practice-based education: small group education within the practice, significant event analysis, enabling PDPs. All this has pre-empted appraisals, so GPs who have engaged with these activities found themselves much more prepared for the appraisal system when it came in than those who haven't.*

Some GP tutors voiced concerns about Deaneries only being performance managed on vocational training and the negative impact this could have on CPD provision.

> *There are no performance measures on providing postgraduate education to qualified GPs, so even if I run a thriving education set up it doesn't count for anything when the Deanery's performance managed.*

We also found evidence in Scotland for a wish to move towards a more coherent and integrated system across the individual Deaneries.

> *We are trying to be responsive to needs but obviously it is not a completely comprehensive programme. We would benefit from an integrated national system where people who identify needs can key them in and find various providers. There is still more work to be done to improve linkages between appraisal and provision.*

A similar view was also encountered in Northern Ireland.

> *I think collaboration is the way forward – to work with as many agencies as possible to avoid the piecemeal situation there has been in the past; to be a bit more coherent. We have to think about the whole primary care scene, and I think we should be part of that in some collaborative form, and I think it should probably be funded partly by the participants in the process centrally. The gains to the patients in the country are glued into that as well.*

f. Varying use of RCGP curriculum.

We found that only a limited number of Deaneries were currently mapping the RCGP curriculum onto local CPD provision, providing their GP tutors with a structured modus operandi.

> *I think the problem with curriculum-based activities, or using the same materials across the country, so trying to standardise CPD, is that you lose an essence of local delivery and what the local punters actually want and need. So I don't think that there is a 'one size fits all' example. I do think, however, that there is scope for materials to be produced by some form of central body, possibly the college that is available for local tutors to use in a way that they want to.*

Much more focus was given to CPD provision that had been determined on a local basis by GP tutors, based on the wants and needs of colleagues. This focus also secured higher attendance rates at educational events.

> *What is best attended would be the kind of activity that is around new developments and things that are going to have a very practical application on the ground…focused activities which have been identified locally as being required.*

(iv) **Quality**

a. **Examples of 'kite-marking' for CPD provision**

We found evidence that, following the demise of PGEA there were concerns about the absence of certification processes for quality assuring GP courses and providers. A number of Deaneries had therefore established systems to counteract this problem and provided a certification process, or 'kite mark' system for educationally approved courses.

> *In this Deanery we put together a voluntary code of education accreditation, which we called QACPD. Organisers can apply for accreditation on-line, which is then sent to our GP tutors for grading out of ten. If successful, the organisers receive a certificate of accreditation, and their educational course or event is included on our website.*

Some Deaneries had set quality indicators for each course registered with them, and courses were regularly checked (through participant feedback) to make sure they were delivering. In some areas we found pre-course needs assessments being sent to GPs registered to attend a course, which were sent to course organisers to modify course content accordingly to make it fit for purpose. Reasons behind certification included reducing the possibility of conflicting interests arising from course sponsorship and ensuring credibility of educational provision.

> *We have had a feeling I think since the absence of PGEA that there is a lack of any sort of certification process for quality assuring GP courses or attendances at GP course. So now, we have finalised a system which we have agreed throughout our patch of quality assuring courses and providing them with a logo, a kite mark which we rubber stamp the courses with.*

With the onset of appraisal as the main vehicle for developing PDPs, some Deaneries no longer maintained quality assurance or accreditation systems for CPD.

b. **Centralised models appear to have more developed QA procedures**

The Scottish Deaneries largely had QA processes which included the registration of courses, each of which had to meet set quality indicators. Any aspect of a course that did not come up to standard was communicated to the organiser for revision.

> *We send pre-course needs assessments to people who are planning to come on the course. Afterwards, they are expected to reflect and see whether they have met the objectives that they originally intended. All that information is collated in the Deanery, sent to the course organiser, and sent back to the person who attends the course. There is a collated evaluation as well, plus the certificate of attendance, so it is quite an extensive system.*

Information on evaluation was made publicly available on the NES website, and was considered by the Deaneries' strategic planning committees.

The majority of English Deaneries had some form of reporting mechanism on the activities of their GP tutor network, in part to demonstrate accountability.

> *We have been working on producing some standardised way of reporting GP tutor activity. There was perhaps a feeling that, because GP tutors were functioning autonomously, it was sometimes quite difficult to be able to demonstrate in an accountable way as to what they do, so we produced a standardised report to our Deanery on GP tutor activity.*

The majority of the sample were aware of GP tutor 'patches' in their Deaneries with some systems in place for quality assuring CPD itself.

> *They collect evidence every meeting. They get them to fill in an evaluation form which gives a rough idea whether they think it was good or bad, useful or not and whether they would like a follow-up session.*

Whilst some English Deaneries shared information with PCTs on, for example, appraiser/appraisee matching, contracts and standards, most Deaneries did not have well developed systems for quality assuring the PCT-led appraisal process. The various PCTs within a Deanery's boundaries usually had different stances and levels of engagement, which had to be accommodated.

Deaneries varied considerably in their methods of collecting data on CPD and GP tutor activity. Some had developed a standardised way of reporting. In many Deaneries, educational events were routinely evaluated through the use of participant feedback forms, but not ever Deanery pulled these data together into an annual report, often because those responsible felt that it was not worth the effort. Some Deaneries had actively chosen not to monitor educational events because the process could not take account of the often very different learning requirements of individual GPs.

c. **Over-emphasis on measuring outcomes may lead to short-term view and reductive approach to education**

We identified concerns about having to justify education in terms of patient outcomes which, although laudable in principle, tended to emphasise short-term measures. This was seen as impeding development of effective learning organisations. Insistence on tangible outcomes and proof of educational benefit had a tendency to lead to a reductive approach to education – the mechanical delivery of mandatory courses.

