Planning and Delivering Primary Care (CPD): Planners' Managers' and Consumers' Views on Process and Outcome

William Spence

Institute of Health and Wellbeing, University of Glasgow, UK

Corresponding author:
William Spence, 1 Lilybank Gardens, Glasgow G12 8RZ, UK
E-mail: william.spence@glasgow.ac.uk; Phone: +44 (0) 141 3302454

Abstract

Background: A Scottish National Health Service organisation commissioned a series of continuing professional development activities for primary health care professionals across seven topic areas and coordinated their delivery. The project was offered over one year and aimed primarily to change secondary care referral practice among general practitioners.

Aim: To explore the experience and views of planners relating to the planning, delivery and evaluation of continuing professional development activities for primary health care professionals.

Method: The qualitative approach involved focus group and individual interviews with 22 participants.

Results: The planning of this CPD programme was successfully completed and a range of lectures and workshops ensued. The period required to plan this complex programme of CPD was underestimated. Some participants declined an invitation to participate in CPD despite significant financial incentives to do so, and several of those with greatest perceived need did not take part. Dissemination of CPD learning in primary care must not be taken for granted and related preparation and provision of incentives may improve this. CPD planners should consider including process and personal knowledge rather than the habitual prioritisation of technical skills and propositional knowledge.

Conclusions: Planning primary care CPD with secondary care facilitation may offer more challenges than are immediately apparent. Implementation of suggestions for improvement highlighted here may well result in increased participation and greater impact of CPD.

Keywords: CPD, planning, planners' views, qualitative

Introduction

Continuing Professional Development (CPD) in general practice can be seen as "a process of lifelong learning for all, to meet the needs of patients and deliver National Health Service (NHS) priorities" (Calman 1998, p2). It should seek to "encourage and support specific

changes in practice" and require medical practitioners "to maintain and improve their standards across all areas of their practice" (GMC 2004, p2). The value of such CPD activities that combine workshop and didactic presentations in improving professional practice has long been known (O'Brien *et al.* 2001). The role and skills of general practice CPD leaders have been identified (Calman 1998), but the process of planning such CPD from the perspective of those involved has not been studied.

This article outlines a CPD project for primary health care staff and reports the experience and views of those involved in its planning and delivery. The CPD project comprised seven educational components delivered as a Local Enhanced Service (LES) (DH 2011) in one of the 14 territorial NHS administration areas (NHS Board areas) of Scotland over one year. NHS control in Scotland has been devolved to the Scottish government. All general medical practices in the NHS Board area were invited to take part in the educational activities offered and of the 60 invited, 29 practices participated. While these practices are under contract to the NHS, General Practitioners are not directly employed in it, although most other primary care staff are. The project was co-ordinated by a different NHS Board. The education components addressed seven practice areas (Table 1) and a range of delivery formats was employed with lecture and workshop methods predominating. The project was driven by the requirement to reduce demand on secondary care in the target NHS Board area, and teaching was provided by three secondary care nurses and 14 consultant hospital physicians.

Table 1 Focus, format, participation rate and timing of seven components.

Component	Delivery format (total number of participants: GPs, nurses, practice managers)		Total workshop attendances	Delivery period
Dermatology	Three one day workshops	(50,1,0)	66	7 months
Diagnostics	Three one day workshops	(18,0,0)	32	4 months
Diabetes	Part-time course	(11,2,0)	-	9 months
Neurology	University distance learning course	(10,0,0)[†]	-	2 months
Respiratory illness	Three one-day workshops	(27,2,0)	29	2 months
Rheumatology	Three one-day workshops	(20,0,0)	44	4 months
Palliative care	Team discussion with experts on team's terminal care Significant Event Analyses (SEAs)	(14,4,3)	20	4 months

*University of Warwick (2007) Certificate Course in Diabetes Care.
[†]Update in Neurology for General Practitioners (GPs) (University of Bath 2006).

The project was planned and coordinated by a steering group comprised of one NHS senior manager, three General Practitioners (GP) employed on a part-time basis by the coordinating NHS Board, one GP researcher, one consultant educationalist, one administrator and one senior coordinating NHS Board manager, who was also a part-time GP. A consumer group was established at the project's mid-point to oversee project evaluation in line with General Medical Council (2004) guidance. This article reports on the project planning and coordination-related experiences and views of: the steering group, practice managers of included general medical practices, health care consumers and of one NHS manager.