> *We are having to justify money, justify education in terms of patient outcomes, and while I think that is a good thing, the emphasis on short-term measures has stopped any of our real learning organisation development.*

We also found evidence within the sample of a wish to re-evaluate the function and purpose of CPD, and how it might best be evaluated.

> *I think this is an opportunity to go back to grass roots and define the appropriate elements of CPD, then deciding the appropriate standards in relation to them.*

Measuring outcomes of CPD was widely perceived to be very difficult in practice. The difficulty of measuring learning was seen as one of the reasons why the appraisal model had been adopted. More robust systems of understanding professionals' learning were required.

> *The Deanery does not monitor or measure educational events for a definite reason, which is that such a process cannot take account of the often very differing learning requirements of disparate GPs.*

d.   Concerns about consistency of quality of appraisal.

Unlike the Welsh Deanery, which operated its appraisal system in-house, and quality controlled 20% of appraisal folders and appraisal discussions, a number of English Deaneries in particular were concerned that the PCT responsibilities for appraisal and CPD were not being adequately fulfilled.

> *There has been virtually nothing happening between the PCTs and appraisal for the last twelve months.*

In some Deaneries, the GP tutors informed local appraiser groups and supported the development of appraiser activity, including CPD appraiser training and performance.

> *The evidence that I saw was that a local tutor was able to co-ordinate, through the soft information as well as perhaps the hard information that appraisal might give, an appropriate learning programme for GPs.*

We found that GP tutors were often perceived as the most appropriate people to 'step in' and support the appraisal process, even though this was often formally outside a Deanery's remit.

> *We have local appraiser groups which have been developed throughout the Deanery and are informed by GP tutors who work under my supervision. Those tutors support the development of appraiser activity and particularly appraiser CPD training and performance.*

Not every interviewee was confident that appraisal was being done in the most skilful way, and we found evidence that there is room for the profession to improve this process. It was believed to be important to ensure that CPD and the appraisal process challenged the high flyers and engaged those colleagues who were perceived as simply going

through the motions and doing a minimum amount to keep their skills and knowledge up-to-date.

> *I think one of the difficulties we have always had is measuring learning and that is why the appraisal model has been adopted and I think that is entirely sensible but my own view is that appraisal cannot measure all the learning activity that the GP undertakes and I think we need to develop more robust systems of understanding professionals learning. We need to see some demonstration of learning and hopefully behavioural change to enable the re-certification to take place.*

Some Deaneries had been particularly pro-active in the quality assurance of appraisal, but even in these instances there was a great deal of uncertainty, as well as recognition of the need for further work.

> *We have undertaken quality assurance for all the PCTs in our patch on an assisted self-assessment basis...but even so we still have a situation where we don't have consistency across the Deanery, in terms of the way that appraisal is implemented and quality assured.*

(v)   **Funding**

a.   **Detrimental impact of reduced funding**

Deaneries appear to have tried wherever possible to maintain funding for GP tutor networks, particularly because of the need to utilise existing structures and expertise in expectation of the requirements of revalidation. All the Deaneries were loath to lose the expertise of their GP tutor network which was seen as vital to the effective support of education and CPD for independent practitioners. Where Deaneries had lost their tutor network, this had resulted in a loss of organisational memory and the loss of the network that supports CPD, which could be detrimental to the effectiveness of implementing recertification.

> *There is extreme uncertainty about the future of GP tutors; a lot of other Deaneries have already made their tutors redundant. We've resisted that line because we think there is still a valuable role for Deanery-supported educators being involved in CPD.*

Funding constraints within PCTs had also had a negative impact on the provision of CPD activity in some areas.

> *Organised educational activities are not as widely supported across PCTs as they used to be, because of financial constraints.*

In Scotland, there was also a desire to see greater financial commitment to the provision of high-calibre CPD.

Increased investment for CPD would enable provision of a better quality, more extensive range of programmes. If appraisal becomes more of a performance-managed process, we may find we are struggling to meet that demand, so it could be something that is going to need further investment in the future.

b.   Effectiveness of PCO/Deanery split-funding for tutors

Tutors with responsibility for CPD were often part-funded by the Deanery and part-funded by their PCO. We found evidence that this can work well because the Deanery provides the educational support and quality assurance, whilst the PCO enables an attainable localised approach to delivery.

CPD is organised through CPD tutors who are part-funded by a Primary Care Trust and part-funded by the Deanery, so people doing the job can have a pragmatic local level approach to delivery but also have the educational support and quality assurance from the denary.

The sample was generally positive about the need to work more closely with PCO in enabling effectively-managed CPD and appraisal.

Politically we have acknowledged that the tutors in the future will need to be much closer to Primary Care Trusts because they have all the responsibility for CPD, appraisal and re-accreditation. Our tutors have always said to us, however, that they value being part of the Deanery and having Deanery support for their role, so funds it and exactly how it will work, I'm not sure, but we'd like to keep some sort of support for them.

We also found evidence of the perceived importance of maintaining a strong Deanery role in the management of CPD activity, so as to ensure a robust educational framework.

I would be concerned if tutors were just in the pay of PCTs because there isn't a guarantee that their professional development would be understood or supported. In terms of management, subsidiarity is good. Trying to devolve the implementation of assessment to the lowest level that is commensurate with credibility is good, but with overarching structures like Deaneries, or the College, setting the broad framework within which those things operate.

c.   Evident belief in degree of individual responsibility for CPD funding (e.g. 'Education Trusts')

Some interviewees believed that CPD provision for doctors was generally very reasonable given what many other professions had to pay. There was a general consensus that GPs should be willing to contribute more financially to their own CPD.

We tend not to charge people apart from the expensive courses such as the minor surgery course or child health surveillance course and we do actually charge for those, the rest of the education that we provide, we tend to provide for free and…the GPs obviously appreciate that, we do however with our core events ask for a refundable deposit, so that if they don't turn up they pay.