Methods

This study reports the results of a series of interviews related to the evaluation of the planning and delivery of a LES. Qualitative data were generated by individual and focus

group interviews; the former in the months immediately following the end of the project and the latter from months five to 12 of the project. An organisational action research approach (Hart & Bond 1995) was adopted in this evaluative study of an educational project that was closely related to the management of practice change underway at the time. Here education related to a change intervention and the evaluative study aimed to improve further training through a cyclical process in which research, action and evaluation were closely related.

All steering group members were invited for interview to explore their experience of steering group membership. Their views on the appropriateness of workshop content, educational level of activities and mechanism for improving dissemination and increasing participation in any future project were also sought. Seven of the eight steering group members participated: one administrator, one part-time GP with a LES evaluation research role, one education consultant, three part-time GPs with advisory roles in the coordinating NHS Board, and one part-time GP holding a senior part-time position on the coordinating NHS Board. A sample of seven practice managers was randomly selected from high-uptake practices and three were randomly selected from low CPD-project uptake practices. The managers were interviewed by telephone to explore their views of factors facilitating uptake, barriers to uptake and factors influencing decision making in uptake of activity choices. The one NHS manager closely involved in the CPD project planning was interviewed by telephone to discuss the practicalities of involving secondary care consultant medical staff in a future similar project. A group of four health care consumers was established via invitations to local health related groups to advise on project evaluation, and meetings were treated as focus group interviews (Table 2). Consumers were not involved in project planning, which limited their contribution to this study.

Table 2 Study participation.

Participants	Research method	No. invited	Participants
Steering group members	Individual interviews	8	7
Consumer group members	Focus group interviews	12	7
Practice managers	Individual telephone interviews	7	7
NHS secondary care manager	NHS Manager interview	1	1
Totals		28	22

Research ethics committee approval was not necessary for this service development evaluation, but written and informed consent was obtained from all steering group members and consumers, while verbal consent was given for telephone interviews. Study participation resulted in no harm to participants and care has been taken to ensure their anonymity in the reporting of findings here. The study complied with the Declaration of Helsinki's ethical principles.

All interviews other than the telephone interviews and focus group interviews were audio recorded then transcribed by the researcher and a qualitative research analysis package used in the analysis (NVivo 2002). The telephone interviews were recorded via note-taking during and immediately after interviews and findings presented in tabular form. Data analysis of transcribed data was guided by the application of a seven-stage process (Colaizzi 1978), beginning with a detailed reading of the transcripts and notes followed by the identification of significant phrases and their coding. Meanings were formulated and the themes and subthemes identified and their number and hierarchical relationships

refined over the re-reading and analysis of the data. Verbatim quotations are given here to represent the interview themes and subthemes. Steering group members are identified by the abbreviation SG, health care consumers by the abbreviation HCC, the NHS manager by the abbreviation NHSM and general medical practice managers by that of PM.

Aim

The study aimed to explore the following: the experience and views of the project steering group; consumer group views; general medical practice manager experience and views; NHS manager views on the planning, delivery, coordination and evaluation of the educational activities. Objectives of the study were to explore: steering group members' views of the planning process; CPD content and level, and views on improving participation rates and dissemination mechanisms; practice managers' views on factors related to promotion of uptake and barriers to this; the NHS manager's views on the practicalities of involving NHS consultant physicians in the provision of CPD.

Findings

Four themes emerged from the discussions with the steering group members, practice managers and NHS manager and these are displayed with respective subthemes in Table 3.

Table 3 Themes and subthemes of findings.

Themes	Subthemes
1. Coordinating NHS Board's role	LES administration & communication. Involving secondary care consultants.
2. Recruiting practitioners with greatest educational need	Increased targeting of marketing. More assertive approach to recruitment.
3. Aspects of the planning and delivery conducted satisfactorily	Planning and delivery of components and activities. Steering group meetings.
4. Aspects of the planning and delivery that might have been improved	Delay in starting LES. Delivery and planning of activities. Dissemination. Remuneration of practices. Recruitment to activities. Participation in steering group.

1. Coordinating NHS Board's role

1a. LES administration and communication

LES administration was shared between the coordinating NHS Board's central office and its locality personnel on the NHS Board of delivery. The need for dedicated and consistent project administrative help in the locality was identified by the same participant who advocated that locality administration should become the future 'central contact' to which queries could be directed, through the building of relationships with workshop facilitators, in any similar future CPD scheme.