In a small number of English Deaneries we found evidence of the establishment of Education Trusts, where local GPs contributed to financing postgraduate education in a non-profit making way, with reciprocity between the Trusts in a single Deanery to allow for increased access to educational provision.

Non-attendance at educational events was apparent in many Deaneries across the UK, with failure to attend courses by individual GPs who had booked a place being a widespread and recurrent issue.

Non-attenders are a recurring problem, People who book courses and don't show.

In some instances, Deaneries had started to charge people in advance for a course, and would refund or part-refund the fee if and when the individual GP attended. Some interviewees emphasised the corporate responsibility of the NHS to provide some CPD. Many CPD events were currently still dependant upon funding from pharmaceutical companies.

I suppose I can't complain about finances. I don't want for finances here because the pharmaceutical industry quite happily fund the food and everything so there is not really an issue with that, but I would rather it not come from the pharmaceutical industry. It would be a lot nicer if it came from the government or even from the GPs themselves.

B.   Results from the quantitative data

We distributed the questionnaire electronically to a sample of 180 GP appraisers, appraisal coordinators and appraisal leads across the UK using the database held by the NHS Clinical Governance Support Team (CGST). As a result, we secured 108 returns (a 60% response rate). The quantitative data derived from the completed questionnaires was inserted into a statistical package (SPSS) and subsequently analysed. The results are set out over the following pages. The questionnaires asked for a response to fourteen statements using a Likert scale from strongly disagree to strongly agree.

CPD for GPs has improved in the past four years
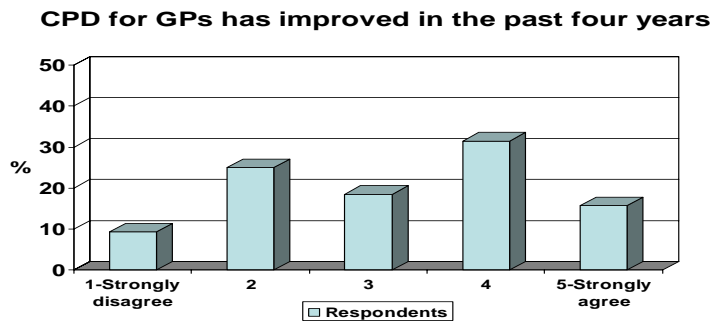
Figure 1

We found that 47.3% of respondents agreed with the statement that CPD for GPs had improved in the past four years. Given that 34.3% disagreed with the statement, however, and 18.5% were neutral, the results suggest that there is scope for further improvement

The quality of CPD provision is generally high
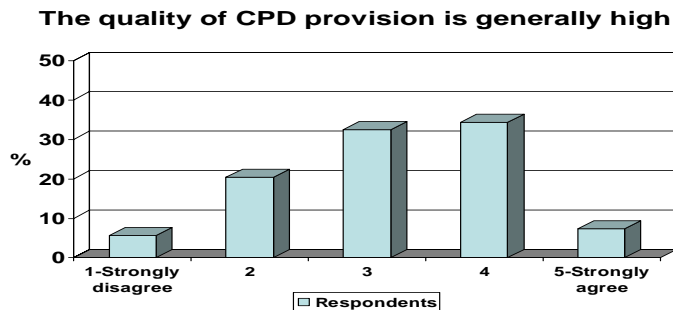
Figure 2

41.7% of respondents agreed with the statement that the quality of CPD provision is generally high, whilst 26% were in disagreement. A statistically significant minority (32.4%) were neutral, suggesting a degree of uncertainty or ambivalence about the quality of CPD.

The learning needs identified from appraisal are used in the planning of CPD
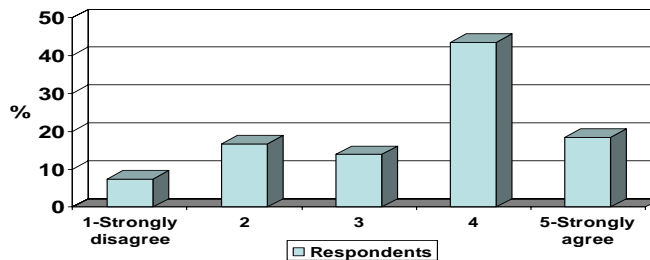
Figure 3

We identified a significant skew of positive agreement (62%) with the statement that the learning needs identified from appraisal are used in the planning of CPD. 24.1% of respondents disagreed with the statement whilst 13.9% were neutral.

My practice has a co-ordinated approach to the development needs of the whole Primary Care team
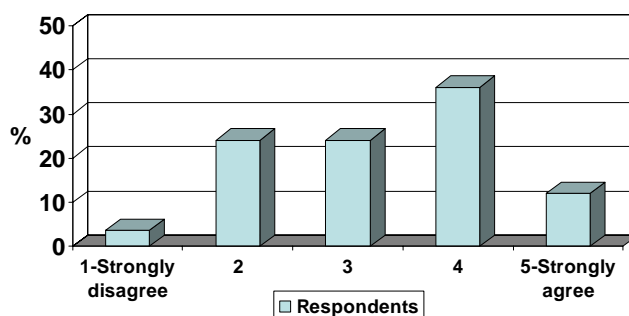
Figure 4

48.1% of respondents were in agreement with the statement that their practice had a co-ordinated approach to the development needs of the whole Primary Care team. 24.1% were neutral and the same number again disagreed with the statement, suggesting that a co-ordinated team approach to CPD is not always the norm.

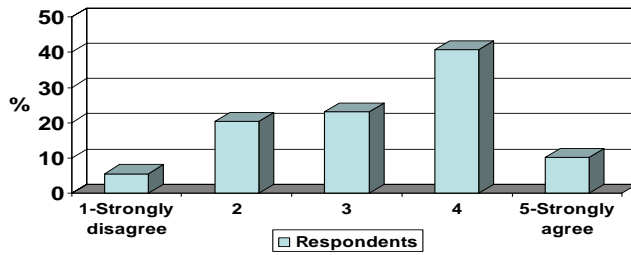**It is easy to obtain information about CPD activity in my locale**

Figure 5

Approximately half of the respondents found it easy to obtain information about local CPD activity. A significant minority (28%) did not, suggesting that channels of communication about CPD are not always in place or effective.
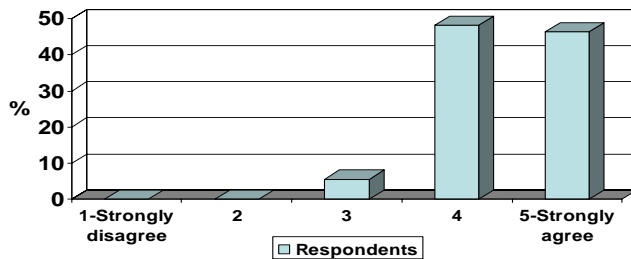
The internet is a useful resource for CPD

Figure 6

A substantial majority of respondents (94.4%) agreed with the statement that the internet was a useful resource for CPD.

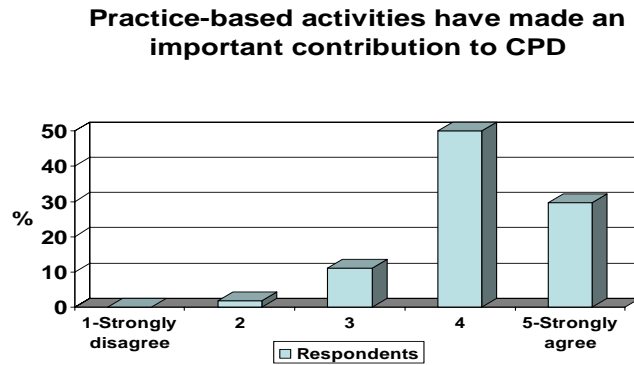**Practice-based activities have made an important contribution to CPD**

Figure 7

A significant majority of respondents (87%) agreed with the statement that practice-based activities had made an important contribution to CPD.
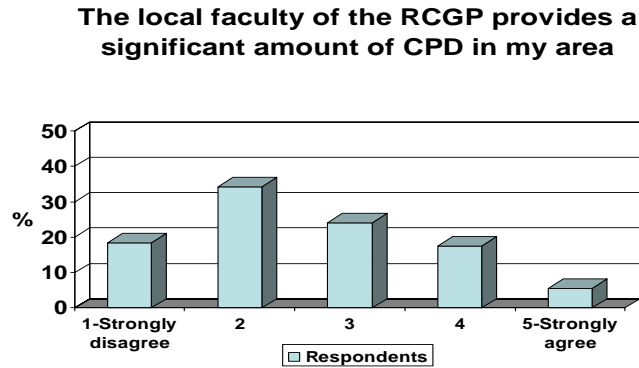
The local faculty of the RCGP provides a significant amount of CPD in my area

Figure 8

The majority of respondents (52.8%) did not agree with the statement that the local faculty of the RCGP provided a significant amount of CPD in their locale, whilst a further 24.1% were neutral on the subject.

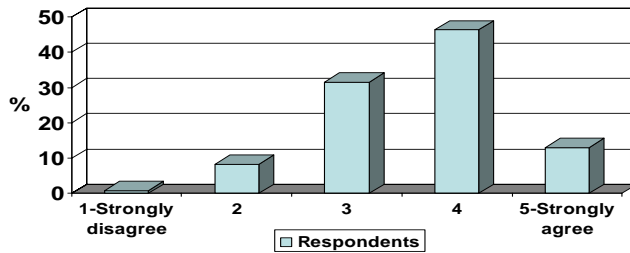## Additional CPD provision is required in my area

Figure 9

59.3% of respondents believed that additional CPD provision was required in their area. Only a very small minority disagreed with the statement, although a significant number (31.5%) were neutral on the matter.

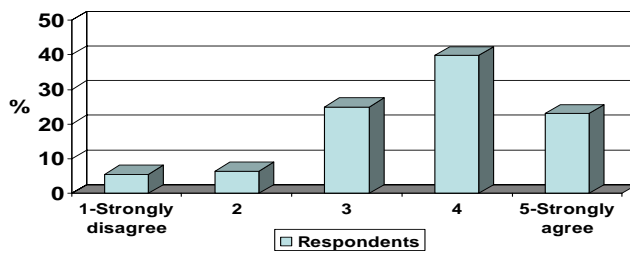## A GP tutor network enables cost-effective CPD provision

Figure 10

The results show a significant skew of positive agreement with the statement that a GP tutor network enables cost-effective CPD provision. 62.9% of respondents were in agreement with the statement, with 25% neutral on the matter.

**My Primary Care Organisation has contributed
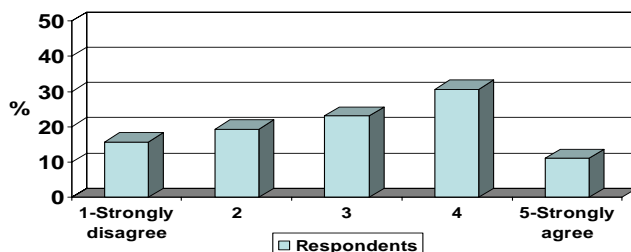to the effective delivery of CPD in Primary Care**

Figure 11

The results show only a slight skew of positive agreement with the statement that Primary Care Organisations contribute to the effective delivery of CPD. Whilst 41.7% of respondents believed that it did, a significant minority (35.1%) believed that it did not and 23.1% were neutral, suggesting that, within this sample group, attitudes towards PCO vary considerably with regard to CPD.