Communication problems were evident and the distance between coordinating and delivery centres and their management by different NHS Boards was causally implicated. Much of the administration was conducted in the delivery locality and "wasn't really communicated" (SG) to coordinating NHS Board staff, who "didn't really know what was going on" (SG). Communication difficulties arose at the general medical practice level also and one steering group member reported that many practices did not know whether they

had agreed to participate or not. Communication difficulties were identified as the only aspect requiring improvement by one steering group member.

1b. Involving secondary care consultants

The need to involve consultants early in order to plan their commitment to CPD provision was clear to participants and the NHS manager advocated a long-term approach to this, advising that three months' notice of participation would work best to "build in time at beginning of year" (NHSM). Such participation was welcomed, but a more formal recognition of "hours allocated to primary care education in consultants' workload when reviewing the consultant contract" (NHSM) was advised.

This participant suggested that local Managed Clinical Networks (Carter & Woods 1999) might be used "in promoting local professionals' involvement in CPD design and content selection" as might "newly developed long-term conditions groups" (NHSM).

In preparing consultant physicians for the role of workshop facilitator, two approaches were advocated. One participant supported the rather informal approach taken, while another believed that a more systematic approach would be worth exploring in future initiatives.

> "I suppose many of them [consultant physicians] would not have time to attend a session… it may just be continuing what we are doing, giving some guidance at the start; some paperwork and tools and techniques… Maybe we need to, kind of, hassle them a wee bit." (SG)

> "If you could even run a two hour session with them [consultant physicians]… and a presentation on this programme, what we are trying to aim for, they could get an understanding that they are part of… the needs' assessment." (SG)

The views of a GP employed as an NHS manager on consultant participation in CPD are given in Table 4. It is noteworthy that the willingness of consultant physicians to participate in primary care education was counterbalanced by the perceived limited availability of this group.

The involvement of local practitioner groups was suggested as a way to promote primary care education by this participant. However, the group was clear on its support for further and earlier involvement of secondary care consultant physicians, with one recommending a CPD working group with "consultants on it, someone from the steering group, a GP and a nurse to really plan… and look at how that might relate to PLT [Protected Learning Time in primary care] or referrals or audit or SEAs [Significant Event Analyses]" (SG).

One participant shared a consultant physician's preference to be "more prepared at the very start" (SG) if the project was offered again. Two participants suggested that the preparation of physicians be increased to include a "briefing meeting" (SG) with the CPD planners.

Consultant physician involvement in GP education was advocated but not always for education reasons; for instance, a steering group member suggested they "ought to be put on the front line every now and again" (SG). There was some speculation about the organisational pressures on GPs and secondary care physicians to participate in the project.

> "To me there would be mileage in coming down and up [being directive and facilitative] to encourage the consultants to be responsive and open to support. You really need to do that [buy into the whole idea] at the time and this is what we are trying to achieve and, 'You [physicians] are key to this working, and…we actually want to give you some support…please come along to this session'." (SG)

Table 4 A Steering Group member's views on consultant participation in CPD.

Positive aspects of Consultant involvement

a. The provision of education is a high priority in the planning of time that consultants spend in Supporting Professional Activities.

b. Consultant physicians are 'motivated to keep waiting times under control' & 'they want appropriate referrals'.

c. Consultant physicians are 'desperate to be engaged' in the CPD of primary health care staff & are 'really interested in working with GPs in their speciality'.

Weaknesses in Consultant involvement

a. 'A key barrier [to consultant input] is time'.

b. Consultants require at least three months' notice for their participation.

c. The use of two or three afternoons for consultant physicians can 'make or break waiting times'.

Opportunities in Consultant involvement

a. Consultants 'need to build in time' at beginning of year to participate in primary care CPD.

b. It would be useful if consultants were enabled to view their contribution in context, e.g. the particular issues that education is designed to address, the particular geographical area that is being targeted, & receive feedback on the outcomes of the education.

c. There is need for secondary care to examine the hours allocated to primary care education in consultants' workload when reviewing the consultant contract.

d. In promoting local professionals' involvement in CPD design & content selection, the Managed Clinical Networks should be used for this & speciality groups could be used where these do not exist, e.g. Dermatology (has GP input), Rheumatology & Respiratory Illness.

e. The long-term conditions groups of Community Health Partnerships & the long-term conditions group with an area-wide responsibility may also be of use in developing primary care CPD locally.

f. Requirements of consultants in the provision of CPD for primary care should be made clear & include fairly detailed information.

One interviewee reported some frustration at the project's reliance on physicians for learning facilitation.

> "But they are not being paid for this and as an additional service it is part of their contract... so how much can you call the shots or give them advice." (SG)

Recruitment to both presenting and participation was not always a free choice and consultants "were told by the [senior] medical officer... 'You have to do it and it is part of your contract'... He did say that GPs always reach for their wallets." (SG)

The praise for secondary care physician participation came with some reservations from three steering group members about involving them.

> "You get some very young demi-gods coming through. There are folk that are running their wee niche in the profession and if you... demi god them, they will run with it. I think that time will improve it." (SG)

When commenting on the positive nature of activities, one steering group member commented on the physicians' role in the project's 'big down side'.

> "... lack of accessibility to some of the specialists and their resistance to meet, their resistance to adopt things which they think are on trial. Again, it is a case of you cannot make people do these things. You are sort of meandering and trying to make things happen." (SG)

2. Recruiting practitioners with greatest educational need

2a. Increased targeting of marketing

Several participants highlighted the educational needs of a small number of GPs who did not participate in any of the project activities. The involvement of those with both greatest need and reluctance to participate was raised in steering group interviews. Interviewees readily acknowledged the challenge faced by non-participation, and the provision of feedback to this group on this missed opportunity was favoured by most to address the problem.

> "…in any sort of learning situation it is always the people that need it most that don't go…what you have to be able to do is to feedback an accurate overview of the first run that says to people who don't go, 'Oh, oh I missed out on something'." (SG)

> "Maybe if GPs had to pay for it they would value it more… but what you get for nothing you don't value. I think… some GPs think that." (SG)

One participant (SG), who believed that the payment to practices for participation and the provision of the project had not been made 'absolutely clearly', identified the advertising and promotion of the project as components that could have been improved. Several steering group members believed that the project was seen by practitioners to be offered only for GPs "and that money was being spent on GPs and I know that people in the CHPs [Community Health Partnerships] felt that it could have been rolled out toward the team involvement" (SG).

2b. More assertive approach to recruitment

Several GP steering group members highlighted the sensitivity of the situation and the need for greater communication of the benefits to those GPs who were considered to be underperforming. There seemed to be a consensus among steering group members on the identity of the GPs in this category, and one reported a perception of arrogance amongst such underperforming GPs.

> "… but a willingness to admit not to say that, 'I don't know' but that, 'This is not my area of expertise and I will try and find you by phoning someone and getting back to you.' I think there is a perceived reluctance." (SG)

A more direct approach for targeting this group was advocated by two of the GP steering group members.

> "… it is that creeping around. 'Oh, you can't [question] the doctor's independence'. I think that is [expletive used]. Some people might take the view that if you offend people, then tough. This is about patients' health and the health of the community and if a practice is underperforming then get in there and sort it out." (SG)

Many members of the steering group reported their wish, and suggestions for, a more assertive approach to recruitment to reach GPs with greatest CPD need. One GP steering group member reported a physician colleague's view that "we know exactly who they are and the bulk of the bad referrals are from them" (SG).

Some participants found the project GP participants to be less than wholehearted in their engagement with the project and suggestions were made for increasing their commitment.

> "Maybe we should say, 'Look you can only come to this if you let me know what your learning needs are and that's your passport into the net'." (SG)

More creative options for improving recruitment were reported.

> "So maybe we have to incentivise these people [primary care staff] in other ways rather than stick and carrot… They may make it a protected learning time issue and, 'If you do that we will put a locum in. We will pay for a locum or we will put a locum in place for that day or two days or whatever it takes…'." (SG)

The absence of a locum option may have accounted for almost all GP non-participation, but primary care nurses would have had to answer the question, "'Who is going to cover that afternoon?'… maybe practice nurses do not have the power to say that [commit to study day participation]" (PM).

Many factors were reported by PMs as useful for facilitating take-up by practitioners (Table 5). Poor communication and the need for more notice were cited by two PMs as barriers to take-up while two cited the issue of their respective GP's appraisal as a factor influencing component choice.