**The deanery has contributed to the effective
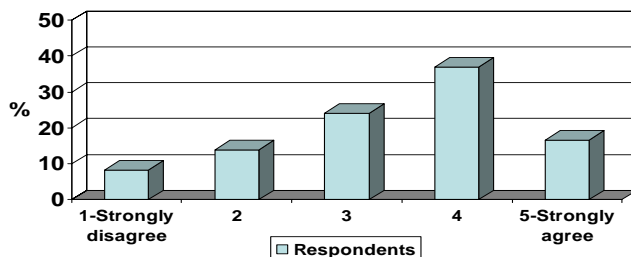delivery of CPD in Primary Care**

Figure 12

In comparison to figure 11, the results here show a more definite trend in support of the statement that Deaneries contribute to the effective delivery of CPD in primary care. 53.7% of respondents believed this to be so, compared with 22.1% who disagreed.

CPD has a positive impact on patient care
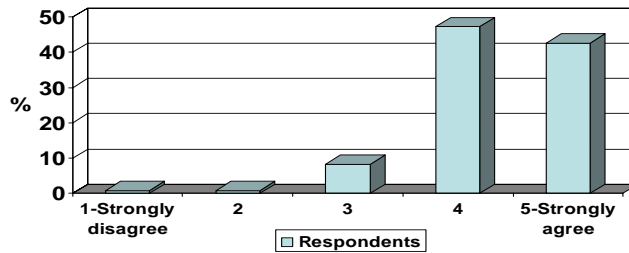
Figure 13

There is a very definite trend here which shows support for the statement that CPD has a positive impact on patient care. 89.8% of respondents were in agreement with the statement.

A managed system of CPD will help to deliver future NHS imperatives

Figure 14

A clear majority of respondents (71.3%) were in agreement with the statement that a managed system of CPD would help deliver future NHS imperatives. 19.4% were neutral and less that 10% disagreed.

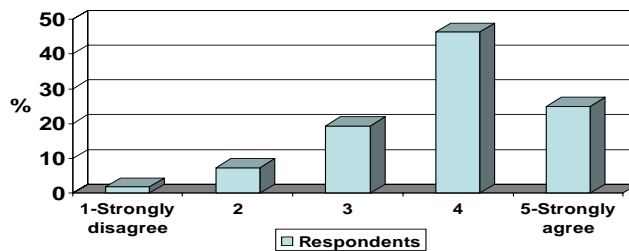## 6.   **DISCUSSION**

As the results show, we identified considerable variance in Deanery-managed CPD across the four home countries of the United Kingdom. Concerns about funding for the structures which support CPD, and particularly the continuing role of CPD tutors, are widely held in the English Deaneries. They are, however, less relevant in the other three countries which have different funding arrangements for their tutor/advisor networks. This position may perhaps be at least partly explained by the close involvement of CPD tutors in Scotland, Northern Ireland and Wales in their national GP appraisal schemes. Some Deaneries have found it necessary to make their tutors redundant in order to make the requisite financial savings. A consequence of this policy, which has been recently confirmed by Howard[12], is that considerable disparities exist across the English Deaneries in relation to the number of CPD tutors they employ.

The questionnaire results suggest that there is scope for further improvement in CPD provision and we found a significant degree of uncertainty or ambivalence about the quality of CPD, which echoes the findings of Grant *et al.*[29] In the qualitative data, we found evidence of a wish within the Deaneries to see a more strategic national approach to the provision and management of CPD, particularly in England. Differences in provision across the UK were also identified in the Deanery Workforce Survey published by UKCEA in January 2007. Amongst the interviewees, we identified a fairly widespread belief that there was too much diversity and variety amongst English Deaneries to enable an effective national revalidation scheme to be established. The general consensus is that there should be much greater cohesion, with a more rational model.

From the quantitative results it would appear that respondents are generally less inclined to believe that Primary Care Organisations contribute to the effective delivery of CPD, with attitudes varying considerably depending on the local situation. This finding is mirrored in the interview data, where we found considerable variation in the level of support for CPD within PCO. While most PCO valued CPD in principle, this was not always accompanied by pro-active engagement or financial support. All the results show a more definite trend in support of Deanery contributions to the effective delivery of CPD.

The interviewees express a general view that CPD should be embedded into a formal governance structure, with strong links into the local health networks. For our sample, CPD needs to be supported in turn by an organisation which places significant value upon it. It is recognised that this need not necessarily be the Deanery – it could be the Strategic Health Authority, the RCGP or some other organisation, as long as it is pro-active. It is also thought to be important by interviewees that CPD/GP tutors should feel supported by an educational, as well as a management-based community.

We found that, in England and Wales, CPD tutors are employed in a variety of models: (i) by a Deanery, (ii) jointly by a Deanery and PCO, and (iii) by a PCO. NHS Education for Scotland (NES) employs tutors on behalf of the Scottish Deaneries, whilst in Northern Ireland tutors are employed directly by Northern Ireland Medical and Dental Training

Agency (NIMDTA).   Responsibility for CPD in England is the personal responsibility of independent practitioners, with 'employers' having to allow time for CPD, whilst responsibility for GP appraisals lies with PCO. NHS Education for Scotland, NIMDTA and the Welsh Deanery however, have responsibility for the provision of CPD and the appraisal process. With the primary care medical educator pay scale there may be potential for its competency framework and associated appraisal system to be used to standardise reporting of activities and the development of educators in the UK. This is a UK NHS framework which could be used positively: all deaneries use it but some use it formatively now. It could be argued that, for educators, it should be mandatory that we all have our own PDPs and appraisals

In the statistical data we found considerable support for the principle of a GP tutor network enabling cost-effective CPD provision, whilst the importance of the multiplicity of roles held by GP tutors is emphasised by many interviewees in the qualitative data. All the Deanery representatives we spoke to were loath to lose the expertise of their GP tutor network which was seen as vital to the effective support of education and CPD for independent practitioners. Where Deaneries had lost their tutor network, this had resulted in a loss of organisational memory and support which might adversely affect the recertification process.