3. Aspects of the planning and delivery conducted satisfactorily

3a. Planning and delivery of components and activities

The venues used and their associated administrative staff were positively evaluated by several steering committee members; indeed, all steering group members offered a generally positive evaluation of the project.

> "I think it has been done fairly well. I think the speakers have all gone down very well looking at the evaluations…they have been great." (SG)

The positive contribution of secondary care colleagues was readily acknowledged.

> "Most of them have really put quite a lot into it…They have tried to do it to the best of their ability." (SG)

Two components received particular praise from two steering group members.

> "[two CPD components named] are the two shining stars for me. The [consultant physicians involved in the delivery of one of these components] were full up for it, really wanting to engage with GPs. The [consultant physicians] were keen to work with GPs to develop management protocols for the more common conditions." (SG)

One steering group member highlighted that it had, for GPs, "Raised their awareness of need to be educated… and an appreciation of the fact that there are specific choke points in the system" (SG). Another complimented one physician for creating relevant learning experiences. Another participant felt that the coordinating organisation had "historically never got on terribly well" (SG) with GPs in the practice area and that the LES may have contributed to improving this relationship legacy. This member also felt that locality GPs were 'more likely to subscribe' to the training partnership organised by the coordinating NHS Board as a result of LES participation and this was seen as a 'benefit'.

3b. Steering group meetings

The efficiency of steering group meetings held over the planning and delivery phases was positively commented on by all steering group members.

> "From an educational point of view we got more out of the steering group in terms of topics, how things work, how things could have been done different [ly]." (SG)

Table 5 Practice Managers' (PM) views of factors influencing take-up and selection expressed in telephone interviews (*n* = 7).

Factors that facilitated take-up of LES	Barriers to take-up of the LES	Factors that influenced participation
a. GPs were interested in topics covered.	a. Availability of time.	a. GPs decided which elements they would benefit most from.
b. GPs wish to increase their knowledge.	b. Time requirements are the major barrier to take-up.	b. Clinical interest.
c. No particular drivers noted by one PM.	c. Problems getting replacement GPs.	c. Staff have limited CPD opportunities.
d. It is straightforward for practice nurse to close clinic to enable attendance. Less straightforward for GPs.	d. GPs do their own out-of-hours service.	d. Professional interest & needs of the practice influenced choices made.
e. CPD [in remote practice area] is well attended.	e. Travel is a significant barrier, particularly in winter.	e. Component topic included in GP's appraisal (reported by two PMs).
f. Enough information provided to promote participation.	f. The distance to the [town] venue – but not [local general hospital venue] - presented a major barrier to attendance.	f. Uptake by one GP possibly as a result of his intention to offer a secondary care clinic in a hospital soon to be built.
g. GPs experience of LES was 'favourable' & they found it to be a 'worthwhile experience.'	g. More notice of LES dates preferred.	g. Decisions on CPD participation are taken as a team at weekly meeting where course information is discussed.
h. Benefit to clinical practice.	h. Limited notice of arrangements. PM meeting took place late in LES.	h. Take up was discussed at practice meeting.
i. Diabetic course useful to those staffing diabetes clinic & those staff who don't provide this service.	i. Insufficient notice offered. At least one month's notice required.	
j. GP appraisal process identifies weaknesses.	j. Notice period of component dates.	
k. LES components covered major contract disease areas & common illnesses.	k. Dates should be arranged to coincide with Protected Learning Time dates.	
l. LES widely viewed as useful & the networking opportunities afforded viewed as good.	l. Communication between NHS Board offering LES & GP practice not always passed to PM.	
m. Practice has training & development budget.	m. PM unaware that LES was open to staff other than GPs.	
n. Payment covered locum costs.	n. Limited flexibility due to workshops being offered once only.	
o. Dates of staff attendance given in advance. Diabetes course attendance dates one year in advance.		
p. At least two months' notice required.		
q. Some sessions should be replicated to enable more than one staff member to attend.		
r. Detailed information on course should be provided.		

Table 5 *(Continued)*

s. The required professional background of intended participants should be made clear in course details.

t. PM meeting improved knowledge of LES.

u. Practice meeting addresses training & development every week.

v. Course information should be sent to PM.

w. Use of E-mail to send course information found to be helpful.

x. Multidisciplinary sessions promote uptake via increasing flexibility of colleague selected to attend.

y. Some sessions should be offered on Protected Learning Time days - same for all [GP locality] – arranged one year in advance.

z. [local town venue] & [local general hospital] proved to be ideal venues.