Like Lyons *et al*,[11] we found that the majority of tutors had moved from being course providers to educationalists in a much broader sense, with an increasingly strategic focus to their work. Some form of structured co-ordination of GP tutor networks, by the Deaneries, was widely believed to make their work more coherent. This was normally done by an Associate Postgraduate Dean/GP Director: a management model which would appear to be fairly effective. The results suggest, for example, that, following the demise of PGEA, there were concerns about the absence of certification processes for quality assuring GP courses and providers, and a number of Deaneries have established 'kite-mark' systems to counteract this problem.

Many English Deaneries appear to have networks of GP tutors that are roughly aligned with those of PCO, and tutors undertake joint objective settings between themselves, the Deanery and the PCO. The other three countries in the UK appear to have more centralised models of CPD management, in part related to having the GP appraisal function in-house. With regard to jointly-funded CPD/GP tutor appointments, we found qualitative evidence that this can work well because the Deanery provides the educational support and quality assurance, whilst the PCO enables an attainable localised approach to delivery. The sample was generally positive about the need to work more closely with PCO in enabling effectively-managed CPD and appraisal, benefits already highlighted by Conlon.[30] We also found evidence of the importance of maintaining a Deanery role in the management of CPD activity, so as to ensure an effective educational framework. Joint working was widely perceived to be the most appropriate for dealing with the retraining of people who were underperforming, and locally managed programmes made professional isolation much less likely to occur.

In contrast to Scotland, Wales and Northern Ireland, which had in-house appraisal processes, many English Deaneries did not have well developed systems for quality assuring the PCT-led appraisal process. The various PCTs within a Deanery's boundaries usually had different stances and levels of engagement, which had to be accommodated. Not every interviewee was confident that appraisal was being carried out effectively. The importance of ensuring that CPD and the appraisal process challenged the high flyers and engaged those colleagues who were perceived as simply going through the motions was also highlighted on a number of occasions.

Only 48.1% of our respondents believed that their practice had a co-ordinated approach to the development needs of the whole Primary Care team, suggesting that, for the other half of our sample this was not always the norm. From the qualitative data we identified a widespread belief in the positive benefits of ensuring that personal and practice development plans are symbiotic, reflecting the earlier findings of Elwyn.[31] It was expressed that great care should be taken by all concerned to ensure that one informs the other, and vice versa. The importance of recognising the effectiveness of both multi-and uni-professional education, and the need to maintain a balance of activity within CPD programmes was highlighted in the qualitative data. This was also identified in the statistical data, where we found considerable support for practice-based activities, which were widely seen as making an important contribution to CPD.

It would appear from the questionnaire results that across the UK the learning needs identified from appraisal are widely used in the planning of CPD. From the interview data we found that the content of CPD events was often based on outcomes of appraisal sessions and PDPs. Topics were normally set by GP tutors in their patch, or by a collective of tutors and/or an Associate Dean/Director in the larger regional events. There was a fairly widespread belief that the revalidation process would inevitably make CPD more prescriptive, which Deaneries largely welcomed as long as it did not stifle the needs and interests of individuals.

A significant minority (28%) did not find it easy to obtain information about local CPD activity, suggesting that channels of communication about CPD are not always in place or effective. A substantial majority of respondents (94.4%), however, believed that the internet was a useful resource for CPD, which was echoed in the qualitative data. This suggests that it may be necessary, therefore, for Deaneries and national bodies to revisit the way in which CPD activity is both publicised and made available, making full use of internet capabilities; a finding mirrored in the literature.[19]

The local faculty of the RCGP was not widely perceived within our sample as providing a significant amount of CPD in their locale, perhaps reflecting the considerable variance across the regional faculties in terms of the level of resource available to support educational activity. This was born out in the interview data, where we found that only a limited number of Deaneries were currently mapping the RCGP curriculum onto local CPD provision. A majority of respondents believed that additional CPD provision was required in their area, although there was no preference as to who the providers should be. We also found evidence of support for informal CPD activity, including

academic/vocational professional conversations between colleagues, being given greater recognition.

In relation to financing, a number of interviewees believed that CPD provision for doctors was generally very reasonable given what many other professions had to pay. The qualitative results show a general consensus that GPs should be willing to contribute more financially to their own CPD, which is clearly taking place given the establishment in some Deaneries of Education Trusts, where local GPs contribute to financing postgraduate education in a non-profit making way

There is a very definite trend in the statistical data which supports the view that CPD has a positive impact on patient care. In the interviews, however, we identified concerns about having to justify education in terms of patient outcomes which, although absolutely laudable in principle, tended to emphasise short-term measures and a reductive approach to education. A clear majority of respondents (71.3%) nonetheless believed that a managed system of CPD would help deliver future NHS imperatives.

The study has identified numerous examples of good practice. Many of these are based on the skills of local educators to develop and deliver high quality education. It is evident that many GP tutors have been involved in developing an effective appraisal system, and also providing education based on PCO priorities. The educators deliver much of the education themselves, or commission other GP educators, and that ensures appropriateness, and acknowledges the professionalism of the way we work. These educators have in many cases been developed and supported by their Deanery for many years and carry the aforementioned "organisational memory" with them. In Northern Ireland, Scotland and Wales they have retained their Deanery affiliations.

The educators have expressed their wish to maintain links with the Deanery. In addition, it is vital that new generations of educators are developed with the appropriate skills to continue this work. Whilst the PCO are often very positive about the contributions of educators, they may not be in a position to develop their replacements. We need to ensure that we continue to develop high quality educators, and possibly bridge the gap more formally between Deanery and PCO. This is a model that has worked well in some areas. It can have additional benefits if the educational experience of GP Educators is shared across the PCO, and a culture of educational quality further developed.

Providing strategic direction will be vital in implementing ongoing developments, including the proposals in the white paper *Trust assurance and safety*. The development of specialist re-certification could potentially drive the need for CPD. This may help to develop an enhanced culture of CPD, and embed it more centrally into GP practice. The GMC is tasked with setting up a board to review CPD, and the wider implications of specialist recertification are likely to engender increased interest in CPD, and this needs to be delivered to maximise patient benefit and development of doctors and practice staff.

Limitations of the study

There are several possible weaknesses to our study. Inherent in qualitative research is the limitation to the generalisability of any findings. Participants in interviews and focus groups were not selected randomly and the number of participants was relatively small. The collection of data from multiple Deaneries across the UK, however, has reduced the possibility of unrepresentative perceptions as a result of area-specific variables. We chose to use interviewing and focus groups to explore the beliefs that participants held about CPD, but we recognise that some will have tended to express views consistent with perceived social standards and not presented themselves negatively. This social desirability may have led respondents to self-censor their actual views. We have attempted to limit this possibility by placing emphasis on the assured anonymity of participants, and explicitly requesting that interviewees be as open and honest as possible.

The quantitative element of the study was limited by the possibility that respondents may have common characteristics which could have influenced their stance on CPD. This may have impacted on results but without data from a larger sample this is difficult to address. The size of the sample was relatively small given the number of practising GPs across the UK. The targeting of individuals who, given their roles, had a significant level of awareness of local CPD and appraisal activity was intended to lessen this limitation.

Proposals

Reviewing the information from the interviews and questionnaires provided a wide range of experience. The proposals below are based on the many examples of good practice across the four countries.

a.   GP Educator role

A GP educator is able to facilitate development of education, support of GPs and links with appraisal and revalidation. A post which links across Deaneries, RCGP and PCO would improve co-ordination and potentially maximise potential outcomes for development and patient care. This would fit with some of the examples of GP tutor roles. In addition ensuring links with appraisal and revalidation helps streamline and quality assure the processes involved.

b.   Developing educators

The educator workforce needs to be developed and supported. Deaneries have traditionally been the site for this. If they are to continue to do this they will require the resources to do so. If the post-CCT educators are going to be supported elsewhere, for example by college, then an appropriate system for their induction, training and employment would need to be developed to ensure appropriate preparation for the role as well as ongoing professional development. Shared learning between educators and links with GP Specialist training may have additional benefits, in particular with the application of the new GP curriculum to post-CCT practitioner education.

c.   Joint working

Shared working between Deaneries, the college and the PCO would help ensure educators are supported, and the provision of education is focused towards the needs of the population identified by the PCO. Shared working will facilitate the developments necessary for appraisal and revalidation. Models exist of joint funding between PCO and Deaneries and this seems to offer positive outcomes. It has enabled professional support for educators whilst incorporating local needs and ensuring the PCO are actively involved in CPD. In Wales, Scotland and NI the Deaneries have been given the funding to deliver appraisal, and this has worked well, with strong links to CPD.

d.   Co-ordination with plans for revalidation

The new plans for appraisal and revalidation are likely to drive the demand for CPD. The plans for specialist re-certification may have a significant impact on the perceived need of GPs for CPD. This is an opportunity to ensure CPD provision underpins the needs of General Practice as it develops, and actively contributes to patient care.[32] If we come in to line with other colleges, and require evidence of 50 hours of CPD there is going to be a demand for a significant increase in CPD provision. Preparation and planning for this will support the development of relevant high quality education. Supporting GPs to recognise and record their own personal learning and practice learning will also support this.

e.   Provision of education

The development of co-ordinated education for GPs within an area seems to be a valuable approach, and can be a cost effective method for providing high quality education. For a relatively small amount of funding from each GP a suitable programme has been developed in NI. In other areas where the college or Deanery has provided local education this has been positively received. The ability to recognise different methods of learning, including reading, reflection and practice work as well as more formal provision of education will support the educational needs of GPs. In addition the value of different styles of educational delivery needs consideration. The potential additional benefits of group work and opportunities for in-depth study need to be accounted for, as, if not, there may be a swing towards more lecture based courses which can seem superficially to fulfil the same need but which, especially for recent recipients of CCT trained using interactive educational techniques, may not meet their learning style. Maintaining an appropriate balance will depend on having appropriately trained educators in place.

f.   Electronic platforms

A powerful outcome from the study was the importance of e-learning. A priority should be the proactive development of electronic platforms to facilitate web-based learning tools and information portals, as well as e-portfolios. The latter will enable collation of learning logs and other information to underpin the role of educators and support an individual's revalidation. It will give the potential to help GPs appropriately record learning from a range of environments.

With such an appropriate focus it can help support the recognition and development of personal development and learning. This will be supported by strong links to the evidence collected for appraisal and GP kept learning logs.

7.   CONCLUSION

This study highlights several key themes. These include the importance of developing a culture of learning, and the benefit to educators of working within such a culture. This may then enable the sharing of this approach with other organisations and the GPs they educate. The need to retain the "organisational memory" of GP education within an area was highlighted repeatedly. The multiple roles of many educators contribute to this, and needs to be taken into account in future plans.

There was a widespread belief that more educational provision is required, and that more educators are needed to deliver this. These educators need to be developed and supported, and to be part of an educational community. Working across different organisations, such as PCO, College and Deanery can have additional benefits in sharing ideas and developments across wider health care provision.

A generic model could be proposed of shared educators within a local PCO area or patch employed between a PCO and Deanery or PCO and College. These educators would use outcomes from appraisal, and plan appropriate education based on need and appropriate educational approach. They would be employed and developed within the Deanery or College, which would encourage the sharing of ideas and expertise. They would also provide educational support for appraisal and revalidation, and facilitate GPs in the collection of evidence they require for relicensure and recertification. If GPs in an area were willing to contribute towards a central fund then this could be used to develop a local educational programme. Similar models to this appear to be working well in parts of the UK.