Steering group members reported their perception that a wide range of LES elements had been successfully carried out, and one felt that bookings and cancellations had been handled well.

4. Aspects of the planning and delivery that might have been improved

4a. Delay in starting LES

Delays in starting the LES were acknowledged by several steering group members and all recognised that increased advance planning might have improved participation.

> "I think there were some problems at the beginning organisationally... There's always a bit of suspicion among certain groups of GPs, 'What's the board up to, what's [coordinating NHS Board] up to?'." (SG)

4b. Delivery and planning of activities

Criticism from two interviewees was reserved for only two secondary care consultant speakers.

> "It started at the very beginning when the guy said he didn't do meetings... When someone says, 'I don't do meetings,' that is putting on the table the message that 'I don't play the game'." (SG)

One education component was singled out for criticism by many participants, one believing it to be 'the big, big, big, disappointment for [him]' (SG) while for another it 'did not go well at all' (SG). One GP steering group member commented on the project's limited focus on primary preventative work.

> "I think there is a perception in GP land or an attitude in GP land that is saying that [primary preventative work] is not our business, how are we going to tackle that? The reality is that we probably see at least 30% of the population every year...if there was a project...that could equip us with some tools to use, it would be good, I could be talked into that." (SG)

The project's emphasis on technical skills at the expense of interpersonal skills was commented upon by one steering group member and one consumer.

> "...they [GPs] have obviously got to realise how the condition affects that individual, their work lives, their family life, their home life. It is not asking them to become social workers it is just asking them to use a bit of empathy in how they are relating to their consumers, their patients." (HCC)

> "I think just having a 'punter' present for five minutes over a day's course focuses the mind on the end result...So I am a believer in punters being present." (SG)

4c. Dissemination

Several participants reported their view that insufficient attention had been paid to preparing GPs to disseminate learning.

> "The expectation that dissemination back in the practice would just happen -no way it can happen like that. You have got to teach people how to do it." (SG)

Two participants listed the skills and conditions necessary for dissemination to take place.

> "...it is time, then the individual's character comes in. Whether they are a sharing kind of individual; whether they like to keep things to themselves." (SG)

"…making courses as interesting as possible, hooking them in that way, making them feel that they are a prophet wanting to tell the world about it. Inspire them." (SG)

One consumer reflected on the lack of structure for dissemination in primary health care and that dissemination in this environment may rely on the personality of the professional. Another participant believed that limited dissemination was a result of 'logistical' factors and that the skills did exist in primary health care to overcome this.

4d. Remuneration of practices

Practices were paid to participate in the scheme and the principles and management of the payments were criticised by several participants. Some practices were erroneously paid and did not take part. Several participants commented on the relatively generous payment offered to practices for participation.

"Practices were given a flat rate of 700 [British] pounds plus 10 pence for every patient on their list plus full partnership [scheme for primary care CPD] membership for their practice [for one year], so it worked out quite a lot for the bigger practices." (SG)

4e. Recruitment to activities

All steering group members commented on the disappointing level of learning activity take-up.

"…if we were to do it again then in March I would do a workshop with practice managers… 'This is what we are looking at; this is why we are doing it…this is what the practice is expected to deliver.' I would expect more buy in from that point of view." (SG)

Confusion relating to the inducements for practices to join the scheme was highlighted by several participants.

"So they probably didn't realise that they [GPs] were going to get money for it, possibly, and again possibly too many people involved." (SG)

"I think with the retrospectroscope on as you know we would have explained the enhanced service in advance of getting people to sign up." (SG)

4f. Participation in steering group

Two GP participants felt that they might have been more involved in the steering group's work.

"…It would be good for people to feel that they are truly involved and not involved in a paper sense… and I think if anything came up again about the steering committee I probably wouldn't go 'cause I'm not really part of it. I am not really steering it." (SG)

Four steering group members commented on the limited time that was available for planning the project and planning more generally was highlighted for improvement.

"We probably should have spent longer in preparing for starting than we actually did. And In terms of what we did we could have prepared the practices a bit more…" (SG)

The limited planning time was evident to one steering group member when it became apparent that the format of the first component "hadn't been put into a more learning

oriented manner". Two steering group members suggested that a three-month planning period would have improved delivery. Limited planning time was seen as at least partly responsible for the inadequate preparedness of general medical practices for participation. At the project launch it became apparent that "quite a lot of the managers did not know much about it" (SG).

The limited investment in planning time was deemed unsurprising by one participant.

> "Everybody is keen to get on and make sure that the money is spent. From my observations it suffered exactly the same as every other project. Not enough of what I call front end loading, not enough preparation…" (SG)

Discussion

1. Coordinating NHS Board's role

The coordinating NHS Board office base was 64km from the delivery locality's administrative centre and this distance strained communications. Local coordination may have worked better. Communications with primary care were not always successful to the point that not all participating practices were aware of their participation! The coordinating Board may have underestimated the complexity of primary care coordination and overestimated both the sophistication of its organisation and colleagues' prioritisation of CPD. Further project communication including clarification, and perhaps repeated clarification, of expectations might have improved the extent and quality of participation.

The longer term planning of consultant physician involvement in learning facilitation was advocated along with the integration of this in physicians' yearly workload planning. The involvement of local professional networks in CPD planning may support this where the argument for the higher prioritisation of primary care education might be more compellingly made and a higher level of professional peer accountability expected. The steering group overestimated the learning facilitation skills of consultant physicians and further use of facilitative and dialogic methods would have been desirable. Several GP members of the steering group aired their negative appraisals – consistent with professional stereotyping – of consultant physicians in general; negative attitudes relating to their less direct contact with the public, relatively high level of professional power and less than desirable interest in primary care CPD. Such tensions may have detracted from the group's task and some open acknowledgment of beliefs relating to, and attitudes towards, consultant physicians in the steering group's early planning stage might have helped here. The professional disloyalty that such disclosure might be deemed to represent may have presented a barrier to this discussion, however.

2. Recruiting practitioners with greatest educational need

It appeared that the GPs in most need of CPD had not opted to participate in the project and this caused frustration among steering group members and angered a few. An unspoken steering group consensus existed on the identities of these individuals and for several members it became clear that improving this practice was an unwritten objective of the project. While both persuasive and more assertive approaches to their inclusion in future similar projects were preferred, clearer support for the latter course was evident. Incentivising participation with cash payments and locum GPs were practical suggestions offered to improve participation. However, uptake of similarly focused GP education has been found to be as low as 10% (Appleby & Lawrence 2001) and the behaviour of professional laggards is bound to frustrate CPD coordinators motivated to improve services.

3. Aspects of the planning and delivery that were conducted satisfactorily

Venue selection was praised by the steering group and workshop speakers were generally well appraised. Although the project was favourably evaluated by steering group members, many advocated an increased preparatory stage. The practical complexities of the project seem to have been underestimated somewhat, as was the motivation of general medical practices to wholeheartedly cooperate. Steering group members were divided in their reflection on the experience of membership, although most believed the group functioned effectively.

4. Aspects of the planning and delivery that might have been improved

A delay in the start of the LES would have been preferable for almost all participants to permit more planning time. The limited dissemination of learning within practices was a disappointment and with hindsight most believed that to improve this, preparation of those undertaking the CPD would have been required. Component attendance was predominantly by GPs and it may have been naive to assume that this group would have been sufficiently skilled and motivated to effect multidisciplinary education at the practice level based on their CPD learning. The steering group might also have been clearer in its expectations of dissemination, and the provision of basic information on expectations and possible mechanisms for this may have improved dissemination at little extra cost. The pecuniary advantage in participating for practices might have been emphasised to improve participation rates and dissemination; although remuneration was generous, it was not matched by GP enthusiasm.

Several participants reported that the teaching session's focus on technical skills was at the expense of a focus on interpersonal skills. This reveals a steering group and facilitator prioritisation of propositional knowledge (Taylor 1998), which may have led to the exclusion of process and personal knowledge – often associated with the user perspective – in the component learning sessions. Calman's (1998) exhortation that such primary care CPD be patient-centred and aim to integrate consumer and patient interests was not well met here where no consumer voice was evident in teaching sessions. The traditional boundaries between doctors and patients have been challenged in a review of postgraduate medical education and an expectation expressed that training systems reflect patient views and continuously improve in response to these (DH 2001). Although consumer involvement in education has been recognised in the field of mental health care preparation (Tew *et al.* 2004), no literature could be found that addressed the involvement of health care consumers or project steering group members in the evaluation of postgraduate GP training. While the UK government has acknowledged that consumers have become more involved in the organisation, planning, development and evaluation of services (DH 2000), there is little evidence of their involvement in postgraduate GP CPD.