This approach will not only utilise and further develop our educators, it will also ensure succession planning for the next generation. We are currently depending on a cohort of very experienced educators, and we need to ensure that we continue to recruit and develop. The expansion and introduction of e-learning and e-portfolios will be needed to underpin whatever systems are introduced. There is a sense of gestalt arising from the data, in the belief that CPD provision must be more than a sum of parts identified within PDPs. An extension of this is that GP educators are more than the sum of the education they provide. Acknowledgement of this will help us appreciate what is required for the provision of education for the years to come.

REFERENCES

1.   Department of Health. *Continuing Professional Development: Quality in the new NHS*. London: Department of Health; 1999.

2.   Chief Medical Officer. *Trust, Assurance and Safety: The regulation of health professionals in the 21st century*. London: Department of Health; 2007.

3.   Crump B. *The future role and responsibilities of Postgraduate Deans and their Deaneries*. London: Department of Health; 2004.

4.   Department of Health. *Modernising medical careers.* London: Department of Health; 2003.

5.   Howard J, Valentine M. Educational governance: a new paradigm. *Education for Primary Care* 2006; 17(5): 436-442.

6.   Kennedy A. Models of Continuing Professional Development: a framework for analysis. *Journal of In-service Education* 2005; 31(2):235-50.

7.   Lewis M, Evans K. Quality assurance of GP appraisal: a two-year study. *Education for Primary Care* 2006; 17(4):319-33.

8.   Jelley D, Cheek B, van Zwanenberg T. Quality assurance of general practitioner appraisal: success and challenges in the Northern Deanery. *Education for Primary Care* 2007; 12:180-91.

9.   Woods L, Boudioni M, McLaren S, Lemma F. Delivering the quality agenda: the experience of implementing appraisal systems in primary care. *Quality in Primary Care* 2006; 14(1):21-7.

10.   Curtis A, While R, Pitts J, Ramsay R, Attwood M, Wood V. An evaluation of the use of a workbook, Professional Development: a guide for general practice, in continuing professional development. *Education for Primary Care* 2004; 15(1)39-49.

11.   Lyons N, Holmes S, Leigh P. The future of general practice continuing professional development educators. *Education for Primary Care* 2006; 17(2):104-8.

12.   Howard J. General practice continuing professional development tutors: an appraisal of options for the future. *Education for Primary Care* 2007; 18(4):425-36.

13.   Cunningham D, Stoddart C, Kelly D. Protected learning time in general practice: a questionnaire study of practice managers' perceptions of their role. *Quality in Primary Care* 2006; 14(4):225-33.

14.   Jones L, Evans N. Learning Together: Facing the Reality of Shared Learning in Health Care. *Journal of Adult and Continuing Education* 2005; 11(2):142-54.

15.   Lemma F, McLaren S, Boudioni M, Woods L. Training experiences, educational priorities and career plans of primary care staff. *Education for Primary Care* 2007; 18(1):67-75.

16.   de Villiers M, Bresick G, Mash B. The value of small group learning: an evaluation of an innovative CPD programme for primary care medical practitioners. *Medical Education* 2003; 37(9):815-21.

17.   Hobma S, Ram P, van Merode F, van der Vleuten C, Grol R. Feasibility, appreciation and costs of a tailored continuing professional development approach for general practitioners. *Quality in Primary Care* 2004; 12(4):271-8.

18.   Sandards J. Using web quests to enhance work based learning. *Work Based Learning in Primary Care* 2005; 3(3):210-7.

19.   Sandards J, Langlois M. Online collaborative learning for healthcare continuing professional development: lessons from the recent literature. *Education for Primary Care* 2006; 17(6):584-92.

20.   Lacey Bryant S, Ringrose T. Evaluating the Doctors. net. uk model of electronic continuing medical education. *Work Based Learning in Primary Care* 2005; 3(2):129-42.

21.   Dagley V, Berrington B. Learning from an evaluation of an electronic portfolio to support general practitioners' personal development planning, appraisal and revalidation. *Education for Primary Care* 2005; 16(5):567-74.

22.   Jones T. Information on the internet: evaluation of a professional development course for primary care physicians. *Education for Primary Care* 2006; 17(4):362-70.

23.   Lynch M, Gallen D. Higher degrees for GPs: supporting a modern Prometheus or being complicit in a 'Brave New World'? *Education for Primary Care* 2005; 16(6):633-43.

24.   Mcdonough R. Accrediting work based learning in primary care for an academic qualification. *Work Based Learning in Primary Care* 2004; 2(3):214-9.

25.   Riain A, O'Riordan M. Quality initiatives as a component of continuing professional development in general practice. *Quality in Primary Care* 2004; 12(3):195-200.

26.   Pitts J, Curtis A, Howard J, Smith F. Higher professional education courses and general practice non-principals in England: a consumer evaluation. *Education for Primary Care* 2005; 16(5):556-66.

27.   Baron R, Mckinlay D, Martin J, Ward B. Master's degree-accredited professional education and development courses for general practitioners in the North Western Deanery 1997–2002: impact on effectiveness, retention and recruitment to additional roles. *Education for Primary Care* 2006; 17(2):147-54.

28.   Bryman A. *Social research methods*. Oxford: Oxford University Press; 2001: 123-4.

29.   Grant J, Chambers E, Jackson G. *The Good CPD Guide: a practical guide to managed CPD*. Sutton: Joint Centre for Education in Medicine; 1999.

30.   Conlon M. Appraisal: the catalyst of personal development. *British Medical Journal* 2003; 327:389-91.

31.   Elwyn G. Professional and practice development plans for primary care teams. *British Medical Journal* 1998; 319:1619-20.

32.   Lakhani M, Baker M, Field S. *The Future Direction of General Practice.* London: Royal College of General Practitioners; 2007.