Limitations

There is a real need for educational evaluation that goes beyond the experiences of participants, teachers and coordinators and focuses on the long-term implications for practice and health improvement. Such ambitious outcome measures could also be applied to CPD activity, including its planning and organisation. Evaluation should seek ultimately to assess the nature and extent of learning's influence on health care provision, and the complex nature of such work lends itself to action research design. The small sample used in this study limits the transferability of results; the relatively novel systematic approach to CPD adopted in the project also limits transferability.

Practice points

- Consideration to health care consumers' involvement in CPD planning through full membership of the CPD steering group should be given.

- CPD activity involving physicians as facilitators should have a one year period of forward planning.

- The management of CPD activity should be conducted as far as possible by local practitioners to promote ownership and consultant physician involvement in this process.

- A more assertive approach may be fruitful in recruiting the weakest practitioners to CPD.

- Primary care practitioners expected to disseminate training in the practice setting should themselves be trained to do so.

Acknowledgements

References

Appleby, A. and Lawrence, C. (2001) From blacklist to beacon, a case study in reducing dermatology outpatient waiting times. *Clinical and Experimental Dermatology* **26**, 548–555.

Calman, K. (1998) *A Review Of Continuing Professional Development In General Practice: A Report by the Chief Medical Officer*. London: Department of Health.

Carter, D. and Woods, K.J. (1999) Introduction of managed clinical networks within the NHS in Scotland. Edinburgh: Scottish Executive. Available at: http://www.sehd.scot.nhs.uk/mels/1999_10.htm (accessed 11 September 2013).

Colaizzi, P.F. (1978) Psychological research as the phenomenologist views it. In *Existential Phenomenological Alternatives for Psychology* (eds. R. Vall and M. King). Oxford: Oxford University Press.

Department of Health (2000) The NHS Plan: a plan for investment, a plan for reform. London: HMSO. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960 (accessed 23 October 2012).

Department of Health (2001) *Postgraduate Medical Education and Training: The Medical Education Standards Board - A Paper for Consultation*. London: Department of Health. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4021191.pdf (accessed 23 April 2012).

Department of Health (2011) *Enhanced services*. London: Department of Health. Available at: http://www.dh.gov.uk/en/Healthcare/Primarycare/PMC/Enhanced/index.htm (accessed 15 November 2011).

General Medical Council (GMC) (2004) *Guidance on CPD*. Available at: http://www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp (accessed 11 September 2013).

Hart, E. and Bond, M. (1995) *Action Research for Health and Social Care: A Guide to Practice*. Buckingham: Open University Press.

NVivo 2.0. (2002) *Qualitative data analysis programme*. Doncaster, AU: QSR International Pty.

O'Brien, M.A., Freemantle, N., Oxman, A.D., Wolf, F., Davis, D.A. and Herrin, J. (2001) *Continuing education meetings and workshops: effects on professional practice and health care outcomes*. Cochrane Database of Systematic Reviews, PubMed PMID: 11406063.

Taylor, I. (1998) *Developing Learning in Professional Education. Partnerships for Practice*, Buckingham: Open University Press.

Tew, J., Gell, C. and Foster, S. (2004) *Learning from Experience: Involving service users and carers in mental health education and training. Mental Health in Higher Education project*. Nottingham: University of Nottingham.

University of Bath (2006) *The RCGP Learning Unit Professional Development Series: Update in neurology for GPs*. Bath: University of Bath. Available at: http://www.rcgp.org.uk/gp-training-and-exams/gp-curriculum-overview/~/media/Files/GP-training-and-exams/Curriculum%20previous%20versions%20as%20at%20July%202012/RCGP-Curriculum-15-7-Neurological-Problems-2009.ashx (accessed 8 December 2013).

University of Warwick (2007) *Certificate in Diabetes Care*. Available at http://www2.warwick.ac.uk/fac/med/study/cpd/subject_index/diabetes/cidc/ (accessed 11 September 2013